Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 June 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	Royal College of Physicians Medical Records Keeping Standards (Reasonable Assurance) Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr 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

The Internal Audit Royal College of Physicians (RCP) Medical Record Standards report was first brought to the Audit and Risk Assurance Committee (ARAC) in December 2018 for discussion, with updates on progress with the report recommendations provided to ARAC in October 2019, April and October 2020, and October 2021.

This report constitutes a further update on progress, as requested at the ARAC meeting held in October 2021.

Cefndir / Background

During discussion at the ARAC meeting in October 2019, assurance was sought on the audit report recommendations and a number of actions were proposed. It has been acknowledged at subsequent ARAC meetings that progress with the actions agreed had been hampered due to the deployment of key staff to focus on the COVID-19 pandemic response. However, some good progress was demonstrated, in spite of the ongoing pandemic response.

Actions agreed to progress this area relate to:

- Yearly audit by Specialty
- Structure for reporting Audit Outcomes
- Update to the Clinical Record Keeping Policy
- Provisions for exploring a digitalised system in future
- Development of an e-learning module – Good Record Keeping Practice for Clinicians – RCP Standards
- Stamps

Working arrangements have yet to fully return to normal, however progress continues to be made in relation to the actions wherever possible, with regular updates being provided via the Health Board's Quality and Governance reporting arrangements.

National / local objectives involved

- RCP Standards for Clinical Record Keeping
- Health & Care Standards –3.1 Effective Care
- Health & Care Standards – 3.5 Record Keeping
- Health & Care Standards – 4.2 Patient Information
- UHB Strategic Objectives:
    1. Putting people at the heart of everything we do
    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
    5. Safe sustainable, accessible and kind care
    6. Sustainable use of resources

Asesiad / Assessment

An update on progress in relation to each of the action areas is noted below.

Update to the Clinical Record Keeping Policy

The Clinical Record Keeping Policy Steering Group has continued to provide oversight for the development of the Clinical Record Keeping Policy. A Task and Finish Group has met to progress key aspects.

The new Clinical Record Keeping Policy is in final draft, having received stakeholder input from members of the Clinical Record Keeping Policy Steering Group. The Group met to review stakeholder comments and agree the version for wider consultation; this process will take place in June 2022.

The new Policy is focused around nine overarching standards, that 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. However, they do not replace the responsibility of staff who are registered to a regulatory body, or other governing body where there is no core registration to adhere to record keeping standards defined by their registrant body, and/or their Code of Conduct.

The nine 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
Standard Nine – Records must be managed and stored appropriately

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, along with ethical aspects. It will provide a basis for communication, education and training activities.

The policy also signposts to more detailed record keeping practices that are required at professional/service level.

In developing the Hywel Dda policy, a search for Clinical Record Keeping policies for Health Boards and Trusts from across the UK was undertaken and best practice has been adopted from the policies that were discovered. Of note, the majority of policies contained high level standards to be adhered to by all professionals, therefore the Hywel Dda Policy is consistent with this approach.

Health Boards from across Wales have been approached with a request to share their Clinical Record Keeping Policies and any experience with regard to improving clinical record keeping. This work is ongoing.

Development of an e-learning module – Good Record Keeping Practice for Clinicians – RCP Standards

It was originally proposed that an e-learning module be developed, regarding good record keeping for clinicians, based on the RCP Standards. However, as was reported to the Committee in October 2021, the content of this e-learning module was dependent on the standards that were agreed for the new Clinical Record Keeping Policy.

The Standards have subsequently been developed and contact made with the Learning and Development Team to discuss the best approach to publishing an e-learning module.

The Learning and Development Manager has advised that e-learning is not the most effective method for a subject matter such as this; furthermore, current statistics indicate that engagement with e-learning is limited, and therefore does not provide a reliable way to reach the audience required.

Instead, the Learning and Development team have suggested that a suite of learning and training resources might be a more beneficial approach, to be hosted centrally as a SharePoint page on the new intranet site. This will allow for interactive and dynamic content such as videos, live sessions, pre-recorded slide sets, posters and written resources, as well as providing access to the Clinical Record Keeping Policy, signposting to key links, and also the ability to book onto training sessions. Work in this regard is ongoing, and will involve the Digital Communications Team to support the establishment of the SharePoint, and the Learning and Development Team to develop the resources.

Yearly audit by Specialty

Clinical Audit will play a key part in monitoring the implementation of the Clinical Record Keeping 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 the policy will be adhered to. To demonstrate this, services will be expected to carry out a clinical audit against these standards at least annually, ensuring that these standards are being maintained. Should areas of non-compliance be identified, it would be anticipated that the frequency of re-audit would increase

to allow further monitoring, following the implementation of change. The audits will 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. Central oversight will be provided by the Effective Clinical Practice Advisory Panel.

A standardised data collection tool will be developed, to be used to demonstrate compliance over time and allow clear comparisons between service areas. An improvement plan will be required each audit cycle where deficiencies are identified. These plans will be submitted to the appropriate Directorate/County Quality and Governance group (or escalated to Operational Quality, Safety and Experience Sub-Committee if necessary). The Clinical Audit Scrutiny Panel will be responsible for monitoring completion of the audits, and will escalate to the Effective Clinical Practice Advisory Panel where necessary.

