journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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Minimum standards for clinical record keeping

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Contents

1 Introduction

These standards support the Trust's pro-active approach to risk management. Some relate to the technical aspects of record keeping and have a direct bearing on the content of the record, e.g., legible handwriting in paper records. Other standards relate to records management processes, e.g., the need to track the movement of paper records and are no less important than the technical aspects. The aim of following the standards is to reduce and limit risk.

There are legal implications associated with clinical records; any document which records any aspect of the care of a patient or client can be required as evidence before a court of law. No records - no defence, poor records - poor defence.

Our Journey to Change sets out that we want people to lead their best possible lives. As part of our first Strategic Goal: 'To co create a great experience for our patient, carers and families', when caring for a patient, it is important to ensure good record keeping to promote patient care and better communication.

Good record keeping is a product of good teamwork and an important tool in developing high-quality healthcare and reinforcing professionalism. Good medical records – whether electronic or handwritten – support effective communication and sharing of information between members of the multi-professional healthcare team and patients, their carers and their families. A complete, up-to-date and accurate medical record can make a positive difference to the patient's outcome.

2 Why we need this policy

Record keeping is an integral part of a health care professional's practice designed to help the care process. All health care professional bodies' standards of professional practice emphasise the importance of record keeping.

UK GDPR and Data Protection Act 2018 introduce the principle of accountability – adhering to record keeping standards supports the Trust's ability to demonstrate compliance with this requirement.

2.1 Purpose

These standards will ensure the Trust keeps records that are consistent and are legally admissible in a court of law.

2.2 Objectives

Good record keeping supports a range of clinical, administrative and educational uses:

- Helps to improve accountability
- Shows how decisions related to patient care were made
- Supports the delivery of services
- Supports effective clinical judgments and decisions
- Supports patient care and communication
- Makes continuity of care easier
- Provides documentary evidence of services delivered
- Promotes better communication and sharing of information between members of the multi-professional healthcare team
- Helps to identify risks, and enable early detection of complications
- Supports clinical audit, research, allocation of resources and performance planning
- Helps to address complaints or legal processes.

3 Scope

The standards listed in this document apply to paper-based and electronic clinical records. All staff writing in the Trust's clinical records must follow these standards.

Any issues with clinical record keeping or queries with record entries should be discussed in clinical supervision.

3.1 Who this policy applies to

This policy applies to all staff who input into electronic records and who write in paper records.

3.2 Roles and responsibilities

Role	Responsibility
All staff who input into electronic records and all staff who write in paper records.	• Adhere to the standards documented in this policy
Data Protection Officer (DPO)	• The DPO is an essential role in facilitating 'accountability' and the organisation's ability to demonstrate compliance with the Data Protection Act 2018 and UK GDPR • To oversee the records management systems in the organisation so that all holding, processing and sharing

	activities are understood and compliant with UK GDPR and data protection principles • This role is assigned to the Head of Information Governance and Data Protection
Head of Information Governance and Data Protection	• Review and implement the standards
Information Governance Manager	• Review the audit tool, select teams for audit, circulate the audit tool, collate audit results, report audit results, create action plan
Team managers	• Include audit reports on team meeting agendas, discuss action plans and carry out actions
Team members	• Participate in team audits and individual audits through clinical supervision, carry out actions
Patient Systems Team	• Conduct regular batch tracing of Patient NHS Number

4 Standards

The standards apply to paper and electronic records. The standards apply to all patient records; inpatient, outpatient and community. Staff working for the Trust may use a variety of electronic systems and must follow system specific policies.

4.1 Documents and filing

No.	Description
4.1.1	**Use Trust approved stationery** for the purpose of record keeping in paper records. Beware of photocopying forms *ad infinitum*; printed text quality deteriorates when copied over and over and becomes blurred and illegible. Be aware of copyright on any assessment tools. Some assessments are protected by copyright and original documentation must be used every time you use the assessment tool. Using a photocopy of an assessment tool may breach copyright law.
4.1.2	**Use Trust approved case note folders.** These are available from the archive records library at Lanchester Road Hospital. You will need to provide a cost centre code. Email tewv.archiverequests@nhs.net with your request.
4.1.3	**Mark every paper page with the service user's name and NHS number** or name and date of birth if the NHS number is not known.

