Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	18 April 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	RCP Medical Record Keeping Standards Internal Audit Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Philip Kloer, Medical Director and Deputy Chief Executive
SWYDDOG ADRODD: REPORTING OFFICER:	John Evans, Assistant Director, Medical Directorate Lisa Davies, Head of Effective Clinical Practice and Quality Improvement (Medical Directorate)

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report constitutes a further update on progress in relation to the Internal Audit Royal College of Physicians (RCP) Medical Record Keeping Standards report, since the previous update, presented to the Audit and Risk Assurance Committee (ARAC) in June 2022.

Cefndir / Background

A number of actions have previously been reported to ARAC, including the development of a new Clinical Record Keeping Policy. The new Policy was developed with multidisciplinary input and wide stakeholder engagement, and approved by the Health Board's Clinical Written Control Documentation Group in February 2023.

The approved Policy contains eight overarching standards for good clinical record keeping, which are applicable to all professional groups. The standards set a minimum expectation for all clinical record keeping, and can be applied by any clinical professional. Whilst they do not replace the responsibility of staff who are registered to a regulatory or other governing body to adhere to record keeping standards defined by their registrant body, and/or their Code of Conduct, it is proposed that the record keeping audit function within the Health Board centres on the eight new clinical record keeping standards, to allow for a standardised auditing tool and process across different professional groups. Therefore, it is proposed that use of the Royal College of Physicians record keeping audit tool is discontinued.

The eight new Clinical Record Keeping standards define good practice for health records and address the broad requirements which apply to all clinical note keeping, ensuring that records will meet these standards. The eight standards are:

Standard One – Records must be accurate, factual, concise and relevant
Standard Two – Records must be comprehensive
Standard Three – Records must be legible

Standard Four – Records must be chronological, contemporaneous and consecutive
Standard Five – Records must contain the patient's full name, date of birth and NHS number
Standard Six – Records must contain the professional's details – printed and signed/initialled, designation/role and registration number (i.e. GMC/NMC number)
Standard Seven – Records must be dated and timed
Standard Eight – Records must be free from abbreviations wherever possible

Each Standard statement is supported by a narrative description and a bulleted list detailing how the standard can be achieved.

As well as highlighting the expected minimum standards for clinical record keeping, the Policy emphasises the importance of good record keeping, and also the legal status of health records.

The development and sign-off of the Policy included multi-disciplinary involvement from the Steering Group, with representation from not only clinical teams such as doctors, nursing and midwifery, Allied Health Professionals, mental health, and pharmacy; but also from corporate teams such as legal, records management, clinical coding, information governance and clinical audit. This has ensured that the Policy developed captures the importance of good clinical record keeping from all relevant perspectives. Additionally, stakeholder engagement was comprehensive and enabled input from a wide range of Health Board teams.

Asesiad / Assessment

The new Policy has been published on the Health Board's Policies and Procedures intranet page (Appendix 1) and, following advice from the Learning and Development department, a suite of communication resources have been developed to support dissemination and promotion of the Policy. It was suggested by the Learning and Development team that the suite of resources would be a more effective training and education tool than an e-learning module, as the latter is not the most effective method for subject matter such as this and engagement within e-learning is limited.

The resources are contained within a dedicated Clinical Record Keeping area on the intranet, hosted within the Medical Directorate section. With the exception of an animated video which is hosted on an external website, the resources are not accessible to staff outside of the Health Board, however will be demonstrated during the meeting if required.

The resources provide interactive and dynamic content, as well as providing direct access to the Clinical Record Keeping Policy, signposting to key links, and also the ability to book on to training sessions.

The suite of resources consists of:

- A short animated video summarising the clinical record keeping policy and introducing the eight standards – the video is available here – Clinical Record Keeping Video
- A page to cover each of the eight standards, including a video of each standard being introduced by a clinical professional or a member of a relevant corporate team, and full details of the standard;
- Links to professional and registrant body record keeping standards webpages
- Clinical Record Keeping Policy resources such as posters and a PowerPoint slide deck

The intranet pages provide a basis for communication, education and training activities, and are in the process of being disseminated to professional groups, and shared in global messages to all staff. The new Clinical Record Keeping Policy and supporting resources are also being promoted at all Directorate Quality and Governance Groups.

Once communicated to all staff, the audit programme will include a Health Board wide Record Keeping audit utilising the Health Board's Audit Management and Tracking (AMaT) system, with standardised audit tools developed. Services are expected to carry out a clinical audit against the standards at least annually; should areas of non-compliance be identified it would be expected that the frequency of re-audit would increase to allow further monitoring following the implementation of change. An improvement plan will be required for each audit cycle where deficiencies are identified. The audits and improvement plans will be reported through the Directorate Quality and Governance Groups, under the Effective Clinical Practice item on the standardised agenda, and escalated to the Operational Quality, Safety and Experience Sub-Committee if necessary. Central oversight will be provided by the Effective Clinical Practice Advisory Panel. It is, therefore, proposed that this item is de-escalated from ARAC's work programme.

Clinical Audit Representatives across Wales will be discussing record keeping audits later this year, seeking to establish best practice in terms of auditing techniques as well as improvement on outcomes. Consideration of a standardised audit methodology and tool using the AMaT system is also expected.

As previously reported to the Committee, self-inking identification stamps have been distributed to all doctors, and the initiative has been well received, with subsequent orders being submitted for new doctors joining the Health Board.

During the previous Committee discussion, points were raised in relation to the stamps. Firstly, a query was submitted on the evidence around the effectiveness of the stamps and a literature review has been undertaken, demonstrating more contemporary evidence of the benefits offered by stamps:

- Douglas-Moore et al – 2014 – The Importance of Clinical Documentation
- Damla and Ryan – 2016 - Get SMART, An Audit of Documentation Practices at the University Hospital Limerick Emergency Department
- Reynolds et al – 2017 - Improving feedback on junior doctors' prescribing errors: mixed-methods evaluation of a quality improvement project
- Alfadhel and Maung – 2019 - ASGBI Abstracts 2019
- Khurshid and Abdullah – 2021 - Evaluation of admission notes discrepancies in paediatric ward in University Hospital Kerry, Ireland (Oral Presentation at Excellence in Paediatrics Conference 2021)

However, it is acknowledged that, over time, a fully digitalised system will provide the most effective and long-term solution.

Secondly, a discussion around information governance took place, and assurance was subsequently provided that, in line with the principles set out in the General Medical Council's (GMC) Good Medical Practice (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice), a Doctor has an overriding duty, under Domain 4 – Maintaining Trust, to "*be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents"* and *"must make sure that any documents you write or sign are not false or misleading."* Doctors must demonstrate that they work in line with the principles set out in Good Medical Practice, and a failure to meet this duty could ultimately

impact on a Doctor's registration with the GMC. As such, a Doctor would be responsible for the security of their own stamp, in the same way as protecting their IT passwords.

For this reason, as the stamps are personalised for each Doctor by containing their GMC number, they cannot be recycled and therefore requesting the surrender of the stamps if a Doctor leaves the Health Board would create a wasted resource when this could otherwise be usefully utilised elsewhere within the NHS.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to:

- **RECEIVE** and **TAKE ASSURANCE** from this report regarding the progress made in relation to the original Internal Audit report recommendations.
- **ACCEPT** the proposal that the Health Board's clinical record keeping audit takes place against the new eight Standards set out within the Clinical Record Keeping Policy and is reported and monitored through the Effective Clinical Practice Advisory Panel, and thereby **AGREE** to de-escalate this item from the Committee's work programme.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 The purpose of the Audit and Risk Assurance Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place, through the design and operation of the UHB's system of assurance, to support them in their decision taking and in discharging their accountabilities for securing the achievement of the UHB's objectives, in accordance with the standards of good governance determined for the NHS in Wales. 2.2 The Committee independently monitors, reviews and reports to the Board on the processes of governance, and where appropriate, facilitates and supports, through its independence, the attainment of effective processes. 2.3 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	689 – RCP Medical Records Standards - Good medical record keeping
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Working together to be the best we can be 3. Striving to deliver and develop excellent services 4. The best health and wellbeing for our individuals, families and communities

Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	RCP Record Keeping Standards Internal Audit Report October 2018, RCP Medical Records Standards
Rhestr Termau: Glossary of Terms:	ESR – Electronic Staff Record GMC – General Medical Council NMC – Nursing and Midwifery Council
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Clinical Record Keeping Policy Steering Group Clinical Audit Manager Head of Effective Clinical Practice and Quality Improvement Assistant Director, Medical Directorate

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	None
Ansawdd / Gofal Claf: Quality / Patient Care:	This recommendation will improve patient safety and care.
Gweithlu: Workforce:	None
Risg: Risk:	This recommendation is to mitigate risks highlighted in the Internal Audit, RCP Medical Record Keeping Standards report, October 2018, and historical issues with the standard of medical record keeping Medical Directorate Risk reference - 689
Cyfreithiol: Legal:	None
Enw Da: Reputational:	None
Gyfrinachedd: Privacy:	None
Cydraddoldeb: Equality:	No negative impacts. The recommendation will have a positive impact as it has the potential to improve the standard of care for all patients.

Clinical Record Keeping Policy

Policy information

Policy number:
195

Classification:
Clinical

Supersedes:
Supersedes:
195 – Clinical Record Keeping Policy
289 - Record Keeping for Nurses and Midwives Policy
414 - Record Keeping Procedure for Psychologists, Psychotherapists Psychological Therapists and Counsellors

Local Safety Standard for Invasive Procedures (LOCSSIP) reference: Not applicable
National Safety Standards for Invasive Procedures (NatSSIPs) standards: Not applicable

Version number:
1

Date of Equality Impact Assessment:
To be inserted

Approval information

Approved by:
Clinical Written Control Documentation Group
Date of approval:
2.2.2023

Date made active:
2.2.2023

Review date:
2.2.2026

Summary of document:

The aim of this document is to outline the policy and standards for the recording and documentation of information within clinical health records.

The policy will provide clear professional and organisational standards for effective record keeping that all clinical staff must adhere to. The aim is that these standards will enable live, accurate, current and comprehensive information about the care provided to our patients.

It is acknowledged that the standards contained within the Policy are best practice standards and that some aspects will not be immediately achievable. Monitoring and audit will enable gaps in achievement of the standards to be identified and action plans will be put in place to address the improvement required. The Policy will be monitored through full and regular audit of the standards. There will be an annual review of the Policy.

This policy covers record keeping standards for all doctors, nurses, midwives, Allied Health Professionals, health scientists and Health Care Support Workers within Hywel Dda University Health Board.

Scope:

A health record includes everything (paper or electronic) that contains information which has been created or gathered as a result of any aspect of the delivery of patient care, including:

- Personal health records (electronic, microfilm, scanned images and paper based)
- Radiology and imaging reports, photographs and other images
- Audio and video recordings
- Computer databases, output and disks and all other electronic records
- Material intended for short term or transitory use including notes and ‘spare copies of documents
- Digital records

This policy will refer to all clinical records. All clinical staff employed by HDUHB are required to ensure confidentiality, integrity, accuracy and appropriate availability of health records whether held manually or electronically.

