BELMATT
HEALTHCARE TRAINING

Documentation and Recordkeeping

Learning outcomes

This session will develop your knowledge and skills in:

- Understand the importance of documentation
- Documenting in a structured logical manner
- Importance of communication and documentation
- Consent and documentation
- Ethical and Legal issues

What is a health record

- There are a couple of definitions of a record, which are useful to highlight. The ISO standard ISO 15489-1:2016 defines a record as:
- "Information created, received, and maintained as evidence and as an asset by an organisation or person, in pursuance of legal obligations or in the transaction of business."
- Section 205 of the Data Protection Act 2018 defines a health record as a record which:
- consists of data concerning health
- 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.

Scope of Records covered by the code

- Records of patients treated by NHS organisations
- records of patients treated on behalf of the NHS in the private healthcare sector
- records of private patients treated on NHS premises
- records created by providers contracted to deliver NHS services (for example, GP services)
- adult service user records who receive social care support
- jointly held records
- records held as part of a Shared Care Records programme
- records held by local authorities such as public health records, contraceptive and sexual health service records
- staff records
- complaints records
- corporate records - administrative records relating to all functions of the organisation

Public Records Act 1958

- The Public Records Act 1958 is the principal legislation relating to public records. Records of NHS organisations are public records in accordance with Schedule 1 of the Act.
- This means that employees are responsible for any records that they create or use in the course of their duties.
- This includes records controlled by NHS organisations under contractual or other joint arrangements, or as inherited legacy records of defunct NHS organisations.
- The Act applies regardless of the format of the records.

UK GDPR and Data Protection Act 2018

The UK GDPR is the principal legislation governing how records, information and personal data are managed. It sets in law how personal and special categories of information may be processed. The Data Protection Act 2018 principles are also relevant to the management of records. Under the UK GDPR, organisations may be required to undertake Data Protection Impact Assessments (DPIA) as set out in Section 3 of this Records Management Code.

The UK GDPR also introduces a principle of accountability. The Information Commissioner's Office (ICO) Accountability Framework can support organisations with their obligations. Good records management will help organisations to demonstrate compliance with this principle.

Legislation

- **Health and Social Care Act 2008**
- Regulation 17 under the Health and Social Care Act 2008 requires that health and care providers must securely maintain accurate, complete and detailed records for patients or service users, employment of staff and overall management. The CQC are responsible for regulating this and have issued guidance on regulation 17. The CQC may have regard to the Code when assessing providers' compliance with this regulation.
- **Other relevant legislation**
- Other legislation requires information to be held as proof of an activity against the eventuality of a claim. Examples of legislation include the Limitation Act 1980 or the Consumer Protection Act 1987. The Limitation Act sets out the length of time you can bring a legal case after an event and sets it at six years

Caldicott Principles

Principle 1: Justify the purpose for using confidential information

Every proposed use or transfer of personally identifiable information, either within or from an organisation, should be clearly defined and scrutinised. Its continuing uses should be regularly reviewed by an appropriate guardian.

Principle 2: Don't use personal confidential data unless absolutely necessary

- Identifiable information should not be used unless it's essential for the specified purposes. The need for this information should be considered at each stage of the process.

Principle 3: Use the minimum necessary personal confidential data

- Where the use of personally identifiable information is essential, each individual item should be considered and justified. This is so the minimum amount of data is shared and the likelihood of identifiability is minimal.

Principle 4: Access to personal confidential data should be on a strict need-to-know basis

- Only those who need access to personal confidential data should have access to it. They should also only have access to the data items that they need.

Principle 5: Everyone with access to personal confidential data should be aware of their responsibilities

- Action should be taken to ensure that those handling personally identifiable information are aware of their responsibilities and their obligation to respect patient and client confidentiality.

Principle 6: Understand and comply with the law

- Every use of personally identifiable data must be lawful. Organisations that handle confidential data must have someone responsible for ensuring that the organisation complies with legal requirements.

Principle 7: The duty to share information can be as important as the duty to protect patient confidentiality

- Health and social care professionals should have the confidence to share information in the best interests of their patients and within the framework set out by these principles. They should also be supported by the policies of their employers, regulators, and professional bodies.

