CLINICAL RECORD KEEPING STANDARDS POLICY – for hand-written records only

POLICY

Reference	CPG-TW-CRKSP		
Approving Body	Medical Records Advisory Group		
Date Approved	28th April 2023		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
Issue Date	30th June 2023		
Version	9.0		
Summary of Changes from Previous Version	• Title changed to clarify this policy is for hand-written records only • Evidence base/ references checked and updated as necessary • No changes in practice		
Supersedes	v8.0, Issued 29th December 2017 to Review Date July 2023 (ext9)		
Document Category	• Clinical		
Consultation Undertaken	• Members of the Medical Records Advisory Group (which includes representation from Improvement and Audit Team; Practice Development and CSTO Deputy DGM)		
Date of Completion of Equality Impact Assessment	17th March 2023		
Date of Environmental Impact Assessment (if applicable)	Not Applicable		
Legal and/or Accreditation Implications	• NHSLA Risk Management Standards • Care Quality Commission regulation and monitoring • Information Governance Framework Toolkit		
Target Audience	Trustwide		
Review Date	April 2026		
Sponsor (Position)	Caldicott Guardian		
Author (Position & Name)	Dr Zahid Noor, Chairman Medical Records Advisory Group		
Lead Division/ Directorate	Medicine		
Lead Specialty/ Service/ Department	*Medicine Divisional Management Team		
Position of Person able to provide Further Guidance/Information	Dr Zahid Noor, Chairman Medical Records Advisory Group		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Not Applicable	Not Applicable
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

1.1 The Trust's clinical records are important sources of administrative, evidential and historical information. They are vital to the Trust to support patient care and treatment and for purposes of accountability. Trust records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision making, protect the interests of the Trust and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver services in consistent and equitable ways.

1.2 This policy is issued and maintained by the Trust Caldicott Guardian, at the issue defined on the front sheet which supersedes and replaces all previous versions.

2.0 POLICY STATEMENT

2.1 The ***Clinical Record Keeping Standards Policy – for hand-written records only*** provides clear guidance for all clinical staff on the core generic standards of professional practice relating to hand-written record keeping. It is also expected that all staff will adhere to recommended professional and Trust standards for hand-written clinical record keeping.

2.2 This policy should be read in conjunction with the other Trust policies, as listed in section 10 (related SFHFT documents).

2.3 Adherence to this policy helps the Trust achieve the recommended standards for compliance with NHSLA Risk Management Standards, Care Quality Commission regulation and monitoring and the Information Governance Framework Toolkit.

2.4 This clinical document applies to:

2.4.1 Staff group(s)

- All healthcare professionals in the Trust (e.g. doctors, nurses, allied health professionals etc).

2.4.2 Clinical area(s)

- All clinical areas – King's Mill Hospital, Newark Hospital, Mansfield Community Hospital. This also includes practitioners visiting patients outside of the Trust premises.

2.4.3 Patient group(s)

- All adult patients and all paediatric patients

2.4.4 Exclusions

- Maternity – Clinical record keeping standards for maternity records are covered by the following separate policy "Maternity Records Policy"

3.0 DEFINITIONS/ ABBREVIATIONS

The Trust	means the Sherwood Forest Hospitals NHS Foundation Trust
Records	are defined as 'recorded information, in any form, created or received and maintained by the Trust in the transaction of its business or conduct of affairs and kept as evidence of such activity' (ISO15489-1, 2016)
Health record	means a record which – a) 'consists of data concerning health, and b) has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates' (Data Protection Act, 2018, Chpt 12)
Core generic hand-written record keeping standards	are the requirements for all healthcare professionals to adhere to in the achievement of effective safe record keeping and documentation of clinical care.
Rough notes or process notes	are those annotations that are made outside the case notes with the intention of transferring the information in formally at a later time. Examples might include hasty scribbles made on scraps of paper during an emergency episode, or when a patient unexpectedly volunteers information, or when information is gathered outside a standard healthcare setting (perhaps in the community or other location that is not a ward or clinic).

4.0 ROLES AND RESPONSIBILITIES

All healthcare professionals are responsible for –

- complying with the core generic hand-written standards for clinical record keeping
- adhering to the additional standards as specified by their regulatory body (e.g. operation notes for surgeons)
- participating in clinical record keeping audits as specified by professional Code of Conducts and/ or Local Trust Policy.

