Health Record Keeping/ Medical Documentation E-Learning Mandatory Training

Definitions

- **Health Record**

  Means that any record consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual.

What is a Medical Record?

Data Protection Act 1998

"A health record for the purposes of the Act is one which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection with the care of that individual."

Anything which contains information (in any media) about a person that has been gathered by any healthcare professional

Your duty

- All clinicians have both a professional and a legal duty of care to patients.

- All professional organisations will expect that high quality standards of care are maintained and this includes record keeping. Record keeping standards are an indication of professional practice. Under the Public Records Act all employees are responsible for any records that they create or use in the course of their duties.

Individual Responsibility

All health care professionals have a legal duty and are responsible for any records they may create or use. They have a duty to comply with the Trusts policies and procedures for health record keeping and to comply with the relevant standards set by their individual professional body and relevant legislation.

DGNHS Foundation Trust

Health Record Keeping Standard Policy - 2012

Our Health Record Keeping Policy is essential to:

- Establish and maintain consistent standards of clinical record keeping throughout the Trust;
- Ensure that all clinical records meet legal obligations;
- Ensure that the requirement under clinical governance for effective monitoring of clinical care and high quality systems for clinical record keeping are met.
- Ensure that the statutory requirements or the EU Directive 2001/20/EC are adhered to regarding Good Clinical Practice in record keeping for clinical trials.

Principles of High Quality Record Keeping

- Promoting high standards of clinical care
- Helping to improve accountability by supporting effective clinical judgements and decisions
- Promoting better communication and dissemination of information between members of the inter-professional health teams so ensuring continuity of care
- Providing documented evidence of treatment and care planning and delivery
- Ensuring the ability to detect changes in condition at an early stage
- Helping to identify risks and enabling early detection of complications
- Supporting the delivery of services

Why is good record keeping important?

Records are an important tool in the care of a patient they provide:

- Communication between staff
- Continuity of care
- Evidence of care

Consequences of poor record keeping

- The NHS Complaints Procedure has lead to increased complaints from patients and has shown that most problems are compounded by issues of poor communication and record keeping

- Patients who see shoddy note keeping, tend to believe they have had shoddy care hence litigation.

How Much Does Litigation Cost ?

Year 2012-13 (Source: Hansard 2014) for the NHS

	Clinical	Non-Clinical	Total
	£'000	£'000	£'000
Damages:	907,529	23,183	930,712
Claimant: legal costs:	274,861	20,647	295,508
Defence: legal costs:	76,489	7,273	83,762
Totals:	1,258,879	51,102	1,309,982

How Much Does Litigation Cost ?

- **£70 millions** in 2011 for the West Midlands
- Almost a third of that – more than **£19 million** – went in to the pockets of **legal teams**.
- Cases involving maternity and obstetrics care in the past year saw The DGNHS Foundation Trust pay out the most with £2.8 million in damages and £530,000 in legal fees.

Medical records could include;

Registers
Notes
Assessments
Prescriptions
Consent forms
Correspondence
Accident / incident forms
Discharge letters
Referrals

X Rays and reports
Photographs
Microform or audio
Computer databases / discs / fobs
Professional diaries
Rough Notes
Statements
Complaints

Dudley Group Standards

Blue or black ink may be used in documentation

Jargon, meaningless phrases or offensive statements are not to be used

Include only abbreviations outlined in the Trust abbreviation policy

If any assessment cannot be completed the reason must be identified.

Ideally records to be written in partnership with the patient/carer and in terms they can understand

Good Health Record Keeping

✓ The patient's complete medical record should be available at all times during their stay in hospital.

✓ Every page in the medical record should include the patient's name, identification number (NHS number) and location in the hospital.

✓ The contents of the medical record should have a standardised structure and layout.

✓ Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order.

Good Health Record Keeping

Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma.

Every entry in the medical record should be:

Dated
Timed (24-hour clock)
Legible
Signed by the person making the entry.
The name and designation of the person making the entry should be legibly printed against their signature.
Deletions and alterations should be countersigned.

Good Health Record Keeping

Entries to the medical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded.

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

On each occasion the consultant responsible for the patient's care changes, the name of the new responsible consultant and the date and time of the agreed transfer of care, should be recorded.

Accountability

The GMC "Good Medical Practice" states a doctor *"keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed"*

The BMA "Access to health records by patients“ adds: *"Doctors should ensure that their manner of keeping records facilitates access by patients if requested"*

Duty of Confidence

Patient records should be treated and used in line with the Trust Policy on the use of confidential information.

“Every employee who records, handles, stores or otherwise comes across information has a personal common law duty of confidence”.

Attorney General (1988).

Professional bodies and record keeping

NMC state:

" Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and **it is not an optional extra** to be fitted in if the circumstances allow".

HPC state:

Standards 1, 2 and 10 of the Code of Conduct, enforce that a registrant must always keep high standards of conduct, act in the best interest of patients, clients or users, maintain patient confidentiality and keep accurate patient, client and user records."

Retention and Claims:

Limitations Act 1980

- Records should be kept for 8 years
- Child until 25th birthday
- Maternity 25 years
- Learning disability, 20 yrs after last treatment

A person has a 3 year period to commence any action which starts from the date of loss, damage, injury or harm.

Or

The date when the claimant becomes aware of the date of damage (referred to as legal knowledge).

Records Storage

Records storage is the practice of maintaining the records of an organisation from the time they are created up to their eventual disposal.

This may include classifying, storing, securing, and destruction (or in some cases, archival preservation) of records, in any form either paper or electronic

Retention of Records: Limitations Act 1980

- Adult records should be kept for 8 years
- Child records until 25th birthday
- Maternity 25 years
- Learning disability, 20 yrs after last treatment
- Some records are retained longer, for research etc.

Access and Ownership

All healthcare professionals need to assume that any entries made into patient/client records will be scrutinised at some point.

REMEMBER

Patient/clients and their representatives not only have a legal right to see their records but they are increasingly starting to participate in recording and holding them.

What about electronic records?

- The practice of transferring clinical data by electronic data bases is still in its early stages in healthcare.
- The NHS plans to introduce electronic communications across all organisations to cut down on paper and storage facilities.
- In the future, GPs can expect to see emails relating to referrals also electronic prescriptions and GP-to-GP transfer of records.

What about text messaging?

As this type of communication develops, local protocols and polices will be put in place that include the use of mobile phones.

However all messages received via text should be documented and include the following information:

- Date and time
- Text message in full
- Telephone number
- Any response made
- Any appointment made or referral to other agencies
- Signature

Security of records

- What ever way we pass on information confidentiality should never be put at risk.
- You must all be aware of local policies and procedures , and comply with, all security measures designed to protect people’s health records.

Remember

Good Record Keeping is a mark of the skilled and safe professional

Approved Abbreviations

The Dudley Group of Hospitals NHS Trust

List of Agreed Abbreviations

Common Medical Conditions

AIDS	ACQUIRED IMMUNODEFICIENCY SYNDROME
CCF	CONGESTIVE CARDIAC FAILURE
COPD	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CVA	CEREBRO-VASCULAR ACCIDENT
DVT	DEEP VEIN THROMBOSIS
HIV	HUMAN IMMUNODEFICIENCY VIRUS
MI	MYOCARIDAL INFARCTION
MRSA	METHICILLIN RESISTANT STAPH AUREUS
PE	PULMONARY EMBOLUS
STAPH	STAPHYLOCCUS
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 Treatments/Procedures

CPR	CARDIO PULMONARY RESCSCITATION
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

a. Route

Ext	EXTERNAL USE
IM	INTRA MUSCULAR
Inh	INHALATION
IV	INTRAVENOUS
Neb	NEBULISATION
O	ORAL
PO	BY MOUTH
PR	PER RECTAL
PV	PER VAGINA
SC	SUB CUTANEOUS
S/L	SUB LINGUAL
Top	TOPICAL

b. Dose

OD	ONCE A DAY
OM	EACH MORNING
ON	EACH NIGHT
BD	TWICE A DAY
PRN	AS REQUIRED
QDS	FOUR TIMES DAILY
TDS	THREE TIMES DAILY
MANE	MORNING
NOCTE	NIGHT

All other routes and doses must be written out in full

c. Other

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
SOS	SEE IF IN TROUBLE
TCI	TO COME IN

Approved Abbreviations

People

CPN	COMMUNITY PSYCHIATRIC NURSE
GP	GENERAL PRACTITIONER
HO	HOUSE OFFICER
HV	HEALTH VISITOR
RMO	RESIDENT MEDICAL OFFICER
REG	REGISTRAR
RSO	RESIDENT SURGICAL OFFICER
SALT	SPEECH AND LANGUAGE THERAPIST
SHO	SENIOR HOUSE OFFICER
SPR	SPECIALIST REGISTRAR
SR	SISTER
S/M	STAFF MIDWIFE
S/N	STAFF NURSE
ST/N	STUDENT NURSE
ST/M	STUDENT MIDWIFE

Speciality

ENT	EAR NOSE AND THROAT
GI	GASTRO INTESTINAL
GYNAE	GYNAECOLOGY
HDU	HIGH DEPENDANCY UNIT
NNU	NEONATAL UNIT
OPD	OUT PATIENTS DEPARTMENT
OT	OCCUPATIONAL THERAPY
PAEDS	PAEDIATRICS

Patient Investigation (Blood)

FBC	FULL BLOOD COUNT
FFP	FRESH FROZEN PLASMA
FSH	FOLLICLE STIMULATING HORMONE
HB	HAEMOGLOBIN
IgA.	FRACTION OF IMMUNOGLOBULIN
IgG.	FRACTION OF IMMUNOGLOBULIN
IgM.	FRACTION OF IMMUNOGLOBULIN
K	POTASSIUM
PCV	PACKED CELL VOLUME
PT	PROTHROMBIN TIME
Rh	RHESUS FACTOR
U/E	UREA AND ELECTROLYTES
WCC	WHITE CELL COUNT

X-MATCH CROSS MATCH

Patient Assessment/Examination

BMI	BODY MASS INDEX
BP	BLOOD PRESSURE
CNS	CENTRAL NERVOUS SYSTEM
CVP	CENTRAL VENOUS PRESSURE
H/O	HISTORY OF
Ht	HEIGHT
NAD	NO ABNORMALITY DETECTED
NBI	NO BONY INJURY
NOK	NEXT OF KIN
SOB	SHORTNESS OF BREATH
TPR	TEMPERATURE PULSE RESPIRATIONS
Wt	WEIGHT

Patient Investigation (General)

BCG	BACILLE CALMETTE- GUERIN
C&S	CULTURE AND SENSITIVITY
CSF	CEREBRO-SPINAL FLUID
CTG	CARDIOTOCHOGRAPH
ECG	ELECTRO CARDIOGRAM
EEG	ELECTRO ENCEPHALOGRAM
HVS	HIGH VAGINAL SWAB
LP	LUMBAR PUNCTURE
MC&S	MICROSCOPY CULTURE AND SENSITIVITY
MSU	MID STREAM URINE

Other

LA	LOCAL ANAESTHETIC
Na	SODIUM
NBM	NIL BY MOUTH
POST OP	AFTER OPERATION
PRE OP	BEFORE OPERATION
RTA	ROAD TRAFFIC ACCIDENT
ROS	REMOVAL OF SUTURES
UV	ULTRA VIOLET
VE	VAGINAL EXAMINATION

Equipment

ET	TUBE ENDOTRACHEAL TUBE
FG	FRENCH GAUGE
IUCD	INTRA UTERINE CONTRACEPTIVE DEVICE
NGT	NASO GASTRIC TUBE
TED'S	THROMBO EMBOLIC DETERRENTS

Health Record Keeping

- I confirm that I have read and understand the contents of the Health Record Keeping module .
- I understand that supporting policies will provide additional information and guidance that may be necessary for my role.
- I understand that it my responsibly to seek further advice regarding policies from my line manager.
- I confirm that I know how and where to access further reading and training.

- Print Name.....
- Signed .....

- Date .....
- Position.....
- Department / Directorate .....

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