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Please note that this Policy **only** deals with the completion of health records. It does **not** specifically address the sharing of information with other agencies. This information can be found in the NHS Borders & Scottish Borders Council Information Sharing Protocol.[8]

Statement of Intent

NHS Borders is committed to the delivery of safe, effective and person centred clinical care to all its patients. Complete and accurate record keeping is fundamental to this. This Policy provides the framework so that all NHS Borders patients will have a personal record of their care, including regular evaluation of treatments given. NHS Borders will scope the number of potential records of an individual's care and work towards developing truly integrated health records.

The aims of the Completion of Health Records Policy are to set standards for:

- quality of documentation
- principles for systematic clinical audit of health records
- a process of continuous improvement of record keeping in response to clinical audit results.

This policy applies to any and all documents that form health records. The principles set out in the policy apply to both manual and electronic health records.

Introduction

All trained staff have a professional and legal duty to plan and record all care and treatments given to their patients. Evaluation of all care must also be made and recorded. Both local and national drivers highlight the importance of record keeping:

- Guidelines on Record Keeping published by various Professional Bodies e.g. Nursing and Midwifery Council, Health Professions Council and Royal College Physicians [11,12,14,15]
- National Standards e.g. Clinical Governance and Risk Management Standards, NHS QIS 2005[1]
- Local Clinical Audits e.g. NHS Borders Completion of Health Records Audit[4]
- Scottish Public Ombudsman Reports [5]

It is the responsibility of **all** staff giving direct care, whether a registered practitioner or someone in a support role, to make a note of all encounters and interventions relating to the patient in the appropriate section of the patient's health record.

The approach to record keeping which courts of law adopt tends to be that 'if it is not recorded, it has not been done'.

Well maintained records ensure:

- staff working more efficiently and effectively by eliminating waste in respect of time spent searching for information
- an audit trail is provided in respect of all health record entries and alterations
- clarity regarding what has been done, what is required to be done and the rationale for this in respect of patient care and treatment

All electronic records held or transmitted are subject to the same controls as manually held records.

Definition of a Health Record

The majority of NHS information about patients, whether electronic or paper, falls into the category of a **health record**. The exception to this is anonymised data. The health record details the physical or mental health of a person and is made by, or on behalf of, a health professional in connection with that person's care.

The Data Protection Act 1998[2] refers to health records as any record which:

- consists of information relating to the physical or mental health condition of an individual

- has been made by or on behalf of a health professional in connection with the care of that individual

A health record is anything that contains information, which has been created or gathered as a result of any aspect of the delivery of patient care. [3]

Standards

1. **Comprehensive records will be kept of all assessment, care, treatment and evaluation carried out.** [6,10,13,17]

   - all assessments will be recorded showing clearly the process followed and plan of care agreed with the patient where appropriate
   - every record will include generic information to be used by all professionals. The patient should only be asked for this information once
   - assessment of any risks will be identified and the management plan recorded
   - health records will include all letters, prescriptions and referral documentation relating to the patient's care.

2. **All patients' records will be an up to date, accurate statement of their condition, the action taken to respond to their needs and their outcomes.**

   - all records will be:
     - factual and consistent [11,12,13]
     - patient centred to include all clinical information, enable communication and reduce duplication.
   - all entries will:
     - be recorded as soon as possible after any encounter or intervention relating to the patient and/or aspect of their care and treatment [11,12,14,15]
     - include any information, verbal or written given to the patient about their care or condition [15]
     - clearly record the clinical content when contact has been by telephone and advice given
     - include any discussions with patient/family concerning treatment, care outcomes and establishment of likes/preferences
     - for community staff caring for patients with Patient-held records, telephone contact information, need to be recorded on the next visit to the patient. In these circumstances it is good practice to make a temporary note of the conversation so that an accurate record can be made.
     - where hospital based staff caring for patients with Patient-

held records do not have access to the Patient-held record, e.g. patients receiving ante-natal care, in these circumstances telephone contact information will be entered in the patient's hospital health records. Where a form for recording messages is available, this will be completed and inserted in the patients health records.

