Talking Out Ltd

CLINICAL RECORD KEEPING POLICY

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Clinical Record Keeping Policy

Summary:

This Policy provides statements and standards for the management of clinical information (electronic and paper) and assurance of compliance with national and legal requirements.

Target Audience:

All staff who contribute or manage clinical information – both paper and electronic

Record Keeping Core Standards

Rationale:

To provide an accurate, timely, relevant clinical record that facilitates the delivery of safe and coordinated care that involves the patient, carer and family. All clinical and administrative staff creating or contributing to the patient record will provide an accurate and timely health record which can determine accountability; facilitate clinical decision making; improve patient care through clear communication of the assessment, treatment and care planning rationale; provide a consistent approach to partnership working; and help in the investigation of complaints or legal proceedings.

Quick Reference Guide

Speech and Language Therapists have a duty to keep up to date with, and adhere to, relevant legislation, case law, Professional Bodies and professional standards, policies relating to information governance and record keeping standards.

Speech and Language Therapists are accountable for any entry they make to a patient record and must ensure that any entry made is clearly identifiable. Every Speech and Language Therapist must check entries they make for accuracy. If students contribute to clinical notes they should be checked and counter signed by a supervising Speech and Language Therapist.

All health records must comply with local policies and procedures, throughout the lifecycle of the record to include management, retention, review and disposal.

Handwriting must be legible and written in black ink to enable legible photocopying or scanning of documents if required.

Clinical records must be accurate and written in such a way that the meaning is clear (paper and electronic).

Clinical records must demonstrate a full account of the assessment made and the care planned and provided and actions taken including information shared with other professionals.

All entries must be recorded as soon as possible after an event has occurred (contemporaneous), providing current information on the care and presentation of the client.

If the date and time differs from that of when the records are written, this must be clearly noted in

the record.

All entries must be recorded, wherever possible in language that the client can understand.

Clinical records must demonstrate any risks identified and/ or problems that have arisen and the action taken to rectify them.

Clinical records should not include unnecessary abbreviations or jargon, meaningless phrases, irrelevant speculation or offensive subjective statements, irrelevant personal opinions regarding the client.

Any corrections in handwritten records must be clear, dated and signed. For electronic records – follow the procedure in the appropriate standard operating procedure or handbook.

Clinical Records must never be falsified.

Speech and Language Therapists must develop communication and information sharing skills with other professionals and providers of care as accurate records are relied on at key communication points, especially during handover, referral and in shared care.

Legal requirements and local policies regarding confidentiality of clinical records must be followed at all times.

Speech and Language Therapists remain professionally accountable for ensuring that any duties delegated to students and/or volunteers are undertaken to a reasonable standard.

The care delivered by volunteers and/or students will need to be overseen by a registered Speech and Language Therapist on a regular basis (determined locally based on the complexity and needs of the client) alongside a comprehensive review of the clinical records.

Clinical records held on any form of media must be protected by appropriate levels of security, for example, lockable filing cabinet, locked room, secure patient record system.

CLINICAL INFORMATION ASSURANCE STATEMENT

This policy has incorporated a range of best practice and related legislative requirements to outline the organisations expectations for record keeping standards, both paper and electronic, including the following:

- Relevant professional bodies
- Royal College of Speech and Language Therapists, record keeping and information governance guidance
- General Data Protection Regulation 2018

The standards within this policy will:

- Maximise client safety and quality of care by advocating accurate and contemporaneous record keeping.
- Ensure compliance with best practice across Talking Out Ltd
- Facilitate Speech and Language Therapy staff to meet their professional records keeping standards
- Provide a framework for non-professional staff to comply with Trust record keeping requirements

- Enable the management of clinical and corporate risk
- Underpin the record keeping audit of health records in the Trust to monitor compliance with expected standards
- Allow for information sharing and communication across and between the patient, clinical teams and partner organisations

To achieve this, clinical records must be timely, accurate, factual, concise and up to date accounts of the assessment and treatment, plan of care and evaluation of individual clients.

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

- provide rationale for clinical decisions
- protect legal and other rights of staff or those affected by those actions
- facilitate audit or examination by internal or external reviewers
- 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; an objective account of care 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 and compliant in their professional standards and guidance.

1. Introduction

Good clinical record keeping is an integral and vital part of professional practice which contributes to:

- support clinical care and continuity of care, including the assessment and management of clinical risk
- support day to day Talking Out Ltd staff activities which underpin delivery of care
- support evidence based clinical practice
- support the decision making process
- meet legal requirements
- assist clinical and other audits
- support improvements in clinical practice
- ensure information is available, whenever and wherever there is a justified need, and in whatever media it is required
- client involvement in their care

This policy outlines Talking Out Ltd's standards to underpin the provision of quality clinical records, in all formats to mandate the way in which information is recorded, managed and used.

2. Who does this policy apply to

This policy applies to all staff who are engaged in the delivery of care to clients and refers to all information, in any media (but particularly paper and electronic), both active and inactive, that is recorded in relation to care provided to an individual to Talking Out Ltd.

This Policy must be read by all Speech and Language Therapy staff from Talking Out Ltd. It also applies to anyone contracted by Talking Out Ltd, who, in the course of their work are required to access clinical records normally restricted to directly employed staff, and to students on placement or volunteering.