	If the patient is not registered on the system the member of staff must undertake a trace on the Personal Demographics Service (PDS) of the Summary Care Record (SCR) to ascertain the correct identifier for the patient.
4.1.4	**Use the Trust, service specific documentation and tools if care pathways are to be used.** File documents associated with the care pathway according to filing instructions in the care pathway.
4.1.5	**Arrange documents in chronological order** as though reading a book.
4.1.6	**File all paper documents in the appropriate sections** of the casenote folder according to filing instructions.
4.1.7	If received in paper format, **file blood, urine and other biochemistry or laboratory results and medical investigations** on a mount sheet in the appropriate section in the paper record.
4.1.8	**A responsible clinician must sign, print their name and date test results** to signify they have been looked at and understood and any necessary action taken.
4.1.9	**File signed consent forms** in the paper record, for example consent to examination or treatment.
4.1.10	**Do not duplicate information in a paper record** that is available in the electronic care record. Avoid printing and filing paper documents including letters from the electronic care record. The Trust is moving towards a paperless record and this practice undermines progress towards this. Teams working in the Children & Young People's Learning Disabilities Service may print out documents from the electronic care record and file these in the paper record because of their lack of wireless connectivity in community locations.
4.1.11	**Bind documents directly into the folder**; there must be no loose pages. Paper *'Stora'* envelopes may be used for keeping items unspoiled and secure, for example: • Children's artwork • Paper traces from machine recordings (EEG and ECG traces) • Notes and letters written by service users Ensure you use the space on the front of the *'Stora'* envelope to catalogue its contents.
4.1.12	**Do not keep handwritten notes made as an *aide memoire*** at the time of the appointment with a service user once the full entry has been recorded in the electronic record. Destroy hand-written notes once they have been written in full into the record.
4.1.13	**Do not use** plastic wallets, staples, sticky notes or highlighter pens in the paper record. Use plastic treasury tags rather than staples. Papers can easily fall out of plastic wallets and sticky notes can detach themselves and be lost. Highlighted text and staples cause issues when the record needs to be copied e.g., for a subject access request.
4.1.14	**Use the NHS number**:

	• Register service users on the electronic care record with their NHS number • Record the NHS number on the outside of paper casenote folders • Record the NHS number on all service user documentation, *e.g.,* letters, reports, medication cards.

4.2 Written content

No.	Description
4.2.1	**Write legibly in indelible black ink** in paper records. Pharmacists may continue to use green ink but must ensure the ink colour is indelible and legible when photocopied.
4.2.2	**Use consistent font in the electronic record**: • Size: 12 point • Font: Arial • Colour: Black Deviating from this standard leads to an unprofessional looking record. Electronic care record records are sometimes printed out, for example for mental health review tribunal meetings and for the Police. Records are easier to read if they have consistent font. If you use different colours to highlight a point bear in mind the font will only print in colour with a colour printer. Not all staff have access to a colour printer. You may need explain the reason for different coloured fonts for patients who access their records through a Subject Access Request and also to professionals who have a legal or justified right of access.
4.2.3	**Write** factual, accurate, clear, relevant, unambiguous, concise entries.
4.2.4	**Write** in terms that the service user can easily understand.
4.2.5	**Write records with the involvement of the service user** wherever possible
4.2.6	**Do not use abbreviations that are ambiguous** or those that cannot be understood by the service user. Abbreviations can mean different things to different people. For example, CH could mean care home, case history, community health. Spell out abbreviations at first use if it is an abbreviation your service user will not understand or if **it is not on the approved list.** Clinicians may use the prescribing abbreviations printed in the British National Formulary. A list of Trust approved abbreviations is published on the intranet and can be found at Abbreviation List
4.2.7	**Record allergies and major medical problems** in: • The allergies module of the electronic record • The allergies panel on the inside front cover of a paper casenote folder
4.2.8	**Do not use** pencil erasers, correction fluid or correction tape. Recording keeping must be transparent.