Chief Executive

Chief Executive has overall responsibility for clinical records management and is responsible for the management of the organisation and for ensuring that appropriate mechanisms are in place to support service delivery and continuity of patient care. The Trust has particular responsibility for ensuring that it corporately meets its legal responsibilities and for the adoption of internal and external governance requirements.

Caldicott Guardian

The Caldicott Guardian has responsibility for approving and ensuring that national and local guidelines and protocols for the handling and management of confidential personal information are in place.

Divisional Management Teams

- Will ensure that the professionals in their division adhere to the policy
- Will monitor the implementation of hand written clinical record keeping audits, action plans and will report progress via the Clinical Governance structures as outlined in section 8 of this policy.

5.0 APPROVAL

Following consultation, this policy (v9.0) was approved by the Trust's Medical Records Advisory Group.

6.0 DOCUMENT REQUIREMENTS

6.1 Information

Accurate, high quality record-keeping is an integral part of Medical, Surgical, Nursing, Midwifery and Allied Health Professionals' practice and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow. The approach to record keeping that courts of law adopt tends to be that 'if it is not recorded, it has not been done'. Good record keeping helps to improve accountability and shows how decisions related to patient care were made.

Records include anything that makes reference to the care of the patient. Clinical record keeping provides a continuous record of each patient's hospital attendance and treatment and plays a vital role in delivering health care.

Failure to record information accurately in patients' health records can have serious consequences for patients and their relatives. These failures may result in reduced quality of care and litigation. Poor record keeping is a major factor in litigation cases brought against Trusts. This in turn hinders the defence of defensible cases.

Good record keeping helps to protect the welfare of patients by promoting:

- High standards of clinical care
- Continuity of care
- Better communication and dissemination of information between members of the multi-professional health care team
- An accurate account of treatment, care planning and delivery
- The ability to detect problems, such as changes in the patient's condition, at an early stage.

Good record keeping also enables professionals:

- To meet legal and professional statutory requirements
- To protect staff in legal situations

Any hand-written record can also be called as evidence as follows:

- in the event of litigation
- to aid the management of complaints, incidents and investigations
- for Inquest and Criminal Justice cases.

Accurate information is essential for the care of patients and the effective management of the Trust. If record keeping standards are not adhered to, then the healthcare professional and the Trust will be exposed to risk. All patient contacts should be recorded legibly, accurately and contemporaneously. Each patient should be identified and the notes should set out diagnosis, history, treatment, results and care plans in a format that promotes continuity of care. Records are also used for teaching, research and clinical audit.

Some of the following sections have been included in a two page Quick Reference Guide for staff, see Appendix A – Clinical Record Keeping Standards (hand-written) – Quick Reference Guide for healthcare professionals.

6.2 The core generic standards of hand-written record keeping expected by the Trust are:

1. The front sheet of every page, booklet, chart and any single pages must include, as a minimum, **two** patient identifiers e.g. full name, NHS/ District Number, date of birth. Special cases to be aware of are: Genitourinary Medicine may use anonymised identifiers such as clinic number and date of birth, but **two** identifiers must always be used; and the Emergency Department may use an emergency District number / dummy date of birth for unconscious and unidentified patients.

2. With the exception of the above special cases, the unique NHS number should always be present on any patient documents, as per the NPSA notice NPSA / 2008 / SPN 001. Use of 'addressograph labels' is the easiest way to achieve this, but always check the sticky labels are the right ones for your patient.

3. All entries in the clinical record should be legible.

4. All entries in the clinical record should be dated, timed and signed.

5. All records must be written in black or dark blue permanent ink (see exceptions in section 5.3.5 below)

6. The name and designation of the person making the entry should also be legibly printed against their signature. For doctors, their regulatory body requires every entry to have their printed name and signature, nurses only need to print name and designation by the first entry (or document in the relevant signature bank) and sign thereafter. For Allied Health Professionals standards are the same as doctors.