- any information added to the BGH base documentation/hospital record should also be documented in the Patient-held record.
- if the Patient-held record is not available – anything pertinent to ongoing care in the community should be sent out to relevant care providers to be added to Patient-held records.

- All care plans will show:
  - a clearly stated review date and evidence of evaluation and amended plans where relevant
  - involvement of the patient and or carers where this has been possible [17]
  - all arrangements for discharge, transfer or continuing care. [6,10]

3. **All NHS Borders patient health records will be of an acceptable quality.** [1]

- every page in the health record will be headed with the patient's identifying details. In the case of manually held records this ideally will be a pre-printed label that includes the patient's name and Community Health Index (CHI) number
- in manually held records patient pre-printed identity labels can occasionally be misfiled in wrong patient's health record, staff must ensure that the patient details on any identity label are correct and relate to the right patient before attaching the label to a health record
- entries in the patient's healthcare record must not contain unsupported value judgements or be made in a manner that may cause unnecessary offense to the patient. Subjective offensive statements are **never** acceptable. This applies equally to manually held and electronic records. Cognisance must be given to the reproducible nature of electronic records thus making it equally important to give due consideration to the content and subjectivity of entries in these as is the case with manually held records. [10,11,12,13]

- all written entries will be:
    - in black ink so that they cannot be erased and will be legible if photocopied [11,12,13] – pharmacists will make entries in green ink
    - dated, timed and signed by the individual making the entry and name and designation/profession/job title of the person responsible for the entry must be clearly printed in capitals, at their first entry on each page
    - where the healthcare record has a Staff Identification Sheet, as proposed for the BGH and Community Hospital Nursing Care Plan, this must be completed prior to an individual making a first entry in the health record and thereafter all entries must be initialled and dated.
    - legible [14,16]
- use of abbreviations should be avoided. [15] When abbreviations are used they will be taken from the NHS Borders Clinical Abbreviations list - Appendix 1
- entries must where possible be in language that is easily understood by the patient. Medical information cannot easily be expressed in plain English and is exempt from this
- all **changes or additions** made to manually held records will:
    - be clearly dated, timed and signed with the name and designation/profession/job title of the person responsible for the change/addition [17]
    - in the case of corrections, the entry will be deleted by **scoring it out with a single line** so that the original entry can still be read, All corrections must be dated, timed and signed [11,12,15] Any changes must be made at the time of making the initial entry, not retrospectively. An update to the original entry may be made at a later date. Any update must be dated, timed and signed.
- **changes must not be made to another individual's entry**. Additional information may be included. Any additions must be clearly dated, timed and signed with the name, and designation/profession/job title of the person responsible for entering the additional information [17]

4. **All staff must ensure that all entries made in electronic records are logged using their own individual log on. Electronic records are supported by audit trails that identify who has made the entry, when, where and what is recorded.**

- an individual is accountable for all entries made using their account[18]
- a member staff must not share their log on with another member of staff [18]
- staff must ensure they log out of the system when finished making an entry in a health record [18]

5. Healthcare records will be managed and maintained in accordance with NHS Borders Records Management Policy, [9] NHS Borders Health Records Management Policy [18] and NHS Borders Medical Records Procedures.

- all loose papers will be filed and secured in the healthcare record at the earliest opportunity to ensure a complete and contemporary record is maintained to help safeguard high quality patient care.

6. A representative sample of records, selected at random, from all clinical areas, will be audited at least annually.

- the audit tool is designated for use in all clinical areas, and can be used for any record completed by any disciplines.

- the Clinical Audit Support Team will assist clinical teams by providing an electronic data collection tool for the audit and support co-ordination as required

- the line manager for each clinical area is responsible for ensuring that records are kept to the standards set by the Policy and that audit is undertaken

- each clinical area will submit data every two years to the Clinical Audit Support Team, who will amalgamate the reports to form the NHS Borders Completion of Records Annual Audit Report

- standards are set for each of the audit criteria at 100%. Targets should be set in each clinical area to improve on current record keeping practice by setting targets for each of the individual criteria. These will be informed by annual audit results

- the Clinical/Integrated Boards will have the overall responsibility for monitoring compliance with the Policy and will receive clinical audit reports and where applicable monitor progress of improvement plans

- review of health records will in part inform the annual appraisal process and contribute to team development.

6. **On discharge from all treatments the patient's health records will be held securely, in accordance with the Data Protection Policy.** [7]

References

1. NHS Quality Improvement Scotland, Clinical Governance and Risk Management Standards, 2005

2. Data Protection Act 1998 http://www.legislation.gov.uk/ukpga/1998/29/contents

3. NHS Scotland Personal Health Records Policy for NHS Boards: Guidance Note 002 http://www.scotland.gov.uk/Resource/Doc/310126/0097859.pdf

4. NHS Borders, Completion of Health Records Audit, Borders General Hospital, 2003, 2004, 2006, 2008, 2010, 2014

5. Scottish Patient Safety Ombudsman, www.**spso**.org.uk/

6. NHS Borders & Scottish Borders Council, Adult Patient Transfer/Discharge Transfer Policy, 2011

7. NHS Borders, Data Protection Policy, 2014

8. Scottish Borders Multi Agency Information Sharing Protocol, 2006

9. NHS Borders Records Management Policy, 2012

10. Health Record and Communication Practice Standards for Team Based Care, NHS Information Standards Board, 2004 http://www.isb.nhs.uk/about/publications/healthrec_compractice.pdf

11. Record keeping: Guidance for nurses and midwives, 2009

12. The Code: Standards of conduct, performance and ethics for nurses and midwives www.nmc-uk.org/Publications/**Standards/The-code/**

13. NHS Professional Guidelines on Record Keeping, 2010 http://www.nhsprofessionals.nhs.uk/download/comms/cg2%20-%20record%20keeping%20clinical%20guidelines.pdf

14. Health Professions Council Standards, 2012 http://www.hcpc-uk.org/assets/documents/10003B6EStandardsofconduct,performanceandethics.pdf

15. Royal College of Physicians, Standards for the clinical structure and content of patient, 2013 https://www.rcplondon.ac.uk/resources/standards-clinical-structure-and-content-patient-records

16. Royal College of Surgeons, Good Surgical Practice,2008 http://www.rcseng.ac.uk/associates/docs/gsp2008

17. Royal College of Psychiatrists, Good Psychiatric Practice, 2009 http://www.rcpsych.ac.uk/files/pdfversion/cr154.pdf

18. NHS Borders IT Security Policy

Responsibilities

Role	Responsibilities
Medical Director and Director of Nursing and Midwifery	Will secure agreement on the Completion of Health Records system and procedures.
Associate Medical Directors/Associate Directors of Nursing/General Manager/Director of Pharmacy/Associate Director AHP	Will incorporate compliance and audit of Completion of Health Records systems within objectives with the aim of improving standards of care. Must ensure that time is given to facilitate the completion of records.
Clinical Governance and Quality	Will support compliance with the Policy, through audit.
Service/Operational/Ward/ Departmental Managers	Must supervise compliance with the Policy, and to organise ongoing audits. Will identify additional time to facilitate the completion of records, if required. Must ensure that audit results are part of performance appraisal and personal development plans. Will facilitate random review of health records as part of the annual appraisal process and team development.
Individual Clinicians	Must maintain records of patient's treatment in accordance with the Policy. Must allocate adequate time to complete the record. Must participate in the audit process relating to this policy. Will participate in random review of health records as part of the annual appraisal process and team development

Implementation Plan

1. **Professional responsibilities**

- **Associate Medical Directors/Associate Directors of Nursing/General Manager/Director of Pharmacy/Associate Director AHP**
  - Disseminate and support implementation of the policy
- **Clinical Governance and Quality**
  - Support compliance with the Policy and Audit of compliance
- **Clinical Executive Operational Group**
  - Agree and sign off the updated Policy
- **Service/Operational/Ward/Departmental Managers**
  - Implement the Policy in their areas
  - Supervise compliance with the Policy, organise audits as per the policy
  - Respond to audit results and take corrective action if required
  - Ensure completion of health record review is part of the annual appraisal process and team development
- **Clinicians**
  - Ensure that their record keeping practice complies with this Policy
  - Participate in regular audit and engage in training and development as necessary
  - Participate in review of health records as part of the annual appraisal process and team development

2. **Audit**

The standards will be audited:

- Clinical teams will audit records for there area
- Audit results will be sent to Clinical Governance and Quality
- Clinical Governance and Quality will collate and report on all audit results
- Clinical Governance Groups within each Clinical/Integrated Board will develop and submit an improvement action plan in response to results for their board area to the Clinical Governance and Quality

3. **Review**

The policy will be reviewed two years after issue or following any change in National Standards. The results of Clinical Audits of Health Records will be used to inform policy review

Review Group Membership 2014

All listed below were invited to contribute to the review process

Karen Grieve	Associate Director of Nursing, Primary and Community Services
George Ironside	Senior Health Information Manager
Diane Keddie	Interim Associate Director of Nursing – Acute Services
Jonathan Kirk	Associate Medical Director, Primary & Community Services
Morag McQuade	Clinical Director Dent Salaried and Community Dental Services
Karen McNicoll	Associate Director AHP
Hamish McRitchie	Associate Medical Director, Acute Services
Anne Palmer	Clinical Governance & Quality Facilitator, Clinical Effectiveness
Marion Paterson	Team Manager, Learning Disabilities Service
Cliff Sharp	Associate Medical Director, Mental Health Service
Isabel Swan	Associate Director of Nursing, Mental Health Service

Appendix 1 NHS Borders - Clinical Abbreviations List

AAA	Abdominal Aortic Aneurysm
ABG	Arterial Blood Gases
ACL	Anterior Cruciate Ligament
ACP	Anticipatory Care Plan
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
AF	Atrial Fibrillation
AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support
ALT	Alanine aminotransferase
APH	Antepartum Haemorrhage
AXR	Abdominal X-ray
ASD	Atrial Septal Defect
ASAP	As Soon As Possible
AV	Atrial Ventricular/Arterio Venus
AVR	Aortic Valve Replacement
Ba	Barium
BBV	Blood Borne Virus
BCG	Bacille Calmette Guerin
BMI	Body Mass Index
BP	Blood Pressure
Ca	Carcinoma
Ca^{2+}	Calcium
CABG	Coronary Artery Bypass Graft
CBT	Cognitive Behavioural Therapy
CCF	Congestive Cardiac Failure
C-dif	Clostridium difficile
CNS	Central Nervous System
c/o	Complains of
COPD	Chronic Obstructive Pulmonary Disease
CPR	Cardio Pulmonary Resuscitation
C&S	Culture and Sensitivity
CSF	Cerebro-Spinal Fluid
CT	Computerised Tomography
CVA	Cerebrovascular Accident
CVP	Central Venous Pressure
CXR	Chest X-ray
DBT	Dialectical Behaviour Therapy
D&C	Dilation and Curettage
Detox	Detoxification
DNA	Did Not Attend
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation

DOB	Date of Birth
DSH	Deliberate Self Harm
DTTO	Drug Treatment and Testing Order
DU	Duodenal Ulcer
D&V	Diarrhoea and Vomiting
DVT	Deep Venous Thrombosis
ECG	Electrocardiogram
ECS	Emergency Care Summary
ECT	Electro-Convulsive Therapy
EEG	Electroencephalogram
eKIS	Electronic Key Information Summary
ENT	Ear, Nose and Throat
ESR	Erythrocyte Sedimentation Rate
ET Tube	Endotracheal Tube
FBC	Full Blood Count
FD	Forceps Delivery
FFP	Fresh Frozen Plasma
FH	Family History
FOB	Faecal Occult Blood
FROM	Full Range Of Movement
F/U	Follow-up
GA	General Anaesthetic
GCS	Glasgow Coma Scale
GI	Gastro Intestinal
GU	Genito-urinary
Gynae	Gynaecology
GUM	Genito-Urinary Medicine
γGT/ GGT	Gamma-Glutamyl Transferase
Hb	Haemoglobin
HDU	High Dependency Unit
Hep A/B/C	Hepatitis A/B/C
HIV	Human Immunodeficiency Virus
H/O	History Of
HPV	Human Papilloma Virus
HR	Heart Rate
HS	Heart Sounds
Ht	Height
IBS	Irritable Bowel Syndrome
IM	Intramuscular
IMP	Impression
INR	International Ratio
INHALE	Inhalation

IPCU	Intensive Psychiatric Care Unit
IQ	Intelligence Quotient
ISQ	In Status Quo (no change)
ITU	Intensive Treatment Unit
IUD/IUCD	Intra Uterine Device/ Intra Uterine Contraceptive Device
IV	Intravenous
IVAD	Intravenous Drug Abuser
IVI	Intra Venous Infusion
IVF	In Vitro Fertilisation
K+	Potassium
LA	Local Anaesthetic
LFT	Liver Function Test
LIF	Left Iliac Fossa
LIH	Left Inguinal Hernia
LOC	Loss Of Consciousness
LP	Lumbar Puncture
LUSCS	Lower Uterine Segment Caesarean section
LUQ	Left Upper Quadrant
MCV	Mean Corpulscular Volume
ME	Myalgic Encephalomyelitis
Med Rec	Medicines Reconciliation
Mg+	Magnesium
MI	Myocardial Infarction
MMR	Mumps, Measles, Rubella
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staph Aureus
MS	Multiple Sclerosis
MMSE	Mini Mental State Examination
MSSA	Methicillin-sensitive Staphylococcus aureus
MSSU	Mid Stream Specimen of Urine
Na+	Sodium
NAD	No Abnormality Detected
NBI	No Bone Injury
NEB	By Nebulisation
NG	Naso Gastric
NOF	Neck of Femur
NOK	Next of Kin
NPI	Neuro-Psychiatric Inventory
O_2	Oxygen
OA	Osteoarthritis
Obs	Observations

OD	Overdose
P	Pulse
PE	Pulmonary Embolism
PEG	Percutaneous Endoscopic Gastroscopy
PFR	Peak Flow Rate
PM	Post Mortem
PMH	Past Medical History
POP	Plaster Of Paris
Post OP	After Operation
PPH	Post Partum Haemorrhage
PR	Per Rectum
Pre OP	Before Operation
PTSD	Post Traumatic Stress Disorder
PV	Per Vaginum
PVD	Peripheral Vascular Disease
RA	Rheumatoid Arthritis
RDS	Respiratory Distress Syndrome
Rehab	Rehabilitation
Rh	Rhesus Factor
RIF	Right Iliac Fossa
RIH	Right Inguinal Hernia
ROM	Range Of Movement
RSI	Repetitive Strain Injury
RTA	Road Traffic Accident
RUQ	Right Upper Quadrant
Rx	Treatment
SAB	Staphlycoccus Aureus Bacterium
SAH	Subarachnoidal Haemorrhage
SC	Subcutaneous
SIRS	Systematic Inflammatory Response Score
SL	Sublingual
SM	Systolic Murmur
SOB	Shortness Of Breath
SOL	Space Occupying Lesion
SPR	Specialist Registrar
SR	Sinus Rhythm
Staph	Staphyloccus
STD	Sexually Transmitted Disease
T	Temperature
TB	Tuberculosis
TED	Thrombo Embolic Deterrents
TENS	Transcutaneous Electro Nerve Stimulation
THR	Total Hip Replacement

TIA	Transient Ischaemic Attack
TPN	Total Parenteral Nutrition
TPR	Temperature, Pulse, Respiration
TOP	Topical
TURBT	Transurethral Resection of Bladder Tumour
TURP	Transurethral Resection of Prostate
UC	Ulcerative Colitis
U&E	Urea and Electrolyte
USS	Ultrasound
UTI	Urinary Tract Infection
UV	Ultra Violet
VF	Ventricular Fibrillation
VT	Ventricular Tachycardia
WBC	White Blood Cell Count
Wt	Weight
X-Match	Cross Match
#	Fracture