- Electronic Information: Includes "data", and is wider than just non-identifiable data used in business processes. This also includes all electronic information relating to a specific client; e.g. activity; mental health act; contracts; demographic information; care plans; assessments; carers/significant others
- Paper records: All volumes and modules of a clinical paper record

3. Definitions

3.1 Health Record

The Data Protection Act 1998 describes the health record as "consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual".

3.2 Paper Record

Any of the following documents which record aspects of care of a patient or client can be required as evidence before a Court of Law or before any regulatory body:-

- Diaries
- Incident forms
- Attendance books
- Messages relating to the care of a patient
- Clinic lists

This list is not exhaustive

3.3 Electronic Record

The Electronic Patient Record is a secure, real-time, point-of-care, patient centric information resource. Electronic Patient Record (EPR) is an official health record for an individual that can be shared among multiple departments and agencies.

3.4 Writeupp

Writeupp is the specific EPR system used by Talking Out Ltd. Further information about Writeupp can be found at www.writeupp.com

3.5 Contemporaneous

Means records should be written at the time of or as close to the event described in the record.

3.6 Confidentiality

All staff have a duty to protect the confidentiality of the patient record. Access to a patients records and the information contained in them must only be for an appropriate reason and by appropriate staff. See Standards of Conduct and Disciplinary Policy (HRP1) and Code of Conduct guidance for further details.

3.7 Access

Means the opportunity or right to see records, under The Data Protection Act 1998, clients have the right to access their health records, subject to certain safeguards.

3.8 Records Lifecycle

This describes the life of a record from its creation/receipt through the period of its "active" use, then into a period of "inactive" retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation.

3.9 Audit

Audit provides a method for systematically reflecting on and reviewing practice to ensure compliance with current standards

3.10 People/User/Client/Patient

These terms can be used interchangeably to represent user of services

4. Duties / Responsibilities

4.1 Directors

The Directors have overall responsibility for Records Management within Talking Out Ltd. Talking out Ltd has a responsibility for ensuring that it corporately meets its legal responsibilities that affect the safe management of health records. This responsibility includes the on-going review, maintenance and upkeep of clinical documentation (both paper and electronic) and associated policies and procedures.

- All relevant staff in the team are compliant with this policy

- Any risks in relation to record keeping standards in the service are identified and managed

4.2 Shareholders

The Shareholders have responsibility for keeping an overview of Talking Out Ltd's activity. Which includes approving policy documentation.

4.3 Individual Employees are responsible for:

- Complying with this policy Talking Out Ltd's procedural documents that outline expected standards for record keeping
- Reporting clinical incidents and near misses
- Keeping up to date with relevant legislation relating to information governance and record keeping

In addition clinical staff are responsible for:

- Developing and updating personalised care plans
- Overseeing the quality of delegated care and related record keeping practice
- Demonstrating that the healthcare record is evidenced based
- Providing a copy of a personalised care plan, where appropriate
- For the safeguarding of confidential information held as paper records (in a structured filing system) and electronically (on computers and within information systems).

All staff are responsible for complying with the common law duty of confidentiality; that any personal information given or received in confidence for one purpose may not be used for a different purpose or passed on to anyone else without the consent of the individual. All staff with authorised access to clinical information have a duty to keep clinical information confidential, secure and in line with the standards and procedures as set out in this and other policies; professional standards and Codes of Practice; NHS Codes of Practice and Data Protection Legislation.

Any unauthorised use of clinical information or any use of information outside of a "legitimate professional relationship" may lead to immediate disciplinary action.

5. Main policy content

In this policy, records are defined as "a recorded document which forms part of a structured file that contains information, in any medium (including electronic, audio, visual, microfiche), created or received and maintained by Talking Out Ltd in the transaction of its business or conduct of affairs and kept as evidence of such activity".

Records management is a discipline which utilises an administrative system to direct and control the creation, version control, distribution, filing, retention, storage and disposal of records, in a way that is administratively and legally sound, whilst at the same time serving the operational needs of Talking Out Ltd and preserving an appropriate historical record.

The key components of records management are:

- Creation
- Quality and accessibility

- Standards and maintenance systems
- Disclosure and information sharing
- Transfer and tracking of movements
- Storage
- Culling/reviewing, closure
- Retention
- Archiving
- Disposing

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".

5.1 Clinical record creation and management:

All clinical records must comply with the standards for record keeping set out in the policy.
(Links to professional body websites are provided.)

Diaries (paper and electronic) must not be used for recording clinical information. Any notes made during an unplanned visit, or in an emergency, must be transferred to the clinical record as soon as possible.

The retention, archiving and destruction of clinical records should be managed in accordance with this policy.

5.2 Basic Record Keeping Standards

This section describes the organisation's standards to ensure that information contained within the health record is correctly recorded, regularly updated, legible, factual, and easily accessible.

Health Professional Bodies also require registered staff to adhere to current professional record keeping standards as required by the following:-

- Royal College of Speech and Language Therapists
- Health and Care Professions Council

The important activity of making and keeping records is essential. These standards are to assist Talking Out Ltd staff to fulfil the expectations of Talking Out Ