

# The Newcastle upon Tyne Hospitals NHS Foundation Trust

## Clinical Record Keeping Policy

Effective: July 2011

Review: July 2012

### 1. Introduction

The Newcastle upon Tyne Hospitals NHS Foundation Trust is dependent on its records to operate efficiently and account for its actions. This policy defines a structure for the Newcastle upon Tyne Hospitals NHS Foundation Trust to provide clearly defined guidelines and standards to all Trust employees when undertaking clinical record keeping. This policy is to be used as a tool for implementing high quality patient care and maximising patient safety by all Trust staff.

Trust records are the property of the Secretary of State for Health. They are Public Records under the terms of the Public Records Acts and must be kept in accordance with following statutory and NHS guidelines:

- Public Records Acts 1958 and 1967
- Data Protection Act 1998
- Freedom of Information Act 2000
- Records Management NHS Code of Practice
- Controls Assurance records management standard, 1999
- Caldicott Review of Patient Identifiable information, 1997
- Audit Commission, Setting the Record Straight, 1995

This policy should be read in conjunction with the clinical records management policy, accessible [here](#).

### 2. Policy Scope

This policy relates to all clinical records created, received or maintained in hard copy or electronically by staff of the Newcastle upon Tyne Hospitals NHS Foundation Trust. The clinical record is defined as a collection of information about the care of a patient, provided by a range of healthcare professionals in one organisation. The primary aim of keeping patient records is to enable the healthcare team to provide the best possible patient care. The clinical record may include:

- Handwritten notes by any healthcare professional
- Computer print-outs from monitoring equipment
- Laboratory reports
- Photographs
- Videos
- Tape recordings
- X-Rays
- Letters and correspondence about clinical care – including handwritten or other transfer and referral letters
- Records may be held in manual systems or computerised systems, or a mixture of both.

### 3. Policy Aims

- To instil good practice in record keeping across the trust in order to provide a clear and chronological record of clinical care.
- To ensure that legal requirements for record keeping practice is met across the trust.

### 4. Policy Objectives

- Accountability: that adequate records are maintained to account fully for all care given to individual patients.
- Quality: that all clinical records are complete and accurate with regards to the information they contain.
- Training: that all staff are made aware of their record keeping responsibilities through appropriate training programmes.
- Audit: that the application of this policy is audited, annually.

### 5. Roles and Responsibilities

**Heads of corporate and clinical departments or directorates** are responsible for ensuring that the policy is implemented in their individual departments.

The **Clinical Governance and Risk Department** and the **Clinical Records Advisory Committee** are responsible for maintaining a rolling programme of annual audit, review, action-planning and re-audit and for producing annual reports for individual directorates.

#### **Clinical Governance and Quality Committee**

The Clinical Governance and Quality Committee will receive annual reports of Directorate record keeping practice.

It is the responsibility of **all staff** to ensure that they keep appropriate records of their work in line with this policy.

### 6. Generic Core Standards

- 6.1 Record keeping in all clinical areas will be subject to annual audit.
- 6.2 The Personnel Department must maintain a register of staff signatures and initials. This must be kept up to date.
- 6.3 All writing in clinical records will be legible.
- 6.4 All entries will be made in permanent black ink to allow accurate scanning.
- 6.5 All entries will be signed, dated and timed (using 24 hour clock). Entries made by student nurses and auxiliary nursing staff must be countersigned by a registered health professional.
- 6.6 When the practitioner is writing in the patient's record they will also print their

name and designation under their signature.

- 6.7 Mistakes will be crossed through with a single line, signed, dated and timed. Correction fluid will not be used. Any sheets containing errors must not be removed from the clinical record.
- 6.8 The record will only include standard and accepted clinical abbreviations (see appendix 2).
- 6.9 Material should be filed in the case record according to the instructions printed on the inside of the front cover of the case notes.
- 6.10 Under the Data Protection Act, 1998, patients have a right of access to the clinical record – see Section 11 of this policy.

## **7. Clinical Content**

- 7.1 Each record will include the following core patient information
  - The medical record number (MRN)
  - NHS number
  - Address
  - Telephone number(s) home and mobile
  - Date of birth
  - Sex
  - Number of person to notify in an emergency (next of kin/designated individual) and General Medical (and Dental practitioner, when required) including name, address and practice telephone number, where known.
  - Children's records: in addition to the child's own address and phone number (and, where appropriate, their own mobile number), contact details for children should normally include two carers, whose names and addresses and contact numbers will be separately identified. These persons will usually be either the mother and the father, or the mother and her partner; occasionally these persons will be foster carers, same-sex partners, the mother and a relative of the mother, or some other combination of adults. This may be an appointed legal guardian. For some single fathers or single mothers there may be no second carer.
  - In the case of school age children the record will identify the school the child attends.
- 7.2 Appendix 3 details markers of good practice included in the annual policy audit (see also appendix 4 for explanatory notes). Additional requirements and information, follows.
- 7.3 While it is desirable that all entries should be recorded contemporaneously (that is, as soon as the clinical event has taken place), when this is not possible, the record itself should be dated and timed for the date and time of writing, and the date(s) and time(s) of the events being recorded should be stated clearly in the record.

- 7.4 All entries should be made sequentially, without unnecessary gaps. Where a gap is unavoidable (e.g. when a temporary file has been used) the gap should be ruled through to avoid recording data out of order.
- 7.5 The content of telephone communications (relevant to clinical care) should be recorded in the notes.
- 7.6 The use of email for communicating patient-identifiable information should be severely restricted in line with [trust policy](#). As well as reasons of security, the use of alternative another means of clinical communication risks a 'disconnect' in the chronology of relevant discussions. Where emails are actually used, they should be printed and filed within the correspondence section of the case-notes.
- 7.7 The clinical notes should contain clinically relevant information only and should not include clinically irrelevant information such as financial information, complaints or legal correspondence. Information of this nature will be stored corporately within the patient relations and / or medical records department(s).
- 7.8 Judgements of a personal nature should not be used in the clinical record. Comments about a patient should be objective, factual and relevant to the clinical assessment and treatment plan.
- 7.9 Medication orders in the patient's records should be made in line with Trust policy (linked [here](#)). Further information can be found [here](#).
- 7.10 Letters between clinicians about an individual patient's care may be copied to the patient by patient request.
- 7.11 Results of investigations should be endorsed by a member of the clinical team (with lead responsibility lying with the team's consultant). In the case of paper copies, these should not be filed without initialling and dating as evidence of clinical endorsement.
- 7.12 Smaller dental X-Ray films should be marked with the patient number, mounted securely and placed inside the designated envelope within the dental record.
- 7.13 Images – X-ray, CT, MR, photographs, copies of recordings etc. and all other images are part of the patient record and the use, access and all other aspects of processing of images are governed by the Data Protection Act, 1998.
- 7.14 Following a death, the details of the death should be entered into the patient's notes (e.g. cause(s) of death and whether a hospital post-mortem or coroner's report is pending).

## **8. Case-note structure**

- 8.1 Please see appendix 3 (and explanatory notes in appendix 4) for markers of good practice included in the annual policy audit cycle. Additional requirements and information, follows.
- 8.2 The eRecord case-note tracker system makes reference to other case-notes held on a patient and should be kept up-to-date. A single MRN should be used trust-wide for each patient. Although the ideal is for one single case-note folder to be used, trust-wide, in practice, a single patient may have more than 1 contemporaneous file due to the complexity of their condition.
- 8.3 All records within each section of the case-note folder should be filed in chronological order.
- 8.4 The clinical records from all professional groups i.e. medical, nursing, physiotherapy, etc. are all a vital part of the client's record. These records should be filed together in the same record wherever possible to ensure that the clinical information is kept together to provide a comprehensive overview of care.
- 8.5 All professionals' records for a patient should be filed together on discharge or death, wherever possible.

## **9 Shared Records/Multi-Professional records**

- 9.1 Multi-professional manual / computer records for patients must allow multi-agency staff to deliver high quality care in a cohesive manner, whilst respecting patient confidentiality. It is required that the patient is fully aware that health/social information about them is being shared amongst the wider health care team. Patient consent should be sought and documented. Staff should comply with trust policies on confidentiality and security. Information sharing between professionals and organisations is governed by established Information Sharing Protocols in place regarding:
- Rights to access and share health records for professionals is governed by the documented establishment of legitimate relationships and workgroups for professionals involved in delivering care and services. The Information Sharing Protocols define what information is to be communicated and is necessary to support the safe and effective delivery of care. Legitimate relationships are designed to control which professionals gain access to sensitive personal information about a patient or client.
  - There are ten types of legitimate relationships. The following eight apply to workgroups/teams
    - Patient Referral Legitimate Relationships
    - Patient Self-referral Legitimate Relationships
    - Patient Registration Legitimate Relationships
    - General Practice Registration Legitimate Relationships
    - Subject Access request Legitimate Relationships
    - Patient complaint or litigation Legitimate Relationships

- Expressed Patient consent to Access Legitimate Relationships
  - Court Order or Other Legal Demand Legitimate Relationship
- The remaining two allow individuals access to a patient clinical record
- Self-claimed Legitimate Relationships
  - Colleague granted Legitimate Relationships

## **9.2. Carers Records and patient-held records**

A “carer” is defined in the Carers Act 2004 as a person who is giving substantial care on a “regular basis”.

9.2.1 Notes of any contact with carers regarding a patient’s care will be included in the patient’s main record.

9.2.2 There is no prescribed format for patient-held records; however the principles of this policy should apply. Where the record is created by a department of the Trust, the physical record will remain the property of the Trust.

9.2.3 When the episode of care comes to an end it is important to ensure that the record is filed within the patient’s main trust records (for example, maternity patient-held records should be returned to the main maternity record at the end of the community midwife’s involvement with the mother).

9.2.4 The Personal Child Health Record (PCHR) is issued by the Primary Care Trust, and is technically their property. Trust staff have a responsibility to enter some of the neonatal information into these records; any staff who subsequently have contact with young children (mainly infants and pre-school children) should use this record to make brief notes of the contact, in addition to entries in the child’s case notes.

9.2.5 Patients (adults or children, or their carers) may be requested to make formal or informal records at home, for example peak flow readings, blood glucose records, symptom diaries etc. Sometimes they may be content to allow their original records to be added to the Trust case notes, but if not, photocopies of this material should be made so that the Trust retains a record of this documentation.

## **10. Ownership/Access**

10.1 Specific information is given in the clinical records management policy, accessible, [here](#). In addition:

10.2 Access to patient records must be restricted to appropriate health care personnel only, for example all members of the health care team involved in the care and treatment of the individual where records are shared. Any other organisation seeking access to patient records, for example an employer,

must obtain the consent of the patient and relevant clinician.

- 10.3 For requests for patient information from the police please refer to the trust policy, available [here](#).

## **11. Security of records**

- 11.1 Security of paper held records should not be left unattended at any time and should never be left in unattended staff cars. Records should not be taken home by staff, except in extreme circumstances, e.g. following evening home visits when it may make individuals vulnerable to return to an isolated centre.
- 11.2 For security of electronic records please refer to the trust policy on access control, available [here](#).

## **12. Confidentiality**

Any waste paper containing identifiable patient information must be secured in a confidential waste bag and disposal arranged separate to the general waste in accordance with the trust policy, available [here](#). N.B. this does **not** apply to the destruction of paper containing identifiable patient information that actually constitutes part of the clinical record (see guidance within clinical records management policy). See also '6.7', above.

## **13. Training Issues**

- 13.1 It is the responsibility of the Directorate Managers / Heads of Department to assess the training requirements of their staff regarding record keeping and to discuss any requirements with the Clinical Governance and Risk Department.
- 13.2 All staff are required to undertake training in the Caldicott guidelines and Data Protection Act, 1998.

## **14. Computer-held records**

- 14.1 Computer based records are a growing element of the clinical record and the trust's strategic goal, in line with NHS policy, is to develop an electronic patient record.
- 14.2 The use of computer based records are, as with other manual types of record, covered by the Data Protection Act, 1998.
- 14.3 The trust's Caldicott Guardian is responsible for authorising all data flows that contain patient information. The Caldicott guidelines require that the minimum level of identifiable information is used at all times. The processing of data items must be justifiable. Guidance on the Caldicott guidelines and Data Protection Act, 1998 is available, [here](#).
- 14.4 Access to computers and the Trust network is governed by the [Access Control Policy](#) which covers access to computer information, network

security, and detection and prevention of unauthorised use. Only authorised staff with legitimate reasons should seek access to the trust network and information systems. Unauthorised access to the trust network and / or information systems is a disciplinary offence.

14.5 Guidance on the processing of information and transfer of information (including off-site) is covered by trust policy, available [here](#).

**References:**

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## Protocol for Completion and Filing of Anaesthetic Record (Form NUTH 68)

### Aim

The aim of this protocol is to ensure the accurate completion and timely filing of form NUTH 68. This anaesthetic record is an essential part of the medical record and can be vitally important in the investigation and / or defence of medical negligence claims.

Of primary interest to all anaesthetists, theatre nursing staff, operating department practitioners and ward staff.

### 1 Completion of anaesthetic record

- 1.1 All forms must clearly identify the patient to whom they relate.
- 1.2 All relevant sections must be clearly and legibly completed using **black** ink to ensure clarity of any required photocopies.
- 1.3 All completed sections **must** be clearly signed and dated in full.
- 1.4 The completed forms must remain with the patient until all post-operative recovery instructions are complete.

### 2 Filing of anaesthetic record

- 2.1 It is the responsibility of the nurse caring for the patient in recovery to ensure the anaesthetic record form is filed in the patient's medical records **immediately** following the completion of post-operative recovery instructions and handover to the ward nurse.
- 2.2 It is the responsibility of the anaesthetic nurse caring for the patient in theatre to ensure the anaesthetic record form is filed in the patient's medical notes before transferring a patient to ITU/CCU/HDU.
- 2.3 It is the responsibility of the person handing the patient over to the ward nurse to ensure the form has been filed if used for patients undergoing Local Anaesthesia.
- 2.4 The anaesthetic record must be filed in strict chronological order within the specialty clinical notes.
- 2.5 The Anaesthetic record must be filed together with the operation record (form NUTH 26) and relevant consent form.
- 2.6 The anaesthetic record constitutes part of the clinical record and must **not** be filed with nursing records.

## Use of Abbreviations in the Clinical Record

### 1. Introduction

The requirements of the National Patient Safety Goals 2007 – Goal 2(B) outline a list of abbreviations, acronyms and symbols that are not to be used throughout the organization (see Appendix 2a). For further information go to [2007 National Patient Safety Goals](#).

### 2. Generic Core Standards

- 2.1 All abbreviations written into the clinical record must be on the Trust wide agreed abbreviations list – Appendix 2b.
- 2.2 Abbreviations on the Official “Do not use” list, must not be used at any time – see Appendix 2a.
- 2.3 Abbreviation use in all clinical areas will be subject to continuous audit.
- 2.4 For any printed forms, any abbreviations must be spelled out the first time used, or must be listed in a key on the form.
- 2.5 Medication names can not be abbreviated. Spell out drug names completely.
- 2.6 Abbreviations cannot be used on consent forms.
- 2.7 Blood values/chemical and physiological symbols are nationally recognised and may be used.
- 2.8 The development of Care Pathways results in the development of additional abbreviations. Any abbreviations must be spelled out the abbreviation section of the Care Pathway and can then be referred to in the main body of that document as the abbreviated version.
- 2.9 The official “do not use” list applies, at a minimum, to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms. This requirement does not currently apply to pre-programmed health information technology systems, but remains under consideration for the future. The Trust needs in contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols, and dose designations from the software.

**Official Do not use list as directed by the National Patient Safety Goals 2007**

<b>Do Not Use</b>	<b>Potential Problem</b>	<b>Use Instead</b>
U (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write unit
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d., qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0mg)* Lack of leading zero (.Xmg)	Decimal point is missed	Write X mg Write 0.Xmg
MS  MS04 and MgSO4	Can mean morphine sulphate or magnesium sulphate Confused for one another	Write "morphine sulphate" Write "magnesium sulphate"

**Additional Abbreviations, Acronyms and Symbols**

<b>Do Not Use</b>	<b>Potential Problem</b>	<b>Use Instead</b>
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
cc	Mistaken for u (units) when poorly written	Write "ml" or "millilitres"
ug	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or "micrograms"

**As advised by the Strategic Health Authority – 2007**

Please do not use the following as their use has resulted in a serious untoward incident in one of the region's Trusts:

<b>Do Not use</b>	<b>Use Instead</b>
1/12	1 month
1/52	1 week
1/7	1 day

## List of Agreed Abbreviations

### Common Medical Conditions

- AIDS Acquired Immunodeficiency Syndrome
- Ca Cancer
- CCF Congestive Cardiac Failure
- COAD Chronic Obstructive Airways Disease
- DVT Deep Vein Thrombosis
- MI Myocardial Infarction
- MRSA Methicillin Resistant Staphylococcus Aureus
- PE Pulmonary Embolus
- STAPH Staphylococcus
- TB Tuberculosis
- UTI Urinary Tract Infection
- # Fracture

### Patient Investigation (Radiology)

- AxR Abdominal X-Ray
- Ba Barium
- CT SCAN Computerised Tomography
- CXR Chest X-Ray
- MRI Magnetic Resonance Imaging
- U/S Ultrasound

### Common Tests/Procedures

- CPR Cardio Pulmonary Resuscitation
- D&C Dilatation and Curettage
- PEG Percutaneous Endoscopic Gastroscopy
- TENS Trans Cutaneous Electro Nerve Stimulation
- TPN Total Parenteral Nutrition
- TPR Temperature Pulse Respiration

### Medication/Drugs

- IM Intra Muscular
- Inh Inhaler
- IV Intravenous
- Neb Nebulisation
- Oral
- PO By Mouth
- PR Per Rectum
- PV Per Vagina
- SC Sub Cutaneous
- S/L Sub Lingual
- Top Topical
- CD Controlled Drug
- IVI Intravenous Infusion
- TTO To Take Home (Drugs)

### **Administration**

- Appt Appointment
- ASAP As Soon As Possible
- DNA Did Not Attend
- DOB Date Of Birth
- FU Follow Up
- S/A Same Address
- S/B Seen By
- TCI To Come In

### **Equipment**

- ET Tube Endotracheal Tube
- IUCD Intra Uterine Contraceptive Device
- NGT Naso Gastric Tube
- TED Thrombo Embolic Deterrents

### **People**

- CPN Community Psychiatric Nurse
- Dr Doctor
- F (1 or 2) Foundation trainee (year 1 or 2)
- GP General Practitioner
- HV Health Visitor
- ST(n) Specialist Trainee (n= year of training)
- SALT Speech And Language Therapist
- SR Sister
- S/M Staff Midwife
- S/N Staff Nurse
- ST/N Student Nurse
- ST/M Student Midwife

### **Specialty**

- ENT Ear Nose and Throat
- GI Gastro Intestinal
- GYNAE Gynaecology
- HDU High Dependency Unit
- OPD Out Patients Department
- OT Occupational Therapy
- PAEDS Paediatrics

### **Patient Investigation (Blood)**

- FBC Full Blood Count
- FFP Fresh Frozen Plasma
- HB Haemoglobin
- K Potassium
- Na Sodium
- PCV Packed Cell Volume
- PT Prothrombin Time
- Rh Rhesus Factor
- U/E Urea and Electrolytes
- WCC White Cell Count

**Patient Assessment/ Examination**

- BMI Body Mass Index
- BP Blood Pressure
- CNS Central Nervous System
- CVP Central Venous Pressure
- H/O History of
- Ht Height
- ICP Intracranial Pressure
- NAD No Abnormality Detected
- NBI No Bony Injuries
- NOK Next Of Kin
- PMH Past Medical History
- SOB Shortness Of Breath
- TPR Temperature Pulse Respirations
- Wt Weight

**Patient Investigation (General)**

- C&S Culture And Sensitivity
- CSF Cerebro-Spinal Fluid
- ECG Electro Cardiogram
- LP Lumbar Puncture
- MC&S Microscopy Culture And Sensitivity
- MSU Mid Stream Urine

**Other**

- LA Local Anaesthetic
- GA General Anaesthetic
- NBM Nil By Mouth
- POST OP After Operation
- PRE OP Before Operation
- RTA Road Traffic Accident
- ROS Removal Of Sutures

## Markers of good practice – audited measures

	2011/12 questions (in-patients)	2011/12 questions (out-patients)	90% cut-off for 'green' rating (Y = yes)? (see also appendix 4)
<b>Section 1 - condition of the record</b>			
Q1.1	**Health record contain clear instructions regarding filing of documentation.	**Health record contain clear instructions regarding filing of documentation.	
Q1.2	**The record is (i) in good condition, and (ii) not overfilled. All items are <u>securely</u> filed in the correct sections.	**The record is (i) in good condition, and (ii) not overfilled. All items are <u>securely</u> filed in the correct sections.	
<b>Section 2 - Documentation Practice</b>			
Q2.1	Patient identified by both name and either MRN or NHS number on each separate page or on the front page if a booklet is used.	Patient identified by both name and either MRN or NHS number on each separate page or on the front page if a booklet is used.	Y
Q2.2	All entries are dated.	All entries are dated.	Y
Q2.3	> 90% of in-patient entries are timed.	X	Y
Q2.4	> 90% of inpatient entries are signed, and identified with a printed name and grade.	All entries are signed, and identified with a printed name and grade.	Y
Q2.5	All entries are completely legible, including prescription sheets.	All entries are completely legible.	
Q2.6	All entries are written in permanent, black ink.	All entries are written in permanent, black ink.	
Q2.7	Record of the in-patient episode is free from correction fluid.	Record of out-patient episodes for that audit area is free from correction fluid.	
Q2.8	Alterations are corrected appropriately.	Relevant alterations are corrected appropriately.	
Q2.9	The record contains only standard and accepted medical	The relevant record contains only standard and accepted	

	abbreviations.	medical abbreviations.	
Q2.10	Daily entries are made for in-patients.	X	
<b>Section 3 - Assessment Records</b>			
Q3.1	The admission clerking records the responsible consultant.	X	
Q3.2	There is a comprehensive admission clerking.	X	
Q3.3	Allergy status is recorded in the admission clerking.	X	Y
Q3.4	**The cover of the folder <b>and / or</b> the eRecord, records or references anaesthetic hazards, allergies or alerts, if there are any.	**The cover of the folder records or references anaesthetic hazards, allergies or alerts, if there are any.	Y
Q3.5	The content of the record is adequate enough to provide a full, chronological picture of the in-patient episode.	The content of the record is adequate enough to provide a full, chronological picture of out-patient management over the preceding 3 months.	
<b>Section 4 - Treatment Plan</b>			
Q4.1	Advice/Information given to patient is recorded	Advice/Information given to patient is recorded	
Q4.2	Documentation that patient/carer is involved in decision making process	Documentation that patient/carer is involved in decision making process	
<b>Section 5 - Operation/procedure record</b>			
Q5.1	An operation / procedure record is present	X	Y
Q5.2	Name of person undertaking operation / procedure is documented (and is signed off with date, time and grade).	X	Y
Q5.3	Name of consultant responsible is documented	X	
Q5.4	Site and / or side is documented without abbreviation.	X	Y

Q5.5	The operation / procedure note is comprehensive.	X	
Q5.6	Post-operative / -procedure instructions are documented.	X	
<b>Section 6 – Anaesthesia (see also appendix 1)</b>			
Q6.1	An anaesthetic record is present and is filed in the correct section	X	Y
Q6.2	Name of anaesthetist is documented (and is signed off with date, time and grade).	X	Y
Q6.3	Name of consultant anaesthetist responsible is documented.	X	
Q6.4	The anaesthetic record is comprehensive.	X	
Q6.5	Site and / or side is documented without abbreviation.	X	Y
Q6.7	Post-anaesthetic instructions are documented.	X	
<b>Section 7 – Consent (policy linked <a href="#">here</a>)</b>			
Q7.1	If consent is required it is documented and includes the date and the signature, printed name and grade of the person taking consent/or the appropriate form has been used for those lacking the mental capacity to give consent.	If consent is required it is documented and includes the date and the signature, printed name and grade of the person taking consent/or the appropriate form has been used for those lacking the mental capacity to give consent.	Y
Q7.2	Discussion of the risks and benefits of the treatment is documented.	Discussion of the risks and benefits of the treatment is documented.	Y
Q7.3	Discussion of alternatives to the treatment is documented.	Discussion of alternatives to the treatment is documented.	Y
<b>Section 8 – Discharge / transfer (see trust policy <a href="#">here</a>)</b>			
Q8.1	The discharge / transfer letter is comprehensive.	X	

### Audit processes

1. Separate tools will be used for in-patients and out-patients.
2. There will be a requirement for each directorate to assess a minimum of 20 records.
3. Prior to commencing the audit, each directorate will be asked:
  - a) to identify their sub-specialties – each sub-specialty will have to assess a minimum of 10 records (the CRAC audit sub-group may change (increase or negate) this requirement, where necessary).
  