4.2.9	**Cross out mistakes with a single horizontal line**. If a correction, alteration or addition is necessary, cross out the error with a single line so the original entry can still be read clearly. For example: ~~Patient went home at 14:00 hours accompanied by her daughter.~~ 06.07.07 16:00 hours. Correction made to record. Entry made in error in wrong patient's file. If the correction was due to an obvious spelling or grammar mistake you do not have to justify the reason for alteration. Other amendments must be dated, signed and timed and a reason recorded for the alteration.
4.2.10	**Cross through the remaining part of a line** if an entry has finished part way along a line to mark the end of the entry in a paper record.
4.2.11	**Do not leave gaps** between entries in paper records
4.2.12	**Do not use "ditto" lines**, i.e., " " " " "
4.2.13	**Do not leave blank pages** between record keeping entries in paper records.
4.2.14	**Reference diagrams made in paper records in the electronic care record**. The location of the diagram in the paper record must be noted and the type and volume number of the record must be noted.
4.2.15	**Time, date, sign, print name and state designation** against entries made in paper records. Every signature must be accompanied by the name in printed text so the identity of the author is known.
4.2.16	**Check your correct professional title appears on the electronic record 'stamp'**. Clinical staff using the electronic care record must make sure their correct clinical designation appears in the automatic stamp of each clinical entry that specifies the time, date, staff name and clinical designation.
4.2.17	**Write entries at the time an event or activity takes place** or at least within 24 hours, *i.e*. contemporaneous record keeping.
4.2.18	**State when entries are retrospective** (*i.e.,* made after the event/activity). The date and time of the event/activity must be included within the text of the record entry. For example: *"06/06/07 14:00hrs: Retrospective note. Patient visited at 16:00 hours on 07/06/07. Patient appeared well and reported…"*

4.2.19	**Explain if a significant time has elapsed between entries**. Guidance on the frequency of entries: • Inpatient notes – usually one entry per shift or in accordance with clinical presentation. • Community notes – one entry per contact. For community patients there may be long periods of time between entries because their long appointments may be spaced some months apart. In this situation it is understandable that there will be long periods between entries. The frequency of entries will be determined by the clinician's professional judgment and local standards and agreements. Clinicians may be required to make more frequent entries for patients who: • Present with complex problems • Show deviation from the 'norm' • Are vulnerable or at risk of harm or abuse • Require more intensive care than usual • Are confused and disorientated or generally give cause for concern Note, this is not an exhaustive list. Clinical staff must use their professional judgment and if necessary, in discussion with other members of the health care team, determine whether these circumstances exist.
4.2.20	**Record disclosures of a child protection, child welfare and vulnerable adult nature word for word**.
4.2.21	**Mark information provided by a third Party as 'third party'**. This will prevent disclosure without appropriate consent.

4.3 Trans service users

No.	Description
4.3.1	Trans is an *umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth (Stonewall 2019).* Staff handling personal information relating to Trans service users must manage it in very specific ways. It must be managed with the same level of confidentiality assigned to adopted individuals and individuals on witness protection.
4.3.2	'Outing' is the act of disclosing an LGBTQ+ person's sexual orientation or gender identity without that person's consent. It is essential that steps are taken to ensure that this does not take place in the patient's clinical record.
4.3.3	A Trans person should always be consulted with and referred to in the gender that they choose to identify with. Language including written words and text entered into the electronic care record and paper records should always reflect the wishes of the patient.

4.3.4	It is important to get patients pronouns correct throughout the written record. Do not assume how a person wishes to be addressed by the way they are dressed or the sound of their voice. You must ask the individual how they wish to be addressed; their preferred pronoun/s should then be used in all contacts with, and referring, to that individual e.g., him/he, her/she, they/them, he/they etc.
4.3.5	The record must be consistent, *i.e.,* not change between pronouns and also use the individual's name correctly. For example, if a person is born male (AMAB) (Assigned Male At Birth) as John Gray, identifies as a woman called Jenny, then this individual will always be known as Jenny Gray and the pronoun **she** will always be used to describe them. Equally, if a person is born female (AFAB) (Assigned Female At Birth) the same would apply.
4.3.6	The Equality Act 2010 protects people at any stage of the gender reassignment process. A person does not need to have undergone any specific medical treatment or surgery to change from their birth sex to their preferred gender.
4.3.7	It is paramount that a blanket approach is *not* used in relation to record keeping for Trans patients. It is imperative that staff are open and honest in their communication and explain to the patient their options and what they entail.
4.3.8	It is essential that we do whatever we can to accommodate the needs of the patient.
4.3.9	In some cases, you may need to obtain written consent from the patient (please complete consent form in Appendix 1), this should be saved to the 'old' record so as not to 'out' the patient.
4.3.10	The Gender Recognition Act 2004 created a process to enable transgender people to get their UK birth certificates and legal gender changed. The transgender person can apply to the Government's Gender Recognition Panel for a Gender Recognition Certificate. If they are successful in their application, the law will recognise them as having all the rights and responsibilities appropriate to a person of their acquired gender. However, a transgender person does not need to have a Gender Recognition Certificate, and the majority do not.
4.3.11	**It is against the law to ask a trans person to show you their Gender Recognition Certificate;** Anyone who breaches the Gender Recognition Act 2004 can be prosecuted and fined.

Information relating to a patients GRC (Gender Recognition Certificate) **must not** be recorded on the electronic care record unless the patient requests this and has given written consent for us to do so.

Conversations with the patient pertaining to someone's gender identity must not take place where other staff or patients are present.

4.4 Trans Patients without a Gender Recognition Certificate (GRC)

No.	Description
4.4.1	**When the patient does not request a new NHS number:** • **Option 1** - Go through the record to redact any references to gender, pronouns and previous name. This can be with or without the involvement of the patient. • **Option 2** - Keep the record in its current form. This does not need patient consent but should be discussed with the patient and a record of the discussion made. The patient must be made aware that unless they obtain a new NHS number, the historical record which would include references to previous gender, pronouns and name could be viewed by clinicians.
4.4.2	**When the patient requests a new NHS number:** • **Option 1** – A new record is created which will include a gender-neutral summary of the historical record in relation to what is relevant which will require clinical judgement. • **Option 2** – A new record is created and the whole previous record is moved to the new record without any amendments made. You should only replicate the previous record in full within the new record where the patient has agreed (please complete form in Appendix 3). Restricted access should be applied. • **Option 3** - No amendments are made to the new record i.e. it contains no reference to the historical record, either by way of summary or otherwise. There should be a robust informed decision-making process to ensure the patient is aware of any risks and future implications such as not receiving invitations for gender-specific screening. Record the fact the patient has agreed to this using the form in Appendix 3. Restricted access should be applied. You should seek further advice from the information governance department if you have any concerns that this option would not safeguard the patient or provide safe care. Currently, it is not possible within the electronic patient record to create a new record and move the whole previous record to the new record and also redact any references to gender, pronouns and previous. However, this will be continually reviewed as new systems are developed and implemented.

If you have any concerns about the ability to achieve the patient's preferred option, contact the information governance team for advice on tewv.ig@nhs.net

4.5 Trans Patients with a Gender Recognition Certificate (GRC)

No.	Description
4.5.1	**When the patient does not request a new NHS number** • **Option 1** – Go through the record to redact any references to previous gender, pronouns and name. This can be with or without the involvement of the patient. • **Option 2** – Keep the record in its current form – written consent must be obtained from the patient who would need to be made aware that, unless they obtain a new NHS number, the historical record, previous gender, pronouns and name could be viewed by clinicians. You should complete the form in Appendix 1 to record their agreement. Restricted access should be applied.
4.5.2	**When the patient requests a new NHS number** **Option 1** – A new record is created which will include a gender-neutral summary of the historical record. If any part of the summary would reveal the previous gender then agreement to include it should be recorded using the form at Appendix 1. If the patient does not agree, any risks should be explained, and you should record the fact the patient has agreed to this option (please complete form in Appendix 3). Restricted access should be applied. You should seek further advice from the information governance department if you have any concerns that this option would not safeguard the patient or provide safe care. • **Option 2** – A new record is created and the whole previous record is moved to the new record without any amendments made. You should only replicate the previous record in full within the new record where the patient has agreed (please complete form in Appendix 3). Restricted access should be applied. • **Option 3** – No amendments are made to the new record i.e., it contains no reference to the historical record, either by way of summary or otherwise. There should be a robust informed decision-making process to ensure the patient is aware of any risks and future implications such as not receiving invitations for gender-specific screening. Record the fact the patient has agreed to this using the form in Appendix 3. Restricted access should be applied. You should seek further advice from the information governance department if you have any concerns that this option would not safeguard the patient or provide safe care. Currently, it is not possible within the electronic patient record to create a new record and move the whole previous record to the new record and also redact any references to gender, pronouns and previous. However, this will be continually reviewed as new systems are developed and implemented.

If you have any concerns about the ability to achieve the patient's preferred option, contact the information governance team for advice on tewv.ig@nhs.net

Information about NHS population screening and what this means for trans and non-binary people can be found here NHS population screening: information for trans and non-binary people - GOV.UK (www.gov.uk).

4.6 Recording incidents in patient records

No.	Description
4.6.1	Incidents involving service users should be noted in the electronic care record, however it is not appropriate to record excessive information about third parties (*e.g.,* staff and visitors) involved in the incident in patient records. The details of the incident should only be recorded in the Trust's incident reporting system. Record the incident first so you have an incident reference number to quote in the electronic care record case note entry. Create a case note entry in the electronic care record with a brief description of the incident including: • The time of the incident • The incident reference number • The names and roles of individuals involved • Information that is clinically relevant

4.7 Records management and other considerations

No.	Description
4.7.1	**Follow the common law duty of confidentiality.** The Trust will take action when someone deliberately looks at service user records without a justified reason or appropriate permission.
4.7.2	**Explain to service users why we ask them for personal information**. This is a requirement of the Data Protection Act. Give patients a copy of the Trust's privacy notice; ***'How we use your personal information'***. This is published on the Trust's website and will be available in the most common languages spoken by individuals in the community we cover. There is also a version of the leaflet for Learning Disability and Children & Young People service users. This is also available on the Trust's internet site. Give this leaflet to service users at the beginning of an episode of care. Explain the leaflet and make sure the patient has understood and is happy for their information to be used in the ways described. Record you have done this in the new Consent module in the electronic care record. Record any objections to sharing information.
4.7.3	**Use the electronic patient record with regard to information security**: • Position your monitor away from public areas • Lock your computer monitor when it is not in use

	• Do not download data from the electronic care record • Do not share your electronic care record password and do not write it down
4.7.4	**Keep paper records in a secure place** and make them accessible, (*i.e.* records can be found and retrieved when needed). The security of records is necessary to safeguard them from breaches of confidentiality. When paper records are not in use they must be locked in a cupboard, filing cabinet or lockable trolley and then locked away in a secure room.
4.7.5	**Do not create duplicate volumes**. All sources of information including the legacy look-up in the Integrated Information Centre must be interrogated for the existence of previous records. When a patient is referred to the Trust, staff must check for the existence of previous records so they can be used as part of the assessment process and also to avoid the creation of a duplicate volume. During office hours health professionals should contact the records libraries at Lanchester Road or Flatts Lane Centre and ask records staff for advice on checking for the existence of previous records.
4.7.6	**Trace and track the movement of paper records**. Use a tracer card or logging-in and logging-out book. Tracing and tracking also applies to documents which may be removed temporarily from records. The location of patient information in paper format applies to whole records and to individual documents that may be removed temporarily from a casenote folder if a single document is required at a place which is at a distance from the casenote folder location. When records or documents removed from folders are moved around and outside of the Trust this must be done securely to prevent loss of information and breaches of confidentiality.
4.7.7	**Archive records in accordance with Trust retention and disposition procedures for paper and electronic records.** Only hold paper patient records for the current open caseload – follow the process for archiving paper patient records for discharged patients.
4.7.8	**Complete the 'Additional Clinical Information/Notes' panel on the front cover of the paper casenote folder if necessary**. Refer to the Trust's records management procedures for guidance. Completion of this panel enables staff to collate records together to view a complete picture of care.
4.7.9	**Complete demographic information accurately and check regularly.** Every effort must be made to collect accurate service user details, for example marital status and ethnicity. This data forms part of the Mental Health Minimum Data Set and the Trust is performance managed on this. Once personal has been collected it must be kept accurate and up-to-date at appropriate intervals; this is a requirement of the Data Protection Act 2018.
4.7.10	**Visiting clinicians' entries must be summarised on the electronic record.** The original paper entry (where there is one) should be kept for the retention time applicable to mental health records.
4.7.11	**Record when appointments are cancelled (by patient or by the Trust) and record when not attended by the patient**.

4.7.12	**Records must be complete**. The electronic care record is the primary care record for most of the Trust's clinical services. One exception is the Children & Young People's Learning Disabilities Service. All services will use supplementary paper records for documents that cannot be held or are not available on the electronic care record. For example external correspondence and specialist assessment tools. All services must record pertinent and risk issues on the electronic care record in enough detail for another clinician to be able to make decisions.
4.7.13	**Record differences of opinion**. If there is a difference of opinion regarding diagnosis between the patient and the clinician, this must be recorded. The safety summary provides an opportunity to record views in terms of the conclusions reached and any facts around risk and safety identified relating to the difference of opinion. Recording difference of opinion should then be the start of a process of dialogue that centres on patient safety and continued engagement and involvement.

4.8 Accountability and competency

No.	Description
4.8.1	**Clinicians remain accountable for entries made on their behalf.** If extenuating circumstances mean that a clinician cannot make a timely entry, they must contact an appropriate clinical colleague to record an entry on their behalf. The entry will be made as a third party entry. Medical Secretaries can also make an entry because of the additional training that they undertake. Clinicians should consider carefully allowing other administrative staff to make clinical entries as the opportunity for error rises considerable when background clinical context is not fully understood. The clinician requesting an entry to be made should ensure that it is countersigned within 24 hours.
4.8.2	Clinicians using the BigHand digital dictation solution must comply with the Standard Workflow and approve the content and accuracy of clinical documents transcribed by secretaries.
4.8.3	**All non-registered** clinical staff making independent entries in electronic case notes or paper clinical records must be competent to do so. Only staff who are competent in clinical record keeping as determined by the clinical supervisor may make entries in the clinical record thus removing the need for countersignature.
4.8.4	Student nurses, student allied health professionals and medical students may have to write access to the electronic care record but they will have to ensure their entries are accompanied by a verification entry made by a registered member of staff.

4.9 Coroner's reports

No.	Description
4.9.1	Coroner's reports (reports prepared for the Coroner) should not be saved on to the electronic or paper care record. Both the electronic and paper care record support the delivery of care so are not appropriate places for Coroner's reports.
4.9.2	Draft and final reports must be forwarded to The Inquests and Legal Services Officer then deleted from where it is stored, e.g. home drive or USB stick.
4.9.3	A copy must not be retained by the author. The Inquests and Legal Services Officer will act as 'gatekeeper' for all draft and finalized reports. Should the author require a copy prior to attending the inquest, contact the Inquests and Legal Services Officer.

4.10 Erasure of personal data and restriction of processing

No.	Description
4.10.1	The Data Protection Act 2018 introduced the right to erasure of personal data and the right to restrict processing. The Act defines the circumstances under which these rights can be exercised. All such requests **must** be forwarded to the Data Protection Officer to be considered on an individual basis **before** any further action is taken.

4.11 Ad hoc advice requests

No.	Description
4.11.1	Clinicians are sometimes contacted for advice, for example from a GP. If the patient has previously been open to the Trust, advice will give consideration to historic data and should be recorded as a casenote/progress note on the electronic patient record. A referral is not to be reopened.
4.11.2	If advice is requested for an individual who is not and never has been a patient of the Trust, advice will be given purely on the basis of the facts shared by the enquirer. In this situation, a record of the advice will be the responsibility of the enquirer, e.g. on the GP record. An electronic care record must not be created.

5 Definitions

Term	Definition
BigHand	BigHand is a digital dictation system which allows creation, tracking, transcribing and managing dictation workloads.
Contemporaneous	Existing at or occurring at the same period of time.
Privacy notice	Also known as a fair processing notice. It is a basic legal requirement under the Data Protection Act to make sure people know who you are, what you intend to do with their personal information and who it will be shared with or disclosed to. This information is provided in a privacy notice.
Retrospective	Looking back on or dealing with past events or situations.
Trans	Trans is an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth.

6 Related documents

The following documents should be read with this policy as they relate directly to it:

- Admission, Transfer and Discharge Policy
- Approved Abbreviations List
- Sharing Information and Confidentiality policy
- Data Management Policy
- Paris Procedure
- Records Management policy
- Records Management Procedures
- NHS Number Procedure

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.

- All staff who write in paper patient records and/or who input into electronic patient records must follow the standards in this document.

7.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All electronic clinical record system users	electronic clinical record system training	e-learning	Yearly
Patient products team staff	Batch tracing induction	1 Day	Once

8 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	IIC data quality reports	Data Quality Group/Clinical Management Groups	Senior Leader Groups
2	Batch tracing process	monthly	Data Quality Group
3	Clinical Audits	Yearly	Information Governance Group

9 How this policy will be audited

9.1 Responsibility for audit

All staff who write in paper records or who input information into electronic records are responsible for adhering to the Trust's minimum standards and their own professional standards for clinical record keeping. Clinical teams will be selected to take part in the

annual Trust-wide audit of clinical record keeping. Management of the clinical record keeping audit is shared between the information governance department and the clinical audit and effectiveness department.

9.2 Frequency of audit

Clinical records will be audited across all clinical directorates on an annual basis, however local monitoring may take place in-between annual audits if teams wish. Local monitoring must not replace participation in the annual audit.

9.3 Audit tools

The clinical record keeping audit tool will be reviewed annually. Only the current, approved audit tool should be used for the purpose of audit. The IG & Records Management department will, in collaboration with the Clinical Audit & Effectiveness department, choose the clinical teams who will take part in the audit.

A short audit tool will be made available for use in clinical supervision by clinical staff .This will identify issues with record keeping in a timely way and immediate action can be taken to improve poor practice.

9.4 Audit reports

The Clinical Audit & Effectiveness Department collates all audit tool results and produces overall directorate results. Audit reports are created for individual clinical directorates. Audit reports are sent to general managers for dissemination to their teams.

Reports contain:

- individual team results
- overall audit results for the clinical directorate
- conclusions on the overall results
- areas of good practice
- areas where improvements are required

Reports will include an analysis of achievement against the clinical record keeping standards in order to assess how effective action plans have been in leading practice change.

9.5 Development and review of action plans

Each directorate will be required to disseminate the clinical record keeping audit report to all clinical teams. The Information Governance Manager will create a directorate action plan. Where necessary individual teams may be required to formulate an individual team action plan.

Action plans will detail how teams will improve poor record keeping practice and maintain good record keeping practice. When formulating the action plan any themes from incident reports or serious untoward incidents in relation to record keeping will be considered.

9.6 Process for monitoring compliance

The audit reports and directorate action plans will be considered at the Digital Performance and Assurance Group in order that training needs and potential policy development areas may be identified and addressed.

The Clinical Audit & Effectiveness Department will review progress against action plans with clinical teams at local governance forums.

10 References

Nursing & Midwifery Council, Record Keeping Guidance for Nurses and Midwives, July 2009

Health & Social Care Information Centre Information Governance Toolkit sequence 404

General Medical Council, Good Medical Practice, Domain 1 Knowledge Skills and Performance, 2013

Royal College of Psychiatrists Good Psychiatric Practice, 3rd edition, college report CR154

Health and Care Professions Council, Standards of Proficiency, 2007

Care Quality Commisison, Summary of Regulations, Outcomes and Judgement Framework, 2010

NHS Care Record Guarantee, January 2011

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	10 November 2023
Next review date	10 November 2026
This document replaces	CORP-0026-002-v1.1 Minimum Standards for Clinical Record Keeping
This document was approved by	Digital and Data Management Meeting 26 September 2023
This document was approved	Digital Performance and Assurance Group 10 November 2023
An equality analysis was completed on this policy on	28 June 2023
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
	13 Jan 2010	Review date extended to 30 April 2010	Withdrawn
	2 Jun 2010	Review date extended to 1 September 2010	Withdrawn
	1 Sep 2010	Review date extended to 1 March 2011	Withdrawn
	Feb 2012	Reviewed	Withdrawn
	7 Nov 2012	Minor amendment	Withdrawn
	20 Nov 2012	Minor amendment	Withdrawn
	1 Oct 2013	Responsible director changed from Director of Nursing and Governance to Director of Finance and Information	Withdrawn
8	Mar 2016	Sections included on Trans service user information and incident reporting.	Withdrawn
8.1	Aug 2017	Wording added re corners reports	Withdrawn
1	Jul 2018	Renumbered to sit with Records Management Policy. Revised in line with DPA 2018 (GDPR). Section 4.8 added. Roles and responsibilities reviewed.	Withdrawn
1	12 Apr 2021	Review date extended to 04 January 2022	Withdrawn
2	11 Nov 2023	Full revision. Latest guidance added re record keeping for Trans patients, Personal Demographics Service and	Published

		Summary Care Record. New section 4.11 re recording ad hoc requests. Also includes: OJTC – added to introduction Roles and responsibilities - amended Documents and filing section - amended Written content section – allergies - amended Section 4.7 Records management and other considerations - amended – including new wording regarding “Record differences of opinion” Accountability and competency – amended re: non-registered staff TNA section – updated	

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Digital and Data Services
Title	Records Management – Minimum Standards for Clinical Record Keeping
Type	Procedure/guidance
Geographical area covered	Trust-wide
Aims and objectives	These standards aim to ensure the Trust keeps records that are consistent and are legally admissible in a court of law.
Start date of Equality Analysis Screening	January 2022
End date of Equality Analysis Screening	28 June 2023

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All staff who input into electronic clinical records and who write in paper clinical records. Patients, and their family and carers, who benefit from good record keeping.
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	None identified
Describe any positive impacts / Human Rights Implications	The procedure has undergone extensive consultation regarding record keeping for Trans patients and incorporates learning from information incidents. The aim of the procedure is to support co-creation of the patient record for Trans patients, particularly those who have a new NHS number, so that the patient's voice is heard,

	and clinical risks are discussed in an open and supportive way. Ultimately there should be 'no surprises' for the patient regarding their record.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Latest legal advice has been sought via the Trust solicitors and current best practice via NHSE.
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	The document has undergone extensive consultation including the staff Rainbow Network and people with lived experience.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	**Training needs**
As part of this equality impact assessment have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Each instance of record keeping for Trans patients will be considered on a case-by-case basis with support provided to staff from the Equality, Diversity & Human Rights and Information Governance teams. This is so that a record is co-created which respects the wishes of the patient whilst managing any clinical risk and providing continuity of safe care.

Describe any training needs for patients	The support described above is also available to the patient should they request this outside of the immediate care team.
Describe any training needs for contractors or other outside agencies	N/A – record keeping for Trans patients will be managed by Trust staff only

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	
7.	**Implementation and monitoring**		

	Title of document being reviewed:	Yes / No / Not applicable	Comments
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

Appendix 3 – RECORD OF AGREEMENT - NEW NHS NUMBER

This is available from ..\..\..\..\Intranet Published Documents\Policies procedures and legislation\Corporate\CORP-0026-002-v2 Min Stds for Clin Record Keeping - Record of Agreement new NHS number.docx

Please also see over the page.

Tees, Esk and Wear Valleys
NHS Foundation Trust

RECORD OF AGREEMENT
NEW NHS NUMBER

All medical records are confidential and only accessed on a need-to-know basis.

This change is only relevant to your medical record at Tees, Esk and Wear Valleys NHS Foundation Trust.

Any other NHS organisation must be informed separately including your GP.

Option 1: New medical record with de-identified gender-neutral summary of history

Option 2: New medical record with de-identified gender-neutral full history

Option 3: Fully identifiable full history

Option 4: New medical record with no history transferred

Benefit: Medical history will ensure the hospital has your continued medical record history available when managing your healthcare, whilst ensuring your identity is recorded appropriately.

Risks and disadvantages: A summarised history may result in relevant information including risks not being available. This may result in decisions about your care being made without being fully informed. Medication history may be relevant to sex at birth and will be visible to health professionals involved in your care.

Discussion summary:

I understand the options available, and the risks as stated and discussed.

Please create a new medical record using:

- ☐ Option 1: New medical record with de-identified gender-neutral summary of history
- ☐ Option 2: New medical record with de-identified gender-neutral full history
- ☐ Option 3: New medical record with identifiable full history
- ☐ Option 4: New medical record with no history transferred

*I understand this form will be retained on my **OLD** medical record*

Name (PRINT): _____

Date of Birth (DD/MM/YYYY): _____

New NHS Number: _____

Signature: _____

Date: _____

Office Use Only: This form must be retained on the patient's old record only.