Essex Partnership University
NHS Foundation Trust

STRUCTURE AND CONTENT OF HEALTH/ SOCIAL CARE RECORDS

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KEY CHANGES FROM PREVIOUS VERSION	Incorporated new General Data Protection Regulations Incorporated the roll out of electronic records for the North of the trust Updated processes
AUTHOR	Records Manager
CONSULTATION	Information Governance Steering Committee Quality Committee Paris Project Board Mobius Project Board
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PROCEDURAL GUIDELINE SUMMARY

The purpose of this procedure is to provide assurance to the Trust via a programme of assurance processes to mitigate any risks identified and ensure good clinical record keeping is maintained

The Trust monitors the implementation of and compliance with this operational policy in the following ways;

This process is monitored via the Information Governance Toolkit and assurance reports are submitted to the Information Governance Steering Committee

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this policy is Executive Chief Finance and Resources Officer

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

STRUCTURE AND CONTENT PROCEDURE

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

STRUCTURE AND CONTENT OF HEALTH / SOCIAL CARE RECORDS

Assurance Statement

The purpose of this procedure is to provide assurance to the Trust via a programme of assurance processes to mitigate any risks identified and ensure good clinical record keeping is maintained as an integral and vital part of professional practice which contributes to a high standard of:

- clinical care
- continuity of care
- information sharing and communication across and between clinical teams and the patient.

1.0 SCOPE

This procedure applies to all staff employed by Essex Partnership University NHS Foundation Trust (EPUT) including those on temporary contracts, students or bank or agency staff involved in handling, contributing to or creating health records and making them aware of their responsibilities to meet the requirements and standards relating to the content and quality standards of health records of all types, regardless of the media on which they are held, e.g., electronic or paper based, x-rays, photographs, slides and other images, audio and video tapes, cassettes, CD-ROM, e-mails.

The procedures are complementary to standards in health record keeping produced by individual professional organisations. This procedure should be read in conjunction with the Records Management Policy which defines the standards for the management of all records by the Trust and underlying procedures

To achieve assurances, clinical records must be **timely, accurate, concise and up to date** accounts of the assessment and treatment of individual patients.

Accountability – records are adequate to account fully and transparently for all actions and decisions, in particular to:

- protect legal and other rights of staff or those affected by those actions
- facilitate audit or examination
- provide credible and authoritative evidence
- facilitate research and evidence based practice

Interpretation – the content of the record can be interpreted; i.e. clear and concise; identification of staff who created or added to the record and when; and how the record is related to other records.

Quality – records are complete and accurate and reliably represent the information that was actually used in, or created by, the delivery of care, and its integrity and authenticity can be demonstrated.

Staff training – all staff are aware of their responsibility for record keeping and where applicable are conversant in their professional standards and guidance.
Note: *The term patient has been used throughout this procedure for consistency, but applies equally to "client" and "service user".*

2.0 INTRODUCTION

Clinical records are the most fundamental and basic of clinical tools and are involved in almost every consultation. They are there to give a clear and accurate account of the care and treatment of patients and to assist in making sure they receive the best possible clinical care. Good records do more than support good patient care, they are essential to it.

- they form a permanent record of individual considerations and the reasons for decisions.
- they help patients/carers/families understand treatment plans and reasons for decisions
- they help health care professionals to communicate with other health care professionals and with themselves.
- they are essential to ensure that an individual's assessed needs are met comprehensively and in good time.

They are also a vital part of professional practice which contributes to a high standard of

- Clinical care
- Continuity of care
- Information sharing and communications across and between clinical teams and the patient
- Business and reporting

The record is a health care professional's main tool in working with a patient and is evidence in defence if assessments or decisions are scrutinised. It is an integral part of professional practice and failure to record information accurately in health records can have serious consequences for the patients, carers and families. These failures may result in reduced quality of care and litigation. Poor record keeping is a major factor in litigation cases and hinders the defence of defensible cases.

Any document which records any aspect of the care of a patient can be required as evidence before a coroner's court, a court of law or before the Professional Conduct Committee of the Nursing and Midwifery Council, or other similar regulatory bodies for health and social care professionals.

Health Records Management and Health Record Keeping Standards are minimum requirement for

- CQC – Outcome 21 – Records Management
- Information Governance Toolkit – Clinical Information Assurance (400s)
- Essence of Care

A health record, as defined in the Data Protection Act consists of ‘’information relating to the physical or mental health or condition of an individual and has been made by or on behalf of a health professional in connection with the care of that individual’’.

Under the Public Records Act 1958, the records created by governmental public bodies, which includes state education, local authority and NHS, are public records. This means that they are subject to both legal and professional obligations. They are not the property of the clinician or the team.

In context of this document, a health record is anything which contains information in direct relation to the clinical history, diagnosis, treatment or review of a patient which has been created or gathered as a result of the work of NHS employees, including:

- patients healthcare/clinical records (electronic or paper based)
- electronically digitalised health records
- audio and digital / videotapes, cassettes, photographs
- E-mails
- digital Records
- computerised Records or any record that has been created or gathered as a result of any aspect of the delivery of care by the NHS.

The purpose of a clinical record is:-

- to support clinical care and continuity of care, including the assessment and management of clinical risk
- an accurate account of treatment, care planning and delivery – evidence based practice
- the ability to detect problems, such as changes in the patient’s condition at an early stage
- sound administrative and managerial decision making
- improvements in clinical effectiveness through clinical audit and research
- whenever, and wherever, there is a justified need for information and in whatever media it is required
- to meet Legal requirements
- to ensure information is available, whenever and wherever there is a justified need

To ensure that consistent and appropriate policies and procedures that meet legal and moral obligations in respect of patient identifiable information, are in place and adhered to, such as:-

- Caldicott
- The Data Protection Act 2018
- Access to Health Records Act 1990
- Common Law Duty of Confidentiality
- Human Rights Act 1998
- Freedom of Information Act 2000

3.0 PURPOSE

The purpose of this Structure and Content procedure is to ensure that the records are:-

- a key part of the delivery of care, and not an additional extra
- All professionally qualified staff must abide by their Professional Codes of Practice
- all clinical records must be kept up to date and accurate – regardless of the media
- all entries in a clinical record must be attributable to an identified individual – either by signature (paper) or by electronic validation
- all records/information must be kept confidential – staff are bound by the Duty of Confidentiality
- all records/information must be kept secure. Do not leave records unattended in cars.
- do not share log-ins and passwords to electronic patient record systems and Smartcards
- patients/service users have rights of access to their clinical records – therefore entries should be professional, non-judgemental, and not contain derogatory remarks or comments
- the records of staff members who are also patients must be treated with the same respect and confidentiality as all other clinical records
- all professionally qualified staff must complete 3 yearly competency training
- staff who do not abide by this policy, supplementary procedures and guidance will be subject to disciplinary procedures, and may be referred to their professional body for investigations
- health records created by the Trust provide accurate, timely and comprehensive recording about the history of each patient's care including, biographical details, presenting symptoms, observations, diagnosis assessment, treatment, care plans and consent.
- identification of the responsibilities and duties of clinicians and support workers to maintain accurate and contemporaneous records
- risks associated with record keeping are minimised through ensuring that all staff follow acceptable standards of practice
- to support the wider purpose of teaching, research and clinical audit is supported and for healthcare services to learn from experience.
- to ensure electronic recording takes place to help facilitate the need the numbers of statutory returns the Trust is required to provide

4.0 DEFINITIONS

A Record comprises of recorded information in any format (e.g. digital, physical), of any type, in any location (e.g. central database server, standalone PC, filing cabinet, archive store, records library), which is created, received, or maintained by the Trust in the transaction of its activities or the conduct of its affairs, and kept as unique evidence of such activity.

A Health Record is defined in Section 68 of the Data Protection Act 2018 (2), and:

(a) “Consists of any information relating to the physical or mental health or condition of an individual”
(b)“Has been made by, or on behalf of, a health professional in connection with the care of that individual”

The health record should be constructed to contain sufficient information to identify the patient, provide a clinical history, details of investigations, treatment and medication.

Health Records Keeping Standards are desirable for the purpose of evaluating the patient's progress, and essential from a legal perspective if arguments should arise about competence or justness of charges made. Health record and communication practice standards for all healthcare professionals are essential for safe and effective practice. Basic standards should be defined, and be evident in all forms of the health record; these may be set in accordance with recommendations from regulatory or professional bodies, e.g. NMC, GMC, RCoP.

5.0 SCOPE OF THE PROCEDURAL GUIDELINE

This document applies to all professional staff employed in the Trust.

HSCIC produced standards (July 2013) for the clinical structure and content of patient records. These standards are needed to ensure that information can be recorded and integrated in electronic patient care records across professions, disciplines and specialities, while properly reflecting best practice and to generate data that can be used for service delivery and performance management, commissioning, audit and research from data recorded for patient care at the point of care.

These standards were developed for use by: clinicians and healthcare professionals from across all clinical disciplines and those who develop and implement electronic or paper care records.

We must ensure that health records made by staff within the Trust are of consistent quality. This will be achieved by:

- establishing and maintaining consistent standards of recordkeeping throughout the Trust
- ensure that health record keeping meets legal obligations
- ensure that the Clinical Governance requirement for effective monitoring of clinical care and high quality record keeping are met
- meet Information Governance Toolkit Standards
- support evidence based clinical practice and improvements in clinical effectiveness
- 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.

Although the primary purpose of health records is to facilitate continuity of care and to act as a tool of communication, good records allow a clear picture of events to be obtained which is vital for legal or evidential reasons. Health records must be objective and worthy of independent scrutiny – in the event of an investigation their content can be critical.

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

All health professionals and staff involved in clinical care are professionally accountable for keeping clear, legible, accurate and contemporaneous health records, which record all the relevant clinical findings, any decisions made, information given to patients and rationale for all treatment, therapies and medications prescribed.

All health professionals have both a professional and a legal duty of care to patients. All professional organisations will expect that high quality standards of care including record keeping are maintained. Record keeping standards are an indication of professional practice.

A health record should inform any clinician who has a responsibility for the patient of all the key features which might influence the treatment proposed. It should also provide a contemporaneous and clear record of the patient's treatment and related features. A good record speaks volumes about the care a patient has received, and has a vital role in minimising clinical risk.

Good record keeping safeguards both patients and health professionals from unsafe practice through the miss-recording or misunderstanding of health record information.

The Data Protection Act 2018 s69 (1) defines "health professional" as: -

- A registered medical practitioner.
- A registered dentist as defined by the section 53(1) of the Dentists Act 1984.
- A registered optician as defined by section 36 of the Opticians Act 1989.
- A registered pharmaceutical chemist as defined by section 24(1) of the Pharmacy Act 1954.
- A registered nurse, midwife or health visitor.
- A registered Osteopath as defined by section 43 of the Osteopaths Act 1993.
- A registered Chiropractor as defined by section 43 of the Chiropractors Act 1994.
- Any person who is registered as a member of a profession to which the Professions Supplementary to Medicine Act 1960 applies. For the time being this extends to clinical psychologists, child psychotherapists or speech therapists, a music therapist employed by a health service body and a scientist employed as head of a department.

This list is not exhaustive

This procedure should be used in conjunction the Records Management Policy CP9

6.0 KEY PRINCIPLES FOR DOCUMENTATION, CONTENT AND STYLE OF HEALTH / SOCIAL CARE RECORDS

6.1 Record Structure

The Trust has rolled out electronic health records (for the South) which are used by all specialties and professional groups to support integrated care. However it needs to be noted that not all the records were scanned on electronically and archived paper records do still exist so staff are required to use the Trust patient records tracking system to identify what archived records a patient has. The Trust is also working to roll out electronic health records for the North of the Trust.