Why is documentation and recordkeeping so important

- Record keeping is an integral part of professional nursing practice and influences the nursing care process. The quality of record keeping is a reflection of the standard of individual professional practice.
- Good record keeping is the mark of a safe and skilled practitioner. The principles of good record keeping in nursing care are well established, and should reflect the core values of individuality and partnership working.
- Accurate documentation is essential to maintain continuity and inform health professionals of ongoing care and treatment. It is not only a legal requirement but also provides legal evidence.

Recordkeeping

- Good record keeping is a vital part of effective communication in nursing and integral to promoting safety and continuity of care
- Nursing staff need to be clear about their responsibilities for record keeping in whatever format records are kept.

What do we record?

- Hand-written contemporaneous notes taken by the health care practitioner.
- Notes taken by previous practitioners attending health care or other health care practitioners, including a typed patient discharge summary or summaries.
- Referral letters to and from other health care practitioners.
- Laboratory reports and other laboratory evidence such as histology sections, cytology slides and printouts from automated analysers, X-ray films and reports, ECG races, etc.
- Audiovisual records such as photographs, videos and tape-recordings.
- Clinical research forms and clinical trial data.
- Other forms completed during the health interaction such as insurance forms, disability assessments and documentation of injury on duty.
- Death certificates and autopsy reports.

Legislation

- You should be familiar with the principles of the following pieces of legislation.
- Data Protection Act 1998
- Access to Medical Reports Act 1988
- Access to Health Records Act 1990

- Good record keeping helps to protect the welfare patients/clients by:
- promoting high standards of care
- accountability
- continuity of care
- better communication.

Good records should have:

o accurate information

o demonstrate chronology of events
o show practice follows evidence based guidance
o show that local guidelines have been followed and critical incidents

- reported.

Why retain documents?

- Further the diagnosis or ongoing clinical management of the patient;
- Conduct clinical audits
- Promote teaching and research
- Research data
- Learning and case reviews
- Basis for accreditation
- Evidence for litigation, occupational disease, clinical incidents

What do we record?

- Name & hospital number on every page/ screen – preferably a printed addressograph label on paper sheets.
- Clear entries made in any paper or electronic records, making sure they are clearly written, dated and timed and do not include unnecessary abbreviations, jargon or speculations.
- In handwritten records a signature should be followed by the nurses or healthcare professionals name in clear print, and also their professional designation.
- All entries should be written or printed in indelible black ink
- Corrections must show the date and the time of the correction and if hand written should be crossed out by a single line. The correction should be clearly attributable to the author.

Guidelines for documentation and recordkeeping

- In handwritten entries, space to the end of the line should be blocked off
- Entries made by students must generally be countersigned by a nurse- or other supervising registered professional
- Only formally approved abbreviations should be used- refer to local hospital policy for list of accepted abbreviations.
- Records should be written as soon as possible following the event – and in chronological order
- Each record should be factual, consistent and accurate (including adverse incident forms)
- Notes should not be written in retrospect and if written in retrospect should be clearly evidenced as such

What do we record

- **Relevant medical history**
- **Examination and other relevant clinical findings** – include important positives and negatives and details of objective measurements such as blood pressure.
- **Differential diagnosis**
- **Investigations** – details of any investigations requested.
- **Treatment** – details of drugs, doses, amount prescribed, and any other treatment organised (include the batch number and expiry date of any medications personally administered).
- **Capacity and consent** – details of the patient's capacity to consent (or lack of) and their consent to proposed investigations, treatments or procedures. Details also of all treatment options discussed (including not receiving treatment), the benefits and risks of each option and any questions that were asked by the patient.
- **Referrals and follow-up** – arrangements that have been made for follow-up tests, future appointments and referrals. Include any 'safety-netting' advice given to the patient about when to seek more urgent review.