7. All entries in inpatients records must reflect the continuum of patient care and will have the date and time recorded in **24 hour clock** format. Patient records in outpatients setting do need the date recording but do not need to have the time annotated. The entries should be in real time and chronological order and be recorded as close to the actual time as possible. If there is a delay the time of the event and the delay should be recorded with the entry commencing with *"Written in retrospect for ……..".*

8. Records should be accurate and recorded in such a way that the meaning is clear.

9. Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases, irrelevant speculation and should never include coded expressions of sarcasm or humorous abbreviations to describe the people in your care in any circumstances.

10. Health care professionals must record details of any assessments, reviews undertaken, significant interventions, treatments, conversations and provide clear evidence of the arrangements/plans which have been made for the future and ongoing care of the patient. This should also include details of written and verbal information given to patients and relatives about care and treatment.

11. Records should identify any risks or problems that have arisen and show the action taken to deal with them.

12. Supervised staff should sign, print and date their annotations, along with a note of their status (eg student nurse). Such entries should be countersigned by their supervising

qualified professional for that day. Staff acting as supervisors must be aware that such entries should meet all professional standards as they can be held accountable for such records. Where locally agreed, some non-registered staff (eg therapy assistants/ healthcare assistants) may record entries in a patient's notes and they do not need to be countersigned.

13. Staff must not alter or destroy any records without being authorised to do so.

14. Aide memoires, rough/ process notes and handover sheets do not need to be filed within individual patient records but must be destroyed/ placed in confidential waste bins for shredding (green bags) immediately as the staff member leaves work.

    However, the rough/ process notes must be kept in the following circumstances:
    - If the transcription took place more than 24-hours after the assessment or appointment
    - If the rough/process note contained any information that might be needed in court, or in criminal proceedings for example if there was reference to an assault or other criminal activity having taken place.
    - If the rough/process note contained any information related to child protection or protection of vulnerable adults
    - If the rough/process note relates to a Serious Incident
    - If the rough note is being retained it must be placed in the patient's notes in a file envelope which must be secured in the page the transcription of the event has been made. The transcription must refer to the retention of the rough/process note. The envelope containing the rough note must be clearly marked with the details of what is in the envelope, the date and time the note was made and the signature of the staff member who made the rough/process note.
    - This follows guidance from the Nursing and Midwifery Council and the General Medical Council.

6.3 Additional standards for hand-written records for specific professions

1. For doctors, every entry in the medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made.

2. For doctors, an entry should be made in the medical record whenever a patient is seen by a doctor.

3. For doctors treating adult patients – when there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why.

4. For doctors treating paediatric patients – all paediatric admissions should be reviewed by a registrar within 4 hours of admission and be documented; for children staying longer than 24 hours they should be seen within 24 hours by a paediatric consultant and be documented; all paediatric admissions should have a daily ward round review and be documented.

5. All records must be written in black or dark blue permanent ink with the exception of:
    - Pharmacist signature on prescriptions and annotations on drug cards need to be made in **green ink** in line with the Trust's Medicine Policy

- Operation notes and other key procedures **must** be readily identifiable. They must be recorded by one of the following means:
  - Written in **red ink** in the specialty medical narrative;
  - Typed and secured in the medical narrative
  - Filed behind the 'operation records' tab of the medical notes (along with the relevant consent form, anaesthetic record and other theatre related paperwork)
- Abnormal results in Genitourinary Medicine **will** be written in **red ink**

6. Other local exceptions may be written in other colours as agreed via the Medical Records Advisory Group. As variations are agreed, the policy will be amended.

7. For test results, the requesting team must initial and date the report, and may also consider annotating detail on the report to indicate the result has been seen (and appropriately acted upon).

8. For nursing documentation, an entry must be made in the evaluation of care record at least twice during the day between 0800 and 2000 hrs, and at least once overnight between 2000 hrs and 0800 hrs. The exception to this is rehabilitation areas, where it is acceptable for only one entry to be made during these times. Untoward events in all areas should be recorded as soon as possible, rather than waiting for end of shift.

9. For all staff, including Administrative staff eg Patient Pathway Co-ordinators, if they have conversations with patients directly or by phone it is encouraged to record such events and file a record of this in the Medical Annotations or Correspondence section. Use of the EPRO function under "Notes" and "Telephone" is highly recommended to record such activity.

6.4 Process for dealing with hand-written deletions, alterations and amendments

1. In the event that a staff member needs to delete or alter their own or another healthcare professional's records they must print their name and job title, and sign and date the original entry. If amending/ making a new entry, they must print their name, job title, and sign and date/ time (24hrs clock) the revised/ new entry. This will ensure that the alterations they make, and the original record, are clear and auditable. All deletions should be struck through with one line to ensure legibility.