All health records in use within the Trust must have an organised structure in which all information relating to the patient is filed.

A standard structure is contained within the electronic record and additional templates (Document Tab Structure) containing a concise index with clear instructions for the scanning and storing of patient documents in each section is available on the intranet and at all clinical and admin staff locations

The agreed structure for the electronic health records is:

Alerts
Admission
Assessment & Risk
Physical Health Assessments
Case Recording
Care / Treatment Plans
Safeguarding
Legal Documentation / MHA
Correspondence
Advance Statement / Decision
Community Documents
Reports
ECT Records
Historical Information
Non-Disclosure / 3rd Party Information
Other
Medical
Patient Information

(please note some electronic systems (systmOne/Paris) may have a different structure to the above)

All aspects of treatment will be recorded and stored in the appropriate section of the health record.

All paper records must be kept on official Trust stationery. Where this is not possible all sheets must be identified by equivalent to official stationery, i.e. same wording. All electronic forms are templated on official trust templates with relevant logos.

All entries in the electronic record will be filed in a contemporaneous, chronological order this is to facilitate ease of access to information, to respond to requests for information, facilitate clinical audit and enable the rapid response to complaints and or possible litigation.

The Trust is currently rolling out electronic health records for the North which is used by all specialties and professional groups to support integrated care. The document structure is available on the Trust Intranet under the Paris tab.

6.2 Core Standards

All staff who contribute to health record keeping will be involved in regular reviews of the quality of the health records.

All staff will subscribe to a confidentiality statement as part of their job description or contract on commencing with the Trust. All students on placements and temporary staff will also be required to sign a confidentiality statement.

All entries will be typed within the electronic record using an electronic format (eform, UDF, template) and the font colour is only black, any paperwork needing to be completed by hand must be in permanent black ink, with the exception of pharmacy which will be in green ink when endorsing the prescription charts.

Electronic documents once either scanned or saved directly cannot be altered. All paper hand written entries must be written clearly, legibly, and in such a manner that they cannot be erased.

All entries will be electronically signed in full and accurately dated. Time of contact must be recorded and time of entry into notes, if different. Any entries made by unqualified staff must be countersigned by qualified staff which can be done electronically or physically signed if using paper.

When staff are writing on documents in readiness to be scanned to the patients' health records they will print their full name and designation under their signature for each entry. Stamps may be used. All paper documents must clearly identify the patient name including the date of birth and NHS number.

Mistakes will be crossed through with a single line, initialed, dated and countersigned by another registered/qualified health professional; there is the facility to do the same within the electronic record for case recordings. Erasers, liquid paper, or any other correction fluids must **not** be used in any circumstances on patient documents.

If using paper forms and there is a gap on any line between recording information and the end of a line, then a single line should be drawn in the space between the last word and the end of the line. This is not applicable for electronic forms as once saved it cannot be altered.

All entries are recorded in either fully type's text or handwriting. If abbreviations are used, these must have been approved first by the service.

The electronic health records should be reviewed regularly by the accountable professional, according to professional guidelines and where audit/incident and/or complaint investigations indicate poor record keeping

The electronic health record will also be subject to auditing upon request via the clinical audit team, using the Trust's health records audit tool. This audit will be recorded on the Trust Audit Plan. Detailed results of the audit will be discussed within the service and with individuals through the staff appraisal process.

6.3 Content of the Health Record

The purpose of health records is to facilitate care, treatment and support of the patient. Therefore, these records should:

- Be factual, consistent, accurate and evidence based notes of all actions and outcomes and not include jargon, meaningless phrases, unnecessary abbreviations, irrelevant speculation or offensive comments or subject statements. Where records are professional opinions, this must be stated.
- Detail all complex problems, or where more input had been required showing a duty of care has been honoured.
- Provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.
- Care should be taken when recording information regarding or given by a third party. Clearly state that the information has been given by a third party and who the third party was i.e. a relative, translator, the police, ambulance service etc. Extra care needs to be taken as this third party information will / can be shared or may need to be redacted as necessary
- Document clearly when a discussion has taken place with a Senior Team Member
- Be typed / written, wherever possible, with the involvement of the patient or carer and in terms that can be understood by all
- Be contemporaneous and continuous
- Be typed / written as soon as possible after a contact (including telephone contact) has occurred, providing current information on the care and condition of the patient/client (within 24 hours). If the date and/or time differs from that of when the records are written up, then the date/ time of the contact, and the date/time of the notes being written must be clearly noted within the body of the text. For paper hand written records this can go under the signature, printed name and position/grade
- The name of the patient, date of birth and NHS number must be included on every single page (both sides) in the electronic health record along with any relevant reference/unit number

Each record will have a unique number to identify the patient. This will usually be the NHS number (reference) or in some cases a temporary NHS number. This is an information governance requirement and is issued as a Patient Safety Incident Data (National Patient Safety Agency (NPSA)) by the NHS Commissioning Board Special Health Authority

Each record will include the following core patient information:

- Patient's name
- NHS number
- address
- telephone number
- date of birth
- gender
- contact name and number for person to notify in an emergency (next of kin / nearest relative) and GP
- GP address and practice telephone number where known.
- name of school attending (for school children)
- ethnic origin
- known allergies
- religion

All entries will be recorded contemporaneously, other than in emergency treatment situations where they must be recorded as soon as possible, but in any event no later than 24 hours of the treatment/care.

. An entry must be made in the electronic health records at every contact including clinic attendances. Entries following telephone contacts must be entered into electronic health records.

The electronic health record will contain clinically relevant information only. Any additional information such as property receipts, incident reports, complaint information or Access to Records requests should not normally be placed within the record, however with electronic records it is easier to segregate this information out and a section called "Other" has been identified for these documents.

Judgments of a personal nature will not be used in the health record. Comments about a patient will be objective, factual and be relevant to their clinical assessment and treatment.

Health records should clearly demonstrate involvement of the patient in decisions about their care.

Treatment/intervention goals are clearly identified where appropriate.

If there is any incorrect information in the electronic health record a report a problem (Mobius) will need to be instigated. This will go to the system admin team and the Head of Electronic Systems & Records / Records Manager will review and amend as necessary. There will be a note / annotation attached to the document explaining why it has been done. If there is any incorrect information in the electronic records for Paris this will be corrected by the Paris System helpdesk team.

Medication administration entries in the patient record card must:-

- be clearly written
- specify the substance administered, using its generic or brand name where appropriate and its stated form, together with strength, dosage, timing, frequency and route and site of administration.

- If applicable, start and finish dates should be stated. Where available, the batch number and expiry date of the product must be recorded
- specify the time and details of each dose administered and give reasons for any non-administration of drugs
- in all situations where injected products are administered the medication batch number and expiry date must be recorded.
- include any additional information required within Patient Group Directives.
- medicines must only be administered in situations where the appropriate prescription (written manually or electronically) by a registered medical practitioner or another authorised prescriber is accessible.
- NB. If a medicine has been dispensed for a named patient by a pharmacist then it can be assumed that such a prescription exists, however it is considered good practice to have a signed and dated order with the patient's health record. The only exemption to this is in situations when working under a patient group direction for the medication in question.
- certain medicines may also be supplied to a patient by a medical practitioner or by other health care professionals (either within their professional jurisdiction or under the terms of a patient group direction). In addition to the information detailed above in **medication supply entries,** patient records must:-
- state the quantity supplied, batch number and expiry date of product supplied.
- once the record card is completed or finished it must be sent for scanning to the electronic record.

For young people under 16 years old there will be signed evidence by the clinician that the correct procedures were followed when obtaining **consent for treatment.** In addition any discussions with others regarding the treatment (e.g. parents, guardians) either face to face or on the telephone, will be documented fully on the relevant documents and saved within the electronic record.

If treatment is required for a patient who may lack the mental ability to make decisions, under the Mental Capacity Act an assessment must be completed to determine if the patient is able to consent to their treatment. In addition any discussions with others regarding the treatment (e.g. welfare attorneys, court appointed deputies, independent mental capacity advocates and relatives) either face to face or on the telephone will be documented fully on the electronic forms and saved within the patients electronic record.

The record should include:-

- An initial assessment of health status, the social context of the illness where appropriate
- Details of medication
- Details of any initial examination
- The history and examination findings will be clearly dated and signed
- A diagnosis and care / treatment plan should be signed by the clinician
- Continuation notes with reports of all investigations and treatments
- In the case of school age children the record will identify the school the child attends

For patients undergoing **surgery,** clinical records should include the following details **prior to the surgery**:

- Signed evidence that informed consent has been obtained by an individual competent of carrying out the procedure;
- A completed NHS consent form;
- Documentation of the procedure undertaken to obtain consent;
- Any care plan will include the site and side of the proposed operative procedure;
- Sites and sides will be written out in full not abbreviated.

A record of the operation will be made immediately after surgery and includes:

- date of the surgery
- place undertaken
- name of the operating surgeon (s)
- the diagnosis made and the procedure performed
- details of tissues removed, added or altered
- details and serial numbers of any prostheses used
- details of sutures used
- an accurate description of any difficulties or complications encountered and how these were overcome
- immediate post-operative instructions
- the surgeon's name (should be printed) and full signature

Test Forms and Results

Laboratory tests and other investigations are requested by health care professionals to assist in diagnosis and treatment. If they are to be of use, clinical staff must see the results and decide on appropriate action. When investigations are requested they should be clearly recorded at that time in the physical health assessments section of the notes

The test reports should be initialled and dated as having been seen by the responsible lead clinician before they are scanned.

Radiology records are to be scanned after the lead clinician has seen the report.

X Rays remain the property of the acute hospital Trust and as such should be processed and filed in accordance with their procedures, i.e., returned to the X-Ray Department.

Any photographs used for documentation should be scanned to the patient's electronic record. A consent form for clinical photography should be completed for each episode.

On **discharge from the service,** a summary note containing the name of the patient, diagnosis, date of discharge, treatment, medications and instructions for follow-up will be completed within 7 days of the patient's discharge and sent to the GP, hospital or institution to which the patient is discharged and/or to the community nurses, AHP's, care staff involved with follow up care.

Information given to the patient, including specific information on the risks of treatment, the goals of care, any instructions on after care and any discussions on resuscitation, will be recorded in their electronic record.

6.4 Writing styles and standard letter guidance

As a matter of good practice, letters between health professionals, which are copied to patients, should be written clearly. They should not use unnecessarily complex language, and should avoid subjective statements about the patient.

Letters between health professionals are technically 'personal data' which forms part of the patient's electronic record. As such, they must be adequate for their purpose, and accurate. A balance is required between simplification for the patient's understanding, and what is needed for the primary purpose of a letter between health professionals discussing symptoms, test results and possible diagnoses or treatment. Clinical accuracy and ensuring the professional receiving the letter has all the information they need, is the main purpose of the letter and should not be compromised in order to make the letter easier to understand.

Templates and standard letters, as developed on the Trusts Information systems and eForms within Mobius and Paris, can make it easier for health professionals and patients to achieve this balance of technical excellence and correctness, and ease of understanding.

There are clear needs within the service for training and support at all levels to improve the quality of communications between health professionals.

Research is needed to clarify what elements of style and content affect the usability and appropriateness of letters for patients and health professionals.