To be read in conjunction with:

191 - Health Records Management Strategy (opens in a new tab)
192 - Health Records Management Policy (opens in a new tab)
Records Management Code of Practice for Health and Social Care 2022 - A Guide to the Management of Health and Care Records (opens in a new tab)
249 - Access To Health Records Policy (opens in a new tab)
244 - Being Open Guidance / Duty of Candour Guideline (opens in a new tab)
275 – Secure Transfer of Personal Information Policy (opens in a new tab)
224 - Information Classification Policy (opens in a new tab)
837 – All Wales Information Security Policy (opens in a new tab)
238 - Information Governance Framework (opens in a new tab)
172 – Confidentiality Policy (opens in a new tab)
173 - Freedom Of Information Policy (opens in a new tab)
156 - Risk Management Strategy & Policy (opens in a new tab)
008 - Consent to Examination or Treatment Policy (opens in a new tab)
282 - Network security policy (opens in a new tab)
243 - Consent To Hospital Post Mortem Examination Policy (opens in a new tab)

201 - Disciplinary Procedure (opens in a new tab)
005 - Clinical Audit Policy (opens in new tab)
EAGLE – Organisational Development Strategy & Governance Framework

Patient information:

Owning group:
Clinical Record Keeping Policy Steering Group
Date approved: 20.01.2023

Executive Director job title:
Dr Philip Kloer, Medical Director and Deputy Chief Executive Officer

Mandy Rayani, Director of Nursing, Quality and Patient Experience

Alison Shakeshaft, Director of Therapies and Health Sciences

Reviews and updates:
Version 1 – Clinical Record Keeping Policy

Version 2 - Data Protection Act references (Approved 03.05.2018 Review Date 30.06.2018)

Version 3 – Fully revised

Keywords
Clinical Record Keeping, Medical, Notes

Glossary of terms
HCPC – Health and Care Professions Council
HDUHB – Hywel Dda University Health Board
GMC – General Medical Council
NMC – Nursing and Midwifery Council
UKCP - UK Council for Psychotherapy
BACP - British Association for Counselling and Psychotherapy
BABCP - British Association for Behavioural and Cognitive Psychotherapies
BPS – British Psychological Society
Data Protection Legislation - UK General Data Protection Regulations and Data Protection Act 2018

Contents

Introduction

Clinical record keeping is a legal requirement and an integral part of professional practice, designed to inform all aspects of the care process. The use of patient information is an essential aspect of any NHS organisation and is a key element in supporting the everyday aspects of the delivery of high quality, evidence based health care. Records need to show how the practitioner has discharged their duty of care with professional skill and diligence (Griffith and Tengnah, 2010). It is essential to maintain high standard records as they may need to be relied upon as evidence in court (Dimond,2008) and will avoid staff having to rely on their memories.

Accurate and effective clinical record keeping is fundamental to patient safety and high quality patient care. It also enables effective communication with other professionals involved in patient care and expresses individual professional accountability and responsibility. It is important that these records are accurate, up to date and easily accessible to those who need to use them.

In addition to any record keeping policies developed within Hywel Dda University Health Board (HDUHB), it is also essential that all regulatory bodies' record keeping standards are adhered to. All clinical staff must also be aware and comply with standards and guidelines developed by the relevant regulatory body (e.g. General Medical Council (GMC), Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC)) and/or other recognised organisations (e.g. Royal College or professional body).

The Records Management Code of Practice for Health and Social Care (2022) (opens in a new tab) states that 'each organisation should also have a policy statement on records management which is made available to staff through induction and training'. Organisations may be asked for evidence to demonstrate they operate a satisfactory records management regime.' Development of a local policy aims to enhance the quality of records and serve to protect the patient, the practitioner and the Health Board.

Policy statement

Health Records completed by clinicians working within HDUHB will provide accurate, current, comprehensive and contemporaneous information that will adhere to the standards for record keeping set out within this policy. This policy will provide a set of clear over-arching principles for clinical record keeping.

Development of this policy is in line with professional/regulatory standards and is designed to enhance the quality of records and record keeping thereby serving to protect the patient, the practitioner and the Health Board.

This policy is designed to provide general guidance but does not overwrite and should not conflict with any further professional standards that may be in existence and these should be referred to and adhered to by each professional group.

Scope

This policy will apply to all clinical records held by the Health Board, and to all staff that contribute to clinical records. A record is anything that contains information, which has been created or gathered because of any aspect of the work of NHS employees, including action taken, or action not taken.

All clinical staff employed by HDUHB are required to ensure confidentiality, integrity, accuracy and appropriate availability of health records whether held manually or electronically.

This Policy applies to all records held within all areas of patient care.

A clinical record is everything (paper or electronic) that contains information which has been created or gathered as a result of any aspect of the delivery of patient care. It is important to note that all of the following constitute a record:

- Handwritten clinical notes
- Electronic/digital notes
- E-mails
- Letters
- Laboratory Reports, Radiology and imaging reports
- Drug Charts
- Care Plans/assessments
- Printouts from monitoring equipment
- Multidisciplinary Team meeting minutes
- Incident forms
- Photographs and other images
- CCTV
- Audio/Video recordings
- Text messages sent and received on work phones
- Handover entries
- Telephone notes
- Diaries
- Anything upon which patient information is written
- Material intended for short term or transitory use including notes and ‘spare’ copies of documents
- Vital signs observations
- Prescription sheets
- Consent forms
- Resuscitation documentation
- Advance or future care plans
- Advance decisions to Refuse Treatment
- Lasting Power of Attorney’s

Aim

The aim of this policy is to outline the standards for the recording and organisation of information within clinical records.

The policy will provide the clear professional and organisational principles for effective record keeping that all clinical staff must adhere to, therefore enabling the provision of accurate, current and comprehensive information about the care provided to Health Board patients.

Development of this policy is designed to enhance the quality of records and record keeping thereby serving to protect the patient, the practitioner and the Health Board.

Objectives

The aim of this policy will be achieved by the following objectives:

- Providing a set of overarching principles for clinical record keeping
- Identifying why good clinical record keeping is important
- Outlining how the principles for clinical record keeping will be:
    - Communicated
    - Audited
- Outlining the training that will be provided to support compliance

The Importance of Clinical Records

Health records act as an information base for health professionals and as a medico-legal record of the care provided. Health records are an essential element in patient care and enable health professionals to maintain a record of diagnoses made, treatment given and the patient's involvement, rationale for decision making, progress and outcomes.

All staff need to be aware of the importance of the health record and record keeping. This is an integral part of professional practice, and should not be seen as a distraction from or secondary to its provision. Any critical information that may be missing, inaccurate or unrecorded such as an allergy alert, medication given, consent etc, could be life threatening to the patient.

Please remember that the patient has a right to view or receive copies of anything that is written about them or held on a computer system, in line with the Access To Health Records Policy (opens in a new tab).

Good clinical record keeping is important because:

- It contributes to improved patient safety
- It supports high standards of clinical care and continuity of care
- It enables better communication and dissemination of information between members of the multi-disciplinary health care team
- It is a legal requirement to keep records
- The information can be used for legal proceedings and complaints having obtained the patient's consent
- It will avoid the need for a staff member to rely on their memory if asked to prepare a witness statement in areas such as:
    - Negligence claims, including indemnity for damages and costs
    - Registration body proceedings
    - Local Health Board enquiries
    - Disciplinary proceedings relating to professional misconduct or incompetence
    - Inquests
    - Complaints
    - Criminal matters arising from professional practice
    - Care proceedings

The purpose of clinical records is to:

- Provide accurate, current, comprehensive and concise information concerning the condition and care of the patient and associated observations and assessments
- Provide a record of any problems that arise and the action taken in response to them
- Provide evidence of care required, intervention by professional practitioners and patient responses

- Include a record of any factors (physical, psychological or social), that appear to affect the patient
- Provide an uninterrupted record of events and the reasons for the decisions made
- Assist with continuity of care
- Support standard setting, quality assessment and audit
- Provide a baseline record against which improvement or deterioration may be judged
- Facilitate the collection of data for research/education and audit with the patient's consent
- Document the patient's consent to treatment

Standards for Record Keeping

Clinical staff involved with patient care must keep clear, accurate and legible records. Records must report the relevant clinical findings, the decisions made, any medication prescribed and the information given to patients. Detail should also be provided on any other investigation, care or treatment (this refers to clinical information, safeguarding issues, family contacts and so on). Clinical records must provide a safe and effective means of communication between appropriate members of the health and social care team and the patient themselves in the appropriate circumstances. The standards set out in this section define good practice for health records and address the broad requirements that apply to all clinical note keeping, ensuring that records will meet these standards.

In addition to meeting the standards outlined within this policy, staff who are registered to a regulatory body, such as the GMC, NMC, HCPC or other governing bodies where there is no core registration (for example UK Council for Psychotherapy (UKCP), British Association for Counselling and Psychotherapy (BACP) and British Association for Behavioural and Cognitive Psychotherapies (BABCP)); will be required to adhere to record keeping standards defined by their registrant body, and/or their Code of Conduct e.g. Code of Conduct for Healthcare Support Workers in Wales. This is designed to guard against professional misconduct and to provide high quality care in line with the requirements of professional bodies (Records Management Code of Practice for Health and Social Care 2022).

The Hywel Dda University Health Board standards which all staff involved with patient care are expected to adhere to are detailed below.

Standard One – Records must be accurate, factual, concise and relevant

To ensure that the clinical record is a useful and accessible clinical tool, the information contained within the record must be accurate, clear, factual, concise and straightforward. To achieve this:

- Records should be free from ambiguity
- Only pertinent information about relevant past medical history, the condition of the patient at any given time and the measures taken to respond to identified need is to be recorded
- The record must not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation
- When information is recorded, practitioners should take care in distinguishing between factual information and information derived from: hypothesis; an impression; a clinical opinion or; in the case of psychodynamic therapies – transference or a person other than the patient such as a relative. Reference to these should be clearly stated in the record
- The record must provide factual evidence to assist in responding to complaints or concerns and claims

- Advance Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record in the Legal Documents section of the record. In circumstances where the patient is not the decision maker, the minutes of the best interest meeting and balance sheet should be easily available within the records and where another person has been nominated to make decision on behalf of a patient (Lasting Power of Attorney for Health and Welfare or a court appointed deputy, that person should be identified.(please see the Advance Decisions to Refuse Treatment Policy (opens in a new tab))
- Next of Kin and any relevant information such as Power of Attorney should be checked during every admission and updated where relevant. If there is any dispute seek legal advice
- Records must never be falsified
- No information should be removed from the record and any inaccuracies should be scored through and signed, including the date and time amended and designation of the person making the change. The original erroneously recorded information should still be legible
- Records must not be destroyed by individual members of staff. There is a specific process for destroying records lawfully (please refer to the Records Management Code of Practice for Health and Social Care 2022 - A Guide to the Management of Health and Care Records (opens in a new tab))
- Records must not contain derogatory or offensive comments, any coded expressions of sarcasm or humorous abbreviations to describe the patient. The patient has a right to view or receive copies of anything that is written about them or held on a computer system, accessed in line with the Access To Health Records Policy (opens in a new tab)
- The record must not be used to record comments, judgements or criticism of other services involved with the patients' care. There are specific processes within the health board to raise concerns about care if need be.
- Patients' requests to delete or rectify information within their records should be processed in line with Information Rights Procedure. It is not always possible to comply with such requests and referral through the correct pathway should be undertaken

Standard Two – Records must be comprehensive

The record must provide a comprehensive and complete picture of assessment, care delivery, associated outcomes and other relevant and useful information. They should provide an accurate account of consultations and evidence to support clinical decision-making. To achieve this:

- All entries must be written in full
- Any clinical decisions, and the rationale for that decision, must be clearly recorded within the record
- All information that is used as a basis to inform an assessment, formulation or therapeutic intervention must be recorded in the clinical record (this includes relevant past medical and psychosocial history, and stage/grade)
- Standard and approved proforma's for admissions or discharge must be used, if available, and all the fields listed must be completed
- Details of all diagnoses (including co-morbidities) and procedures (including those done on the ward) must be clearly recorded in the correct order in notes, writing the main diagnosis first. Best practice is to summarise all of these as the last entry in the notes. For injuries, note the cause/mechanism of injury; for overdoses, note the drug, quantity if known quantity if known and time of ingestion; and for infections, note the organism
- If a clear diagnosis has not been reached, ensure the main symptoms are detailed in the notes or discharge summary. Differential diagnosis can be recorded however, any "query" diagnoses,

or diagnoses preceded by a “?”, “possible”, “likely”, “impression” etc cannot be coded by clinical coding staff and should therefore be avoided. If histology is awaited for a definitive diagnosis, note this down in the record

- Clinical professionals should be aware of the patient’s identity preferences where it is relevant to their treatment and care; and should be aware of when and how it is appropriate to record and share within the clinical record and correspondence, in accordance with legislation (Gender Recognition Act, 2004)
- The entry must identify any risks or problems that have arisen and the action taken to rectify them. Identify factors which jeopardise standards or place the patient or client at risk
- An entry must be made in the health record whenever a patient is seen by a professional involved in their care such as a doctor, nurse, therapist or social worker, or when a patient was planned to be seen and this did not occur and the reason for this must be recorded
- Entries within a patient or parent held record must not be the only record that is kept, and visits must be written up and transferred to the main patient record (with the exception of pre-and post-natal records which are held by the patient/parent for the duration of the pregnancy and immediate post-natal period, prior to being returned; and the Health Visiting Personal Child Health Record (‘the Red Book’) which is a shared record that stays with the child’s legal guardian. It is used to record Health Visitor, or other clinical interactions and interventions with the family during any face-to-face contacts, and parent’s reflections on the child’s development, but does not constitute the main record kept on the child
- Patient or parent held records can be retrieved at the end of an episode of care by the following means:
    - Retrieval by the healthcare professional during the last visit
    - Return by the family/carer following the end of care
- On completion of the care and treatment any hardcopy/paper Patient Held Records must be scanned and uploaded to the patient’s Electronic Record (where relevant). The record should be scanned as a complete document
- Items that are maintained by a patient and given to the health care practitioner, such as a symptom diary, should be kept as part of the record, if the record is digital a scanned copy can be retained.
- Where relevant to community settings, the care delivery venue, or contact type, must be stated
- In situations where the condition of the patient is assessed as unchanging, the clinicians’ overall assessment may be recorded as ‘no change’. If reassessment is necessary, this must occur within a maximum of seven days, the results of which must be recorded
- The record must provide evidence of the need, in specific cases, for referral to practitioners with special knowledge and skills
- Consent must be recorded where required e.g. for intimate examinations or invasive procedures, and any capacity assessment or decision taken on behalf of someone who lacks capacity to make that decision for themselves should be clearly documented (Consent to Examination or Treatment Policy (opens in a new tab))
- Details of any information provided to patients (i.e. leaflets) as part of their treatment should be included in the record. The detail should be sufficient so that information provided can be tracked during the lifetime of the record. This could be a copy or title and date of publication or reference number where an information management system is in place
- The discharge record/discharge summary must be commenced at the time a patient is admitted to hospital. A summary of the reason for the patient’s admission and any care and treatment provided should be given and a record of the arrangements made for the continuity of a patient’s care on discharge from hospital must be included

- The Discharge Advice Letter (DAL) (or TTO form - To Take Out/preliminary discharge summaries) must be completed fully and accurately, and in accordance with the timescales set within the specific department

Standard Three – Records must be legible

It must be possible to read the information contained within the record. To achieve this:

- Writing must be clear and legible
- The record must be written in black ink ONLY
- Staff must write in a clear handwriting style, with good grammar and correct spelling
- Errors made **must not be obliterated** (for example there must be no use of correction fluid or any other means of covering the entry)
- Mistakes should be crossed through with a single line (the original should remain legible), the written statement 'written in error' should be made and the entry signed, dated and timed. Reasons for the error should always be noted e.g. wrong patients' records
- Any alterations or additions must be dated, timed and signed in such a way that the original entry can still be read clearly and is auditable.
- The record must remain readable when reproduced, e.g. scan/photocopy
- Following an entry, the remainder of the line must be scored through to the end. There are to be no empty spaces between entries.

Standard Four – Records must be chronological, contemporaneous and consecutive

Records should be contemporaneous and made as soon as practical after the event. Documentation within the health record should reflect the continuum of patient care and should be viewable in chronological order. To achieve this:

- All entries to records must be completed at the time or as soon as possible after an event. If the notes are written sometime after the event this must be noted in the record as a retrospective entry. Best practice is to record information within 24-48 hours as research identifies that details surrounding an event are 'lost' after the first 24-48 hours. If not within this timeframe, the reasons for the delay must also be recorded
- Demographic data i.e. name, address, next of kin and first point of contact etc. must be documented immediately on admission or in the event of an emergency, as soon as possible
- Written evidence supporting an initial assessment must be documented prior to the health care professional finishing their shift
- Records must be kept up to date
- Inpatient notes must contain a minimum of one entry per shift (or per contact for health care professionals who do not see all patients every shift) in accordance with clinical presentation; and community notes should contain one entry per contact
- Individual professional regulatory or governing bodies will determine acceptable time intervals for gaps in the record (please refer to your own regulatory or governing body). If a significant time has elapsed between entries there must be an explanation in the next entry
- Registrants will 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 disoriented or generally give cause for concern

Standard Five – Records must contain the patient's full name, date of birth and NHS number

It must be possible to identify the patient within the record. To achieve this:

- Every page in the clinical record must include the patient's name, date of birth, NHS number. These details must be indicated at the top of the first history sheet and all subsequent continuation sheets (which must be numbered)
- Wherever possible, patient labels should be used as they provide this information in an easy to use format
- If the patient does not have an NHS number (e.g. overseas patients who have not had an NHS number generated) then the patient's full name, date of birth and hospital number must be used
- If possible, location (in the hospital or community setting) should be included

Standard Six – Records must contain the professional's details – designation/role and registration number (i.e. GMC/NMC/HCPC number), and be printed and signed

It is essential that records contain the details of the professional making the entry, so that this can be identified. To achieve this:

- All entries must be signed (not initialled). The signatory's name must be printed at the side of the first entry or be matched to an authorised signatory list)
- The signatory's designation/role and registration number must also be recorded (this can be alongside the signature or in a specific signature list held within the record). For digital systems, this may be the Cymru ID number
- Pre-registration and non-registered practitioners must have their documentation countersigned by a registered practitioner, unless there is a profession specific protocol in place which enables pre-registration and non-registered practitioners to record.
- The registrant is required to document the decision to delegate a component of care in the records.
- Every entry in the health record made by a Doctor 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

Standard Seven – Records must be dated and timed

It must be possible to identify when the entry was made in the record. To achieve this:

- All entries must be dated (including the year), timed (using the 24 hour clock) and clearly signed using a full signature (not initials)

Standard Eight – Records must be free from abbreviations wherever possible

The use of abbreviations in records should be avoided. However, if using:

- Only standard and universally accepted clinical abbreviations should be used, from an approved abbreviation list held in the patient record they are used in, and kept to an absolute minimum
- Abbreviations must be written out in full the first time they are used within that particular episode of care. The abbreviation will follow this full use, in brackets

Digital records

The record keeping standards contained within this policy apply equally to digital records.

Staff must always utilise their own Cymru ID to log into clinical record keeping systems. This allows for ease of identification.

Clinical staff are not permitted to access digital notes of clients/ patients that are not in their care or it is not part of their role to check/ audit or monitor.

All staff are required to undertake information governance mandatory training awareness as part of their induction and undertake regular updates as required.

Patient record systems are moving towards a more digital format. Therefore some areas may have paper and digital systems in operation. It is the responsibility of the health professional to follow the standards set out within this policy for every system being used for record keeping (including any patient held record) in use, enabling visibility and continuity of care.

Involving Patients in Record Keeping

Clinical records should:

- Be recorded/written, wherever possible, with the involvement of the patient, carer or parent
- Aid patient or client involvement in their own care
- Be written, wherever possible, in terms which the patient or client will be able to understand.

The legal status of the health record

Any document which records any aspect of patient care can be required as evidence before a Court of Law or before the Preliminary Proceedings Committee or Professional Conduct Committees of regulatory bodies for health care professionals including the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC).

Health Records are public documents under the Public Records Act of 1958.

Under the Data Protection Act 2018/UK General Data Protection Regulations (GDPR) or any subsequent legislation to the same effect, patients have the right to access records held about them (please refer to Access To Health Records Policy (opens in a new tab).

In view of this, all records should provide:

- A comprehensive picture of the care delivered, associated outcomes and other relevant information.
- Pertinent information about the condition of the patient at any given time and the measures taken to respond to identified need.
- Information about all the options that were offered to the patient, and document the risks explained to the patient.
- Evidence of how the clinician was satisfied that the patient has understood the options and risks.
- Evidence that the practitioner understands and has complied with the common law of duty of care, duty of candour and duty of confidentiality.
- A record of the arrangements made for the continuity of a patient's care on discharge, where relevant.

In the event that a particular matter is not documented (such as a piece of advice, or treatment given), it is usually very difficult/impossible to persuade the Court that the advice or treatment was provided. A failure to document relevant information will be not only a reflection of the person's own ability to fulfil their duties but also a reflection on the Health Board's general compliance with health care standards.

It can give rise to many more questions than needed if a matter is in court proceedings. Professional judgment must be used to decide what is relevant and what should be recorded.

The information contained within records must be used for the purpose for which it was obtained and only shared appropriately and lawfully.

Records management

Health records are highly sensitive and confidential documents and are a valuable resource because of the information that they contain. They are essential to the delivery of high quality evidence based health care. Health records are contemporaneous and form the basis for the organisation's accountability for clinical care. They are evidential documents and as such must comply with legislative requirements, professional standards and guidelines. Health records management is the process of managing records throughout their life cycle, from their creation, usage, maintenance and storage to their ultimate destruction or permanent preservation.

All individual NHS employees have a personal responsibility for any health records which they create, handle or use. This responsibility is established and defined by the law (Public Records Act 1967 and Section 118 of the Government of Wales Act 1998). All Health Board staff, whether clinical or administrative, who create, receive and use health records have records management responsibilities. All staff must utilise, store and transport records in accordance with Health Board policies - Health Records Management Policy (opens in a new tab). Relevant records Management policies are listed in the *To be read in conjunction with* section of this Policy.

Where there are paper copy records, the location of all records must be recorded on the relevant system or by using a records register. It is important that all records are able to be identified and traced in order to provide prompt access to them when required.

Ethical aspects of health records

A correctly made record, honours the ethical concepts on which good practice is based and demonstrates the basis of the professional and clinical decisions made.

A basic principle of records and record keeping is that those who make, access and use the records understand the ethical concepts of professional practice which relate to them. These will include, in particular, the need to protect confidentiality, to ensure true consent and to assist patients and clients to make informed decisions.

Entries made in a record must be totally accurate and based on respect for truth and integrity.

When a patient requests access to medical records, prior to disclosing them, ethical consideration must be given as to whether or not harm might be caused in disclosing them. After consideration a decision will be made either to disclose the records, not to disclose them or to disclose them in redacted form.

Monitoring and Audit

Clinical Audit will play a key part in monitoring the implementation of this policy. Clinical Audit is a requirement of a number of professional bodies and clinical record keeping audits will form a key part of these requirements.

It is expected that all record keeping standards outlined within this policy will be adhered to. To demonstrate this, services will be expected to carry out a clinical audit against these standards on a regular basis and in line with the Clinical Audit Policy (opens in new tab), ensuring that these standards

are being maintained. The frequency of the audits should depend on previous audit results, where high levels of compliance can be audited less frequently. In areas with poor compliance, further intervention and demonstration of improvement would be expected. A typical audit cycle would be conducted on an annual basis. These audits should form part of the annual Clinical Audit Programme and be reported to the relevant senior governance committee or group within the Health Board's governance framework.

A standardised data collection tool should be utilised to demonstrate compliance over time and allow clear comparisons between services areas. Standardised tools can be developed in conjunction with the Clinical Audit Department. An improvement plan must be developed for each audit cycle where deficiencies are identified. These plans should be submitted to the appropriate Governance group.

The frequency of audits should be on an annual basis as a minimum for each service area. Should areas of non-compliance be identified it would be expected that the frequency of re-audit would increase to allow further monitoring following the implementation of change.

Clinical Audit can also be used to provide evidence and assurance for Welsh Risk Pool, Health & Care Standards for Wales, and various accreditations as well as be used as evidence in revalidation and appraisals.

Communication

This Policy will be communicated through:

- Distribution of the Policy to all staff areas
- Publication of the Policy on the Health Board's Intranet.
- Executive summary of this document to be circulated to professionals

Training

The Board will undertake training on the Clinical Record Keeping Policy through:

- The Corporate Induction Programme(s)
- Ongoing e-learning
- Professional development workshops
- The Training and Development Programme for Health Records Staff
- Action plans arising from Audits of patients notes

Responsibilities

Chief Executive

The Chief Executive has overall accountability for clinical record keeping and ensuring that health records management operates appropriately and in compliance with the requisite legislation within the Health Board. As the accountable officer they are responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity. Good clinical record keeping is key to this as it will provide appropriate, accurate information as required. The Chief Executive delegates this responsibility to the Medical Director and Deputy CEO; Director of Nursing, Quality and Patient Experience; and Director of Therapies and Health Sciences

Medical Director and Deputy CEO/ Director of Nursing, Quality and Patient Experience/Director of Therapies and Health Sciences

The Medical Director and Deputy CEO; Director of Nursing, Quality and Patient Experience; and Director of Therapies and Health Sciences are responsible for ensuring the quality of record keeping by clinical staff meets the standards within this policy. They have the responsibility to:

- Have systems in place for maintaining compliance with the respective codes of conduct (GMC, NMC and HCPC) including the standards for record keeping
- Have systems in place for maintaining compliance with this policy and all Health Board policies relating to record keeping
- Seek assurance that audits of compliance feature on the Clinical Audit Programme and that the results are reported through the Health Board Governance Framework

Senior Managers

All senior managers are responsible for their staff and that local practices and procedures follow the principles set out in this policy. Senior managers are responsible for:

- Identifying all areas to which this policy is applicable
- Raising awareness of the policy and the documentation requirements within with all staff
- Raising the profile of good record keeping practice within their department
- Developing appropriate local induction and ongoing training programmes
- Conducting regular audits of compliance and reporting the results through the Health Board Governance framework
- Managing identified risks in relation to record keeping standards in the service and addressing areas of concern with individuals and teams
- Ensuring that staff access training and educational opportunities and evidence their work based learning in their portfolios

Department, service or ward management

The Ward Manager/Team Leader is responsible for:

- Monitoring compliance within their area of responsibility
- Addressing any areas of concern with individuals and teams
- Including record keeping as part of individual personal development reviews
- Escalating concerns as appropriate

All Staff

All staff employed by the Health Board are responsible for complying with the relevant professional standards for record keeping as well as the principles set out by the Health Board within this policy. This includes:

- Compliance with their Professional Codes of Conduct e.g. Nursing and Midwifery Council (NMC) The Code 2015, Health and Care Professions Council (HCPC) Standards, Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England and General Medical Council (GMC) Good Medical Practice: guidance for doctors
- Compliance with this policy and all Health Board policies relating to record keeping
- Attending mandatory training to keep up to date with best practice

- Maintaining their individual professional development around record keeping ensuring that evidence of learning is included in their portfolio
- Compliance with the UK General Data Protection Regulations/Data Protection Act (2018) and related Data Protection Principles
- Keeping up to date with relevant legislation relating to information governance and record keeping

Quality and Governance Groups

The Quality and Governance Groups are responsible for:

- Ensuring that service areas undertake regular audits of compliance
- Discussing the findings of record keeping audits as a standing Agenda item, and identifying areas for improvement required by service areas

Information Governance Sub-Committee

The Information Governance Sub-Committee is responsible for:

- Receiving assurance from Quality and Governance Groups that service areas have been audited to assess if they are compliant with all standards set out within this policy
- Receiving assurance from Quality and Governance Groups that the regular auditing of all record keeping is included in the Health Board forward Clinical Audit Programme
- Overseeing any changes required to the policy

References

Records Management Code of Practice for Health and Social Care 2022 - Records Management Code of Practice for Health and Social Care 2022 - A Guide to the Management of Health and Care Records (opens in a new tab)

General Medical Council - Good medical practice - GMC (gmc-uk.org) (opens in new tab)

Nursing and Midwifery Council - The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk) (opens in new tab)

Health and Care Professions Council - Record keeping | (hcpc-uk.org)

Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England Code of Conduct Healthcare Support.pdf (skillsforhealth.org.uk)

British Psychological Society - Homepage - The British Psychological Society (bps.org.uk)

UK Council for Psychotherapy - Home | UKCP (psychotherapy.org.uk)

British Association for Counselling and Psychotherapy - British Association for Counselling and Psychotherapy (bacp.co.uk)

British Association for Behavioural and Cognitive Psychotherapies - BABCP | British Association for Behavioural & Cognitive Psychotherapies

Hywel Dda University Health Board

Royal College of Physicians Medical Record Standards

FINAL INTERNAL AUDIT REPORT

December 2018

NHS Wales Shared Services Partnership

Audit and Assurance Services

Assurance Rating

REASONABLE Assurance

Previous Assurance Rating:
Limited Assurance

Contents **Page**

Review reference:	HDUHB-1819-31
Report status:	FINAL INTERNAL AUDIT REPORT
Fieldwork commencement:	9th October 2018
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Auditor/s:	Gareth Heaven
Executive sign off:	Philip Kloer (Medical Director & Director of Clinical Strategy)
Distribution:	Karen Preece (Assistant Director - Medical Directorate) Steven Bennett (Health Records Manager)
Committee:	Audit and Risk Assurance Committee

ACKNOWLEDGEMENT
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Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared in accordance with the Service Strategy and Terms of Reference, approved by the Audit and Risk Assurance Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Hywel Dda University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction and Background

The assignment originates from the Internal Audit plan and the subsequent report has been submitted to the relevant Executive Director and the Audit & Risk Assurance Committee.

The relevant lead Executive Director for the assignment was the Medical Director, whilst the Assistant Director – Medical Directorate was the relevant operational lead for the assignment.

2. Scope and Objectives

This review has considered the application of Royal College of Physicians approved "General Medical Record Keeping Standards" in the Health Board's clinical note keeping arrangements.

The objective of the audit was to provide a baseline that the Health Board can use to measure and demonstrate its compliance with the above standards. This work has also evaluated the adequacy of the systems and controls in place for the management of clinical note keeping, compliance with Regulations and the requirements of internal Hywel Dda University Health Board policies and procedures.

The risks considered in the review were as follows:

i. Improper completion or organisation of medical records, resulting in unnecessary delay, frustration, clinical misadventure and litigation;

ii. Non conformity to agreed best practices and standards for records content, creating opportunities for ambiguous or omitted data; and

iii. Quality improvement work, measures of clinical performance, strategic decisions and benchmarking made on inaccurate or incomplete information.

3. Associated Risks

The approach to audit assignments is risk based, where the risks are identified with the lead manager. Controls would then be identified to manage those risks and the assignment scope designed to provide assurances on those issues.

The outcome of this review can be linked or contribute towards the Board Assurance Framework and Health and Care Standards 3.1 (Safe & Effective Clinical Care) and 3.5 (Record Keeping).

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with establishment controls for the Royal College of Physicians Medical Record Standards is **Reasonable** assurance.

RATING	INDICATOR	DEFINITION
Reasonable Assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5. Assurance Summary

The summary of assurance given against the individual Royal College of Physician Medical Record Keeping Standards is described in the table below:

	Assurance Summary*			
RCP Standard				
Standard 1				✓
Standard 2		✓		
Standard 3			✓	
Standard 4			✓	
Standard 5			✓	
Standard 6		✓		
Standard 7			✓	
Standard 8			✓	
Standard 9			✓	
Standard 10				✓
Standard 11		✓		
Standard 12				✓

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design in the compliance of the Royal College of Physicians Medical Record Standards.

Operation of System/Controls

The findings from the review have highlighted **one** issue that is classified as a weakness in the operation of the designed system/control for compliance with the Royal College of Physicians Medical Record Standards.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

STANDARD	DESCRIPTION	AUDIT FINDINGS
1	The patient's complete medical record should be available at all times during their stay in hospital.	Of the 80 patients reviewed on the Welsh Patient Administration System (WPAS), we can confirm that medical records were coded to the appropriate wards and clinics upon request at the time of the patient's admission.
2	Every page in the medical record should include the patient's name, identification number (NHS number) and location in the hospital.	Of the 80 health records requested, eight files were unavailable at the time of fieldwork as clinics and coding departments required the medical records. Of the 72 health records tested, we noted 57 instances where the patients name and NHS number had not been recorded on every medical record, whilst no patient file recorded the location of the patient on every medical page.
3	The contents of the medical record should have a standardised structure and layout.	Of the 72 health records tested, the contents of four health records were not structured or laid out in a standardised fashion.
4	Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order.	Of the 72 health records tested, the contents of four health records did not display the continuum of patient care in chronological order.
5	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma.	Of the 72 health records tested, we noted two instances where data recorded or communicated on admission, handover and discharge had not been recorded on a standardised proforma, with one file noting that the patient was an "overseas resident with no NHS number, therefore unable to obtain an NHS number for the baby".

6	Every entry in the medical record should be dated, timed (24 hour clock), legible and 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, dated and timed.	Of the 72 health records tested, we identified the following: • There was no evidence of dated or timed entries by clinical staff for two patients. • We noted instances in 38 patient files where time entries were either not recorded or not recorded in a 24-hour clock format. • We noted five instances where the name and designation of an entry by a clinician was not legible and one instance where a clinician had not signed an entry in the clinical notes. • Out of 12 patient health records where deletions or amendments were evident, six had not been countersigned, dated or timed.
7	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.	Of the 72 health records tested, entries to the medical record were not evident as soon as possible after the event to be documented and before the relevant staff member goes off duty in three health records.
8	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.	Of the 72 health records tested, we were unable to identify the most senior healthcare professional present at the time the entry was made for two patients.
9	On each occasion the consultant responsible for the patient's care changes, the name of the new responsible consultant and the date	Of the 72 health records tested, we noted four instances where the consultant responsible for the patient's care changes, the name of the new responsible

	and time of the agreed transfer of care, should be recorded.	consultant and the date and time of the agreed transfer of care was unable to be identified.
10	An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why.	Of the 72 health records tested, we noted one instance where it had taken a doctor more than four days between his initial entry and next entry on the clinical notes. However, an explanation to the delay was recorded in the patient notes.
11	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital.	Of the 72 health records tested, we identified 16 health records where a discharge record/discharge summary was not on file. However, nine were regular day admissions or day cases where the patients were attending regular clinics for ongoing treatments such as intravenous infusions (chemotherapy).
12	Advanced Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified.	Of the 72 health records tested, we noted that two patients had a signed copy of the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form on file.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below:

Priority	H	M	L	Total
Number of recommendations	**1**	**0**	**0**	**1**

Finding (O) - RCP Medical Record Keeping Standards	Risk
A review of 72 health records selected from the four acute Health Record Departments identified a number of instances of non-compliance against the Royal College of Physicians Medical Record Keeping Standards and Clinical Record Keeping Policy specifically with Standards 2, 6 and 11.	Non-compliance with the Royal College of Physicians Medical Record Keeping Standards and Health Board policy.
Recommendation	**Priority Level**
We would recommend that clinical staff are reminded of their responsibility to comply with the Royal College of Physicians Medical Record Keeping Standards and Health Board Clinical Record Keeping Policy, and mechanisms are established to review health records and identify any issues of non-compliance.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
Recommendation accepted. The Medical Director will write to all medical staff reminding them of the RCP record Keeping Standards and The Health Board policy. He will agree with the Hospital Directors, the Clinical Directors and the Clinical Audit Department an appropriate process to review health records and identify and address issues of non-compliance.	Medical Director December 2018 March 2019

Appendix B - Assurance opinion and action plan risk rating

2018/19 Audit Assurance Ratings

 **Substantial Assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable Assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

 **Limited Assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows:

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Office details: St Brides
St David's Park
Carmarthen
Carmarthenshire
SA31 3HB

Contact details: 01267 239780

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services