Clinical Records Policy

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Endorsing Body: Quality Planning and Professional Governance Group

Governance or Assurance Committee: Healthcare Quality Assurance and Improvement Committee

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Responsible Person: Director of NMAHP Practice Development
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# CONSULTATION AND DISTRIBUTION RECORD

| Contributing Author / Authors | • NMAHP Practice Development  
|                              | • Clinical Records Steering Group |
| Consultation Process / Stakeholders: | • Clinical Records Steering Group  
|                                    | • Quality Planning and Professional Governance Group  
|                                    | • Area Clinical Forum  
|                                    | • Medical Illustration  
|                                    | • Procurement |

| Distribution: | • NHSL Intranet: FirstPort  
|              | • Departmental Safety Huddles |

### CHANGE RECORD

<table>
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<tr>
<th>Date</th>
<th>Author</th>
<th>Change</th>
<th>Version No.</th>
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<tbody>
<tr>
<td>June 2012</td>
<td>Patricia Kent</td>
<td>Implementation Version 1</td>
<td>1</td>
</tr>
<tr>
<td>September 2013</td>
<td>Amanda Minns</td>
<td>Section 10– addition of requirement to have a summary or list of FAQ with each policy</td>
<td>1</td>
</tr>
<tr>
<td>August 2015</td>
<td>Patricia Kent</td>
<td>General update to policy and incorporation of summary</td>
<td>2</td>
</tr>
<tr>
<td>May 2018</td>
<td>Patricia Kent</td>
<td>GDPR statement added into section 3 and updated name of Data Protection Act</td>
<td>2.1</td>
</tr>
<tr>
<td>May 2019</td>
<td>Patricia Kent</td>
<td>General update to policy and extension of policy to all staff groups in NHSL</td>
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Clinical Records Policy

1. INTRODUCTION

NHS Lanarkshire is committed to the delivery of safe, effective and person centred clinical care to all its patients. Complete, timely, accurate and professional record keeping is fundamental to this. This policy provides the framework for a systematic approach to record keeping for all staff. A Clinical Records Steering Group leads and co-ordinate this work, reporting on progress through clinical governance structures: http://firstport2/staff-support/nurses-midwives-allied-health-professionals/nmahp-clinical-records/Forms/Clinical%20Records%20Steering%20Group%20Reporting%20Structure%20May%20202019.pdf.

Digital technology should be one of the key enablers to delivering excellent care. The issue is not whether it has a role to play in the delivery of healthcare services but that ‘it must be central, integral and underpin the necessary transformational change in services in order to improve outcomes’ (Scotland’s Digital Health and Care Strategy, April 2018) for the people of Lanarkshire. As technology advances there is a desire locally to seek eHealth solutions for clinical records to enable safe, person centred and effective healthcare.

2. AIM, PURPOSE AND OUTCOMES

The policy has two aims: to set out the principles for the content and format of all clinical records; to outline a single system of quality control and governance for the development, ratification, implementation and review of these records.

The purpose of this policy is to provide NHS Lanarkshire staff with clarity regarding the design, development and review of clinical records. The expected outcomes are:

- The policy will apply to any and all documents that form health records. The principles set out in the policy apply to both manual and electronic health records.
- All clinical records will be evidence based and reviewed at least every 5 years (or earlier if required) to ensure they reflect current evidence and best practice.
- All paper records will be created or updated by Medical Illustration using a standard template and are bar coded as required.
- Paper records will be supplied via the in-house printing service at Medical Illustration or via the PECOS system depending on volume required, format, colour, etc. Photocopies or local printing is only acceptable in urgent circumstances. This will ensure that only up to date versions are in use, printed double sided to save paper; thus preventing poor quality or unreadable versions and a more cost effective method of production.
- The ordering of clinical record supplies or the development of any new records should follow the NHS Lanarkshire Printing Protocol V2.0 which outlines the process for sourcing printed materials, see link: http://firstport2/staff-support/procurement/contracting-and-tendering/default.aspx?RootFolder=%2ffstaff%2dsupport%2ffprocurement%2fcontracting%2dand%2dtendering%2fDocuments%2fExternal%2fPrint%20Guidance%20inc%2e%20promotional%20materials%29&FolderCTID=&View=%7bE1DED928%2dD108%2d473E%2dA2B0%2d49B36FAB95BF%7d
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- All clinical records will be listed and reported as required by each department/service.
- Where appropriate, records will be standardised across departments/specialties/hospitals in NHS Lanarkshire and with partner agencies where joint working arrangements are in place, and only the most current version of any record will be available for use.

3. SCOPE

3.1 Who is the Policy intended to Benefit or Affect?

This policy on clinical records will be of benefit to:
- Patients, public and partners through the recording of person centred, safe, effective care.
- All NHS Lanarkshire registered practitioners, healthcare assistants and students.
- Staff involved in the development of clinical records.
- The wider NHS Lanarkshire and partner agencies.

3.2 Who are the Stakeholders?

The stakeholders are all directly employed NHS Lanarkshire staff and all patients.

"NHS Lanarkshire take care to ensure your personal information is only accessible to authorised people. Our staff have a legal and contractual duty to keep personal health information secure, and confidential. In order to find out more about current data protection legislation and how we process your information, please visit the Data Protection Notice on our website at www.nhslanarkshire.scot.nhs.uk or ask a member of staff for a copy of our Data Protection Notice."

4. PRINCIPAL CONTENT

It is important that all clinical records are designed to support the recording of safe, effective, person centred care. These must also comply with local, national, professional and legal requirements. Clinical records must support practitioners to evidence the care and communication undertaken with patients (and relatives and carers where appropriate) in line with their requirements from professional regulatory bodies.
Attributes of high quality record design and record keeping:

- Clear
- Concise
- Complete
- Correct
- Consecutive
- Contemporary
- Confidential
- Person Centred
- Collaborative
- Comprehensive

Clinical records must be able to demonstrate:

- A full assessment of the person, the care and treatment planned, implemented and evidence of evaluation,
- Relevant information in relation to the person’s condition at any given time and the interventions and actions taken to achieve identified health therapy outcomes and/or respond to actual or potential adverse events,
- Evidence that all reasonable decisions and actions to provide the highest quality of care have been taken,
- Completed with the involvement of the person and relatives/carers (where appropriate) and,
- A record of all communications by those involved with the delivery of that care with the patient, e.g. relatives, carers, other professions, services and agencies is maintained.

4.1 Guiding Principle 1: Safe

Registered practitioners are obliged by their regulatory bodies to record care in keeping with legal and professional guidance and standards, e.g. Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC), General Medical Council (GMC), General Pharmaceutical Council (GPhC). The following aspects are highlighted within legal and professional standards:

- A clear, concise, complete record of clinical care (including assessment, plan of action, outcomes and evaluation of care), which is representative and reflective of professional observations and avoids duplication.
- Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the record have all the information they need.
- Records need to demonstrate open, honest and supportive care interventions and may be used within a Duty of Candour procedure.
- Complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.
- Ensure that records completed by healthcare assistants or students under your supervision are clearly written, accurate and appropriate.
- Complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event. If there is no medical entry in the notes for more than 4 days (acute) or 7 days (long-stay continuing care), the next entry should explain why.
Clinical Records Policy

- a single chronological record for each episode of care/treatment to present a clear picture and sequence of care/interventions provided and events over time.
- identify the source of information (including information provided by another health care professional or provider).
- paper based records must be clearly written and easy to read, and you should write, sign and date/time all entries.
- ensure records do not include unnecessary abbreviations, jargon or speculation.
- avoid transcription of data which potentially increases the risk of error.
- records should be easily reviewed over time and after significant time has elapsed.
- detail information in relation to critical incidents such as patient falls, harm to patients or medication errors (as well as completing any other documentation/electronic recording as per NHS Lanarkshire policies and procedures for such incidents).

4.2 Guiding Principle 2: Effective

Record keeping systems (including electronic) should ensure and maintain patient confidentiality in all care settings, appropriate to the requirements of the service, including:

- protect information in records from being lost, damaged, accessed by someone without appropriate authority or tampered with.
- develop and implement practices that protect confidentiality of information and data.
- keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection legislation requirements.
- confidential storage and archival of records.
- systems and practice are in place that maximise the confidentiality of documentation and records in diverse settings.
- systems for gaining consent to share information should be explicit and ensure that only relevant information is shared with relevant others.
- before agreeing to communicate with the patient or their carer(s) via email or text, the risks must be discussed with them and a disclaimer/consent signed.
- patient records are secure from unauthorised access, loss or theft during transfer, transmission (electronic transfer) or transportation.
- those accessing (or seeking to access) documentation have the authority to do so and that electronic documentation systems are used in accordance with relevant NHS Lanarkshire policies and procedures.
- copyright licence policy is adhered to and permissions sought as required.
- records are readable, including faxes where appropriate.
- records are used, managed, stored and/or destroyed appropriately.
- clinical records are disposed of (where appropriate to destroy) in a manner which maintains confidentiality and in accordance with local policies and procedures.
- clinical records are audited by and results actioned upon by relevant clinical groups at least annually to ensure compliance with professional and NHS Lanarkshire standards.

4.3 Guiding Principle 3: Person Centred

Records are person centred, collaborative and appropriate to the setting in which the care is provided and the purpose for which the information is recorded. This includes:
Clinical Records Policy

- record systems and practices appropriate to the specific needs of the person/patient population and care context.
- all sections of clinical records are completed. On paper records, if they are not applicable they should be struck through with a single line and marked ‘not applicable’. Electronic records must be completed according to the relevant standard operating procedure and/or service specific guidance.
- demonstrate the ability to accurately process all information gathered during the assessment process to identify needs for individualised care and develop person centred, evidence based plans for interventions with agreed goals.
- document informed consent of any clinician proposed intervention or operation.
- appropriate systems to support shared documentation processes and according to joint working agreements and protocols.
- a record of independent and collaborative actions with other health professionals or care providers, e.g. those ordered by another appropriate health professional.
- contemporary, secure and resource efficient record systems.
- systems relevant to the setting in which the care/treatment intervention occurs, including patient held records, electronic records and mobile record systems.
- identify objective and subjective data in recording assessment of the person’s needs/health status.
- records should not reflect value judgements about a patient, their behaviour or circumstances.
- reflect dignity and respect for the person, their significant support network and other members of the health care team to meet NHS Lanarkshire organisational values.
- record the clinical actions, any information given and the person’s response to illness and the care/therapy that they receive, including declining treatment.
- identify problems that have arisen and actions taken to rectify/address.
- record with a frequency consistent with professional judgement in relation to complexity/stability of the person, organisational policy, standards and legislation.
- enable access to relevant previous/other records, including patient history, long and short term interventions, diagnostic interventions and most recent previous records by other clinical staff.
- document any intervention via telephone, teleconference and other electronic or communication technology, including information obtained and advice given.

4.4 Clinical Records System

All paper based and electronic clinical records used by registered practitioners, healthcare assistants and students will be developed and managed through the Clinical Records Steering Group, Sub-Groups and/or eHealth Services. Components of the system include:

- only clinical records which have gone through the required procurement process can be used.
- use of a standard template for formatting paper documents.
- all records to include the patient’s name and identification number on every page.
- records are additionally bar coded as required for access via the clinical portal.
- each department/service lists their clinical records and reports as required to the Clinical Records Steering Group.
Clinical Records Policy

- a database on FirstPort enables staff to view and access printing details for all clinical records that have been updated. See link: http://firstport2/staff-support/nurses-midwives-allied-health-professionals/nmahp-clinical-records/Documents/Forms/AllItems.aspx

5. ROLES AND RESPONSIBILITIES

- **Executive Director for NMAHPs** is the named executive lead for clinical records in NHS Lanarkshire and is responsible for ensuring that appropriate governance arrangements are in place and are monitored, reviewed and reported within the organisational management and governance systems.
- **Clinical Records Steering Group** is responsible for the development, ratification, implementation, monitoring and review of the policy as per NHS Lanarkshire Policy on Developing Organisational Policies (NHS Lanarkshire, April 2015).
- **Registered practitioners, healthcare assistants and students** are responsible for complying with this policy; raising and escalating any concerns in respect of the policy and ensuring that records are completed in accordance with legal, professional and organisational standards.

6. RESOURCE IMPLICATIONS

a) Staff:
- oversight by the Clinical Records Steering Group and ongoing support by Sub-Groups for management of clinical records.
- ongoing input by NMAHP Practice Development, Medical Illustration and Procurement.

b) Financial:
The programme of work and governance for the review, development, monitoring and cataloguing of clinical records requires additional resource primarily from NMAHP Practice Development and Medical Illustration. In addition to clinical staff time to inform the content of records the following resource is required:
- ongoing Quality Directorate resource to assure effectiveness of application of clinical records policy.
- ongoing resource for the effective management of clinical record resources, i.e. removal of obsolete records and appropriate and timely ordering to meet demand.

c) Education/Training/Awareness:
- staff development to increase awareness and understanding relating to the implementation of new or revised clinical records.

d) Environmental Impact:
- ongoing work to meet the corporate objectives in relating to meeting environmental targets by reduction in paper-based records.
7. COMMUNICATION PLAN

The policy will be ratified by the Clinical Records Steering Group and launched in August 2018. This will be communicated through:

- Staff Brief
- Pulse Newspaper
- NHS Lanarkshire Intranet (FirstPort)
- Departmental communication channels.

8. QUALITY IMPROVEMENT – Monitoring and Review

This policy will be reviewed in three years’ time or sooner if needed. An article will appear in the staff brief in advance of the review date advising that the policy is coming up for review in order to give staff the opportunity to comment.

9. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

This policy meets NHS Lanarkshire’s EDIA (tick box)
Clinical Records Policy

10. Summary or Frequently Asked Questions (FAQs)

Clinical Records Policy 2019: Summary/Frequently asked Questions

NHS Lanarkshire has a framework for a systematic approach to record keeping for all staff. The policy has two aims:

- to set out the principles for the content and format of clinical records (paper or electronic) which reflect professional standards and personal accountability; caring and compassionate practice; values and best practice.
- to outline a single system of quality control and governance for the development, ratification, implementation and review of these records.

Clinical Records must be able to demonstrate:

- a full assessment of the person, the care and treatment planned, implemented and evidence of evaluation,
- relevant information in relation to the person’s condition at any given time and the interventions and actions taken to achieve identified health/therapy outcomes and/or respond to actual or potential adverse events,
- evidence that all reasonable decisions and actions to provide the highest quality of care have been taken,
- completed with the involvement of the person and relatives/carers (where appropriate) and,
- a record of all communications by those involved in the delivery of that care with the patient, e.g. relatives, carers, other professions, services and agencies is maintained.

Guiding Principles

1. Safe – Registered practitioners are obliged by their regulatory bodies to record care in keeping with legal and professional guidance and standards, e.g. Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC), General Medical Council (GMC), General Pharmaceutical Council (GPhC).
2. Effective – Record keeping systems (including electronic) should ensure and maintain patient confidentiality in all care settings, appropriate to the requirements of the service.
3. Person Centred – Records are person centred, collaborative and appropriate to the setting in which the care is provided and the purpose for which the information is recorded.

Policy Highlights

- All new clinical records require agreement from department/service to proceed and must go through the required procurement process before use.
- All clinical records will be evidence based and reviewed at least every five years (or sooner if required) to ensure they reflect current evidence and best practice.
- All paper records must be created or updated by Medical Illustration using a standard template and are bar coded as required.
- Paper records to be supplied via the in-house printing service at Medical Illustration or via the PECOS system depending on volume required, format, colour, etc. Photocopies or local printing is only acceptable in urgent circumstances.
- All new and updated clinical records will be produced with a view to incorporating them into any electronic systems which may be available now or in the future and will be standardised across areas where appropriate.
- All clinical records must be listed and reported as required by each department/service.
11. REFERENCES

1. Copyright Policy, NHS Lanarkshire, February 2017
2. Duty of Candour Factsheets for staff working in health and social care in Scotland, NHS Education for Scotland, 2018
3. Future Nurse: Standards of proficiency for registered nurses, Nursing and Midwifery Council (NMC), 17th May 2018
5. Good Practice Guide to Written Communication, NHS Lanarkshire May 2013
10. Policy on recordings (photography and video) for clinical and service use, Medical Illustration Network Scotland (MINS), November 2016
12. Retraction of Sites, Policy for the safe and effective removal of data, NHS Lanarkshire, August 2010