2. It is expected that when a clinical record keeping alteration is found which does not meet the above standards, that the staff member who finds it will take proportionate action with regards the amendment. Falsifying or deleting records without authorisation should always be treated as an incident as per the Trust's Incident Reporting Policy with the potential for disciplinary action.

6.5 Additional information

1. Professional judgement should be used to decide what is relevant and what should be recorded.

2. Staff must not falsify records.

3. Advance decisions, consent and resuscitation status statements must be clearly recorded in the medical records. Full details for this documentation can be found in the relevant policies.

6.6 Good record keeping standards for the safe, effective care of patients are endorsed and supported by:

1. Nursing and Midwifery Council (NMC)

2. The Chartered Society of Physiotherapy (CSP)

3. Royal College of Occupational Therapists

4. The Society of Radiographers

5. **Academy of Medical Royal Colleges** (including Royal College of Anaesthetists, College of Emergency Medicine, Faculty of Dental Surgery, Royal College of General Practitioners, Royal College of Obstetricians and Gynaecologists, Faculty of Occupational Medicine, Royal College of Ophthalmologists, Royal College of Paediatrics & Child Health, Royal College of Pathologists, Faculty of Pharmaceutical Medicine, Royal College of Physicians of Edinburgh, Royal College Physicians of Ireland, Royal College of Physicians of London, Royal College of Physicians & Surgeons of Glasgow, Royal College of Psychiatrists, Faculty of Public Health, Royal College of Radiologists, Royal College of Surgeons of Edinburgh, Royal College of Surgeons of England, Royal College of Surgeons of Ireland)

6. **The Health and Care Professions Council (HCPC)** (including Arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, speech and language therapists, social workers)

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

No.	Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
1	The Medical Health Record Keeping Audit (which is hosted on the AMaT system) record the elements which will be audited and focus on: • legibility; • attributability; and • timeliness of entries.	Each Specialty (via their respective Specialty Clinical Governance Lead / Specialty Clinical Audit Lead / Divisional Quality Governance Lead)	Audit of compliance and participation using a minimum of 20 sets of notes every 6 months. Target compliance is: 89% • Red = 0-84% • Amber = 85-88% • Green = 89% or more Within the quality section of the divisional performance dashboard	every 6 months monthly	Results viewed/ discussed via Specialty Clinical Governance meetings and if there are any non-compliance and/ or non-participation issues these should be included in the monthly specialty highlight/ exception report to their respective Divisional clinical governance group Divisional Performance Meetings
2	That monthly audits for record keeping are undertaken by their respective specialties	Each Division (via Divisional Clinical Governance Lead)	Receipt of highlight/ exception reports where there are issues of non-compliance and/ or non-participation via the Specialty Clinical Governance Lead/ Specialty Clinical Audit Lead	monthly	Highlight/ Exception reports viewed/ discussed via Divisional Clinical Governance meetings and if there are any non-compliance and/ or non-participation issues these should be included in the monthly divisional highlight/ exception report to Patient Safety Committee

No.	Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
3	Elements identified in the **Nursing** Health Record Keeping Audit hosted via the AMaT System	Matrons Corporate Practice Development Matron Corporate Matron	Performance review meeting with Ward/ Department Leaders Dashboard Audit	Monthly Monthly Annual	Corporate Matron Nursing, Midwifery and AHP Committee An annual report for the Nursing Health Record Keeping Audit will be submitted by the Corporate Matron to the Documentation Group/ Nursing Midwifery and AHP Committee
4	Incidents related to record keeping	All staff / CSTO Deputy General Manager	Anyone can raise a record keeping incident via Datix as and when one is identified which will in-turn be aligned/ categorised for a monthly report pulled by the Datix System Manager and sent to the CSTO Deputy General Manager for onwards submission to the Medical Records Advisory Group	monthly	Medical Records Advisory Group

1. Specialties are responsible for reviewing and disseminating their own results, instigating actions/ action plans where appropriate and reporting improved/ good practice within their specialties and through the divisional governance/ committee structures.
2. Divisional Clinical Governance teams should ensure audits of health records are carried out as above by each specialty and also raise any concerns regarding non-submission of data and/ or declining performance or lack of action to improve performance.
3. The current electronic data collection tools are hosted via the AMaT system.
4. Outside of this monthly audit, ad hoc profession and type specific audits of record keeping can be instigated as and when necessary to help improve practice.
5. It is anticipated that the most intensive scrutiny of health records is undertaken when things have not gone well. It is entirely appropriate for those involved with or aware of a concern/ issue regarding record keeping, to report directly to the Medical Records Advisory Group. Incidents reported via the Datix System will also be reviewed by the Medical Records Advisory Group.