  - b) to define whether they or any of their sub-specialties are predominantly in-patient or predominantly out-patient - this will determine whether the in-patient or out-patient tool is to be used, exclusively, otherwise the requirement will be for a 50:50 split.
4. CGARD, through Information Services, will identify the records that each audit area will need to assess:
  - a) For in-patients, all relevant in-patient episodes will be identified in the 1 month prior to the start of the audit. A random sample of 150% of the anticipated number of returns will be presented to the audit area from which they will have to select the required number of returns.
  - b) For out-patients, all relevant out-patient contacts will be identified in the 1 month prior to the start of the audit. A random sample of 150% of the anticipated number of returns will be presented to the audit area from which they will have to select the required number of returns.
  - c) Responsibility for retrieval of records will lie within the audit areas.
5. The majority of in-patient audit measures will be confined to the identified in-patient episode or part, thereof, for which the audit area held responsibility. More generic record keeping practice (e.g. the general condition of the notes) cannot be allied to a specific in-patient episode, though, and are indicated with a \*\* in appendix 3. Identification of the index in-patient episode within 1 month of the audit start increases the likelihood that generic audit measures reflect practice within that area.
6. The majority of out-patient audit measures will be confined to the identified out-patient contact and all similar contacts over the preceding 3 months, for which the audit area held responsibility. More generic record keeping practice (e.g. the general condition of the notes) cannot be allied to specific out-patient contacts, though and are indicated with a \*\* in appendix 3. Identification of the index out-patient contact within 1 month of the audit start increases the likelihood that generic audit measures reflect practice within that area.
7. The 'traffic light' scoring system will function as a broad indicator of achievement.
  - a) The scoring stratification for most questions will be as follows:

Green	≥ 80% compliance
Amber	50 – 79% compliance

- Red  $\leq$  49% compliance
- b) A more stringent requirement will be applied to certain audit measures, though (e.g. documentation of allergy status), as follows:
- Green  $\geq$  90% compliance
- Amber 60 – 89% compliance
- Red  $\leq$  59% compliance

8. Results will be analysed by the audit department and reviewed by the CRAC audit sub-group before final presentation to the main CRAC.

9. The requirements for re-audit will be as follows:

A score is 'red' or 'amber' rated - re-audit all 'red' and 'amber' measures within 2 months, continue 2 monthly re-audit of all 'red' and 'amber' measures until they are 'green'.

10. Scores will be calculated against the anticipated, rather than the actual, number of returns.

11. The section on operations and procedures will only require completion if the area under audit held direct responsibility for it. This is to avoid disadvantaging the scores of other services.

12. The section on anaesthesia will only require completion by peri-operative directorates. Cases will be identified for the 1 month audit period, as follows:

Peri-op, FH: through the FH theatre database

Peri-op, RVI / NGH: as there is no comprehensive theatre database, this will be by self-selection for this audit cycle.

**THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST  
IMPACT ASSESSMENT – SCREENING FORM A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Clinical Record Keeping Policy	Policy Author:	Dr Suren Kanagasundaram
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)		The policy applies equally to all employees of the Trust and does not impact on any of the protected groups detrimentally
	• Race *	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender *	No	
	• Culture	No	
	• Religion or belief *	No	
	• Sexual orientation including lesbian, gay and bisexual people *	No	
	• Age *	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems *	No	
	• Gender reassignment *	No	
	• Marriage and civil partnership *	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? <i>(If “yes”, please answer sections 4(b) to 4(d)).</i>	N/A	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d)	Can we reduce the impact by taking different action?	N/A	

<b>Comments:</b>	<b>Action Plan due (or Not Applicable):</b>
	N/A

Name and Designation of Person responsible for completion of this form: ..... Dr Suren Kanagasundaram (Chair CRAC) ..... Date: 02/08/2011 .....

Names & Designations of those involved in the impact assessment screening process: ..... Dr Suren Kanagasundaram (Chair CRAC) .....

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

*For advice on answering the above questions please contact Frances Blackburn, Head of Nursing, Freeman/Walkergate, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) [steven.stoker@nuth.nhs.uk](mailto:steven.stoker@nuth.nhs.uk) together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.*