Investigations are currently ongoing in terms of using the new system in place for Clinical Audit (AmaT), to enable completion of the specialty audits. This would entail the development of a proforma within the system for the standardised data collection tool, which could be rolled out to end users to complete within the system, providing a central repository and oversight of findings, and allowing easy identification of areas for improvement, via a dashboard approach. Improvement projects will be supported by the Quality Improvement and Service Transformation Teams, including the site QI Leads.

Structure for reporting Audit Outcomes

The revised Clinical Record Keeping Policy will be presented at the Directorate/County Quality and Governance Groups, under the Effective Clinical Practice item on the standardised agenda.

Findings from ongoing annual audits against the new Clinical Record Keeping standards are to be presented at the respective Directorate/County Quality and Governance Group, with issues escalated to the Operational Quality, Safety and Experience Sub-Committee (OQSESC) and Quality, Safety and Experience Committee (QSEC) where necessary.

As reported previously (and as above), the Record Keeping Audit is included on the formal Clinical Audit Programme and discussed at the Health Board's Clinical Audit Scrutiny Panel, with an opportunity to escalate via the Effective Clinical Practice Advisory Panel.

Provisions for exploring a digitalised system in future

As previously reported, responsibility for digitalisation sits with the Clinical Informatics Group and there is cross-representation at that group and the Clinical Record Keeping Policy Steering Group.

It is acknowledged within the new Clinical Record Keeping Policy that the standards outlined within the Policy apply equally to digital records, which allows for the standards to be followed within digitalised systems.

A new Chief Clinical Information Officer (CCIO) is in the process of being appointed, who will be responsible for leading on the innovation and improvement of clinical services through the use of informatics, and leading on new ways of working using digital and informatics technologies, transforming care delivery across all clinical environments and professions. This role will provide a key link between the improvement work in relation to clinical record keeping and the digitalisation agenda.

Stamps

Self-inking identification stamps have been purchased for every Health Board Doctor, and they are in the process of being distributed. During a recent discussion held at Grand Rounds, several Doctors mentioned and advocated the benefits of stamps to improve record keeping; in response, the Health Board has purchased a personalised stamp for every Doctor. This initiative has been well received.

The provision of stamps is intended to assist with achieving **Standard Six** – *Records must contain the professional's details – printed and signed/initialled, designation/role and registration number (i.e. GMC/NMC number)*.

The self-inking stamps contain the doctor's name and GMC number, and can therefore assist with the achievement of the above standard.

A Royal College of Surgeons article (Sac McKeith et al, 2012)[1] details an audit which demonstrates the benefits of a personalised self-inking stamp in improving identification standards in medical records. The article recognises the importance of identification of doctors' entries in medical notes for patient safety, audit, clinical governance and medico-legal reasons. The audit, undertaken in Northampton General Hospital, involved an initial audit of 90 case notes from ENT outpatient, emergency treatment room and inpatient entries. The doctors' entries in the notes were examined for legibility of their name and presence or absence of their unique GMC number. The name was considered legible if it could be identified by someone who did not have prior knowledge of the departmental staff names. Self-inking rubber stamps were then issued to all doctors working in the ENT department. These were small enough to attach to the doctor's identity badge lanyard or key ring and contained the name and GMC number of the doctor. A further 90 case notes were reviewed following introduction of the stamps, also from outpatient, emergency treatment room and inpatient entries. Again, the notes were examined for legibility of the doctors' names and the presence of their GMC numbers.

The first audit identified that the legibility of the doctors' names in the case note entries was extremely poor, particularly for the emergency and inpatient notes. Understandably, as none of the doctors was accustomed to using their GMC number, compliance with this GMC recommendation was nil. In the second audit, the majority of doctors working in the department were using their stamps when making entries in notes. As a result, there was a significant improvement in the overall name legibility scores from 42.2% to 92.2%.This can be seen to be associated with a significant increase in the number of case note entries with a GMC number present, as this was included every time the doctor stamped his or her name in the notes.

Similar audits have been planned for the A&E and ENT departments at Glangwili General Hospital; however, time has been allowed for the stamps to be embedded at these units prior to undertaking the audit, to demonstrate the impact of the stamps.

Argymhelliad / Recommendation

The Audit and Risk Assurance Committee is requested to:

- Receive this report as a source of assurance regarding the progress made in relation to the original Internal Audit report recommendations, and subsequent actions agreed by the Record Keeping Audit Working Group, following the delayed progress previously noted due to the COVID-19 pandemic response.

[1] Could Personalised Self-Inking Stamps Improve Identification Standards in Medical Records? (rcseng.ac.uk)

- Note the actions taken and the ongoing audit plan against the new Clinical Record Keeping Standards. This will be reported and monitored through the Effective Clinical Practice Advisory Panel, which reports to QSEC.

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 Current Risk Score – 3x4=12
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 2018-2019	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:	ENT – Ear, Nose and Throat 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.