6.5 Issues to be considered in drafting letters include:

- use of plain English to improve readability
- the adoption of styles to avoid giving offence unintentionally or generating misunderstandings
- avoiding unnecessarily technical terminology and acronyms, including using alternative terms without losing meaning or clarity, such as 'kidney' for 'renal' or 'heart attack' for 'myocardial infarction', or explaining a technical term in a short additional sentence or phrase
- setting out the facts and avoiding unnecessary speculation
- reinforcing and confirming the information given and discussion with the patient in the consultation
- where appropriate, inclusion of advice on care management, life style changes or treatment options

6.6 Information Quality Assurance

In order to ensure the quality of records, staff need to understand:

- What they are recording
- Why they are recording it
- How to validate information with the patient or against other records so that the correct data is recorded
- The correction of errors and how to report them when found
- The use of information – understanding what the records are used for (and therefore why accuracy is so important)

7.0 CALDICOTT PRINCIPLES

The general principles of the Caldicott report are as follows and should be considered when using the health record:-

Principle 1 – *Justify the purpose(s).* Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2 – *Don't use patient –identifiable information unless it is absolutely necessary* Patient-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose.

Principle 3 – *Use the minimum necessary patient-identifiable information.* Where use of patient-identifiable information is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

Principle 4 – *Access to patient-identifiable information should be on a strict need-to-know basis.* Only those individuals who need access to patient-identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls, as with the TPP community services computer system, or splitting information flows where one information flow is used for several purposes.

Principle 5 – *Everyone with access to patient-identifiable information should be aware of their responsibilities.* Action should be taken to ensure that those handling patient-identifiable information both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6 – *Understand and comply with the law.* Every use of patient-identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.

Principle 7 - *The duty to share information can be as important as the duty to protect patient confidentiality.* Health and social care professionals should have the confidence to share information in the best interests of their patients within the

framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

8.0 FAMILY FRIENDLY

Wherever possible, records should be written with the involvement of the patient or their carer.

Health records should be written in terms that the patient can understand. It is not necessary or practical for health records to be written entirely in non-technical or 'lay' terminology. It is suggested that a patient friendly section is included in the records i.e. a summary of information discussed with the patient. As well as re-enforcing the patient understanding of the discussions, the summary also informs other health professionals what the patient knows about their condition, problems and care.

9.0 AUDIT

An annual audit of record keeping will be undertaken in all clinical areas. Community Health services will carry out the audit once a year. Mental Health and Specialists Mental Health services will carry out an ongoing audit which is reported twice a year. Audit tools are held by the Clinical Audit team. The audit will include the following themes;

Communication	does the record clearly communicate what is necessary
Legality	would the record stand up in court or at a professional enquiry
Integration	where unified health records are kept does the record clearly show the progress of health care
Partnership	are all the health care professionals working together, from planning to discharge, on agreed goals for the patient/client

The Clinical Audit Department will collate audit results and report outcomes to the Clinical Governance and Quality Committee and local Operational Services Quality groups.

10.0 RESPONSIBILITIES

All health professionals are responsible for maintaining accurate and contemporaneous health records and appraising themselves of the content of this procedure.

11.0 MONITORING AND REVIEW

The Executive Director of Clinical Governance and Quality will be responsible for reviewing this procedural guideline in association with the Trusts Electronic Records Project Board.

12.0 REFERENCES / BIBLIOGRAPHY

The Public Records Act 1958
- http://www.nationalarchives.gov.uk/
- NHS Code of Practice: Records Management, Parts 1 (2006) & 2 (2009)
http://www.dh.gov.uk/
- The Data Protection Act 2018
  - https://ico.org.uk/
- Access to Health Records Act 1990
- NHS England Confidentiality policy
https://www.england.nhs.uk/wp-content/uploads/2013/06/conf-policy-1.pdf
- NHS Health & Social Care Information Centre
  - http://www.hscic.gov.uk/
- Information Governance Toolkit
  - https://nww.igt.hscic.gov.uk/Home.aspx
- Care Quality Commission
  - http://www.cqc.org.uk/
- Nursing & Midwifery Council
  - http://www.nmc.org.uk/
- General Medical Council
  - http://www.gmc-uk.org/
- Royal College of Physicians work on record keeping standards
  - http://www.rcplondon.ac.uk

Freedom of Information Act 2000
Access to Health Records Act 1990
NHSLA Risk Management Standards for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Independent Sector Providers of NHS Care 2011/12

END