Benefits of Good recordkeeping

- Better communication and dissemination of information between members of the inter-professional team and parents/carers
- An accurate account of treatment, care planning and delivery of such care
- The ability to detect problems, such as changes in the patient's condition, at any stage during the care process and deliver appropriate care promptly

Good recordkeeping benefits for staff

- Good record keeping helps to protect the welfare of staff by:
  o Demonstrating how decisions related to patient care were made
  o Providing documentary evidence of services delivered
  o Facilitating the management of complaints or legalprocess
  o Support clinical audit, research, allocation of resources and performance
- planning

Legal Implications

- Remember that in a court of law “if it is not recorded, it has not been done”.
- Documentation which includes patient identifiable data should be stored safely to ensure confidentiality.
- Any documentation containing patient identifiable data attached to emails should only be sent from and to ‘nhs net’ email addresses.
- Personal information about patients held by health professionals is subject to a
- legal duty of confidence.
- The content of the health record should include information which permits the
- reader, a full understanding of events that have occurred and the ability to
- retrospectively analyze care delivered.
- Staff must be aware of responsibilities to maintain confidentiality according to
- Trust policy.
- There should systems in place for storage and retrieval of patient records.

Alteration of Records

- No information or entry may be removed from a health record.
- An error or incorrect entry discovered in the record may be corrected by placing a line through it with ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible.
- Additional entries added at a later date must be dated and signed in full.
- The reason for an amendment or error should also be specified on the record

Duration for retention of health records

- Health records should be stored in a safe place and if they are in electronic format, safeguarded by passwords.
- Health records should be stored for a period of not less than six (6) years as from the date they became dormant.
- In the case of minors and those patients who are mentally incompetent, health care practitioners should keep the records for a longer period:
  - For minors under the age of 18 years health records should be kept until the minor's 21ST birthday because legally minors have up to three years after they reach the age of 18 years to bring a claim. This would apply equally for obstetric records.
  - For mentally incompetent patients the records should be kept for the duration of the patient's lifetime.

Access to information in health records

- In terms of the law the following principles apply in regard to access to information in health records:
- A health care practitioner shall provide any person of age 12 years and older with a copy or abstract or direct access to his or her own records regarding medical treatment on request (Children's Act (Act No. 38 of 2005)).
- Where the patient is under the age of 16 years, the parent or legal guardian may make the application for access to the records, but such access should only be given on receipt of written authorization by the patient (Access to Information Act (Act No. 2 of 2000)).
- Information about termination of a pregnancy may not be divulged to any party, except the patient herself, regardless of the age of the patient (Choice on Termination of Pregnancy Act (Act No. 92 of 1996)).
- No health care practitioner shall make information available to any third party without the written authorisation of the patient or a court order or where non- disclosure of the information would represent a serious threat to public health (National Health Act (Act 61 of 2003)).

Checklist for Recordkeeping

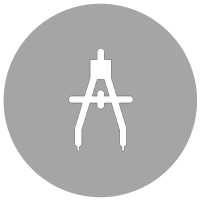
- Records should be complete, but concise.
- Records should be consistent.
- Self-serving or disapproving comments should be avoided in patient records. Unsolicited comments should be avoided (i.e. the facts should be described, and conclusions only essential for patient care made).
- A standardised format should be used (e.g. notes should contain in order the history, physical findings, investigations, diagnosis, treatment and outcome.).
- If the record needs alteration in the interests of patient care, a line in ink should be put through the original entry so that it remains legible; the alterations should be signed in full and dated; and, when possible, a new note should refer to the correction without altering the initial entry.
- Copies of records should only be released after receiving proper authorisation.
- Billing records should be kept separate from patient care records.
- Attached documents such as diagrams, laboratory results, photographs, charts, etc. should always be labelled. Sheets of paper should not be identified simply by being bound or stapled together – each individual sheet should be labelled.

Paperless documentation

- The onset of paperless documentation means staff must be proficient in the use of computer technology. This includes;
- Staff must be trained in the use of relevant programmes
- Computer programmes are password protected
- Staff maintain confidentiality by observing computer protocol e.g. log off, guarding the screen
- Staff accurately input data
- Staff regularly update information

Conclusion

Correct errors promptly, using proper technique



Write on every line, leave no spaces

Sign each entry with full signature and correct title

Follow institution policy and procedure for charting information

Keep up to date notes.