8.0 TRAINING AND IMPLEMENTATION

Training in clinical record keeping standards within the Trust is identified for:

- Junior Doctors as part of their teaching programmes; and
- Nursing Staff and Healthcare Assistants as part of their local (ward) induction.

New members of Pharmacy staff undertake clinical record keeping training as part of their local induction.

Newly qualified Therapy Staff (Band 5 Physiotherapists, Occupational Therapists and Orthotists) will undertake clinical record keeping training as part of their Preceptorship Programme. All other staff will receive clinical record keeping training as part of their local induction.

If and when clinical record keeping standards change, the relevant information will be electronically communicated via the earliest weekly Trust staff bulletin and/ or other agreed communication method to all staff (substantive and new).

Information from sections 6.2, 6.3 and 6.4 is contained within the ***Clinical record keeping standards (hand-written) – Quick Reference Guide for healthcare professionals*** which is a two page resource available for staff at Appendix A

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix B
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

The evidence base to justify the need for high standards of record keeping is contained within a number of documents:

Evidence base for core generic standards

- General Medical Council (March 2013). *Good Medical Practice*. GMC, London.
- Health Professions Council (2016) *Standards for conduct, performance and ethics*. HPC, London
- Nursing and Midwifery Council (March 2015, updated Oct 2018) The Code – professional standards of practice and behaviour for nurses, midwives and nursing associates. NMC, London.
- Nursing and Midwifery Council (July 2009) Record keeping: guidance for nurses and midwives. NMC. London.
- Royal College of Physicians (June 2015) Generic medical record keeping standards. RCP. London.
- Royal College of Paediatrics and Child Health (Revised 2015) *Facing the Future: Standards for Acute General Paediatric Services.* RCPCH.

Evidence base for general health record keeping advice and professional conduct

- Audit Commission (1999) Setting the Record Straight: A Review of Progress in Health Records Services.
- Care Quality Commission (March 2010): Essential standards of quality and safety – Outcome 2: Records

- Data Protection Act 1988, 1998 and 2018
- Department of Health (2000). An Organisation with a Memory. Report of an Expert Group on Learning from Adverse Events in the NHS, Department of Health, London
- Department of Health (March 2006). *Records Management: NHS Code of Practice – Part 1*, Department of Health, London.
- Department of Health (Jan 2009). *Records Management: NHS Code of Practice – Part 2, Edition 2*, Department of Health, London.
- International Organisation for Standardisation (ISO) (ed 2.0, April 2016) International Standards on Records Management ISO 15489-1 (last reviewed and confirmed in 2021)
- NHS Litigation Authority (2013-14). *Risk Management Standards (Standard 1 (Governance), criterion 8 (health record-keeping standards)*
- NHSx (Aug 2021) Records Management Code of Practice – A guide to the management of health and care records
- NHSx (Sept 2021) Information Governance Framework for Integrated Health and Social Care: Shared Care Records
- NPSA (2008) National Patient Safety Agency Safer Practice Notice Risk to patient safety of not using the NHS Number as the national identifier for all patients (Safer Practice Notice NPSA/2008/SPN001) 2008

Related SFHFT Documents:

This Policy is limited to record keeping standards. There are other policies and standards that relate more generally to the management of records in the Trust. These are:

- Cardiopulmonary Resuscitation Policy
- Consent to examination, treatment and care policy
- Health Records Management Policy
- Incident Reporting Policy
- Medicines Policy
- ReSPECT Policy
- Retention and Destruction of Records Policy

11.0 KEYWORDS

Medical, Records, Document, Documentation, Note, Notes, Write, Writing, Case, Health, Patient, patients, Quick Reference Guide, QRG, staff, CRKS

12.0 APPENDICES

Appendix A – Clinical Record Keeping Standards (hand-written) – Quick Reference Guide for healthcare professionals

Appendix B – Equality Impact Assessment (EIA) Form

Clinical Record Keeping Standards (hand-written) –
Quick Reference Guide for healthcare professionals

To be read in conjunction with the trust's *Clinical Record Keeping Standards Policy*

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1. The front sheet of every page, booklet, chart and any single pages must include, as a minimum, **two** patient identifiers e.g. full name, NHS/ District Number, date of birth. Special cases to be aware of are: Genitourinary Medicine may use anonymised identifiers such as clinic number and date of birth, but **two** identifiers must always be used; and the Emergency Department may use an emergency District number / dummy date of birth for unconscious and unidentified patients.

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4. All entries in the clinical record should be dated, timed and signed.

5. All records must be written in black or dark blue permanent ink (see point 5 of section below for exceptions)

6. The name and designation of the person making the entry should also be legibly printed against their signature. For doctors, their regulatory body requires every entry to have their printed name and signature, nurses only need to print name and designation by the first entry (or document in the relevant signature bank) and sign thereafter. For Allied Health Professionals standards are the same as doctors.

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- Pharmacist signature on prescriptions and annotations on drug cards need to be made in **green ink** in line with the Trust's Medicine Policy
- Operation notes and other key procedures **must** be readily identifiable. They must be recorded by one of the following means:
  - Written in **red ink** in the specialty medical narrative;
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  - Filed behind the 'operation records' tab of the medical notes (along with the relevant consent form, anaesthetic record and other theatre related paperwork)
- Abnormal results in Genitourinary Medicine **will** be written in **red ink**

16. Other local exceptions may be written in other colours as agreed via the Medical Records Advisory Group. As variations are agreed, the policy will be amended.

17. For test results, the requesting team must initial and date the report, and may also consider annotating detail on the report to indicate the result has been seen (and appropriately acted upon).

18. For nursing documentation, an entry must be made in the evaluation of care record at least twice during the day between 0800 and 2000 hrs, and at least once overnight between 2000 hrs and 0800 hrs. The exception to this is rehabilitation areas, where it is acceptable for only one entry to be made during these times. Untoward events in all areas should be recorded as soon as possible, rather than waiting for end of shift.

19. For all staff, including Administrative staff eg Patient Pathway Co-ordinators, if they have conversations with patients directly or by phone it is encouraged to record such events and file a record of this in the Medical Annotations or Correspondence section. Use of the EPRO function under "Notes" and "Telephone" is highly recommended to record such activity.

Process for dealing with hand-written deletions, alterations and amendments

20. In the event that a staff member needs to delete or alter their own or another healthcare professional's records they must print their name and job title, and sign and date the original entry. If amending/ making a new entry, they must print their name, job title, and sign and date/ time (24hrs clock) the revised/ new entry. This will ensure that the alterations they make, and the original record, are clear and auditable. All deletions should be struck through with one line to ensure legibility.

21. It is expected that when a clinical record keeping alteration is found which does not meet the above standards, that the staff member who finds it will take proportionate action with regards the amendment. Falsifying or deleting records without authorisation should always be treated as an incident as per the Trust's Incident Reporting Policy with the potential for disciplinary action.

Additional information

22. Professional judgement should be used to decide what is relevant and what should be recorded.

23. Staff must not falsify records.

24. Advance decisions, consent and resuscitation status statements must be clearly recorded in the medical records. Full details for this documentation can be found in the relevant policies.

APPENDIX B – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Clinical Record Keeping Standards Policy – for hand-written records only			
New or existing service/policy/procedure: Existing policy			
Date of Assessment: 17/03/2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	None	None
Gender:	None	None	None
Age:	None	None	None
Religion:	None	None	None
Disability:	None	None	None
Sexuality:	None	None	None
Pregnancy and Maternity:	None	None	None
Gender Reassignment:	None	None	None
Marriage and Civil Partnership:	None	None	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	None	None

What consultation with protected characteristic groups including patient groups have you carried out? • None
What data or information did you use in support of this EqIA? • Information from within the policy
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • None known

Level of impact
From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Dr Zahid Noor, Policy Author
Signature:
Date: 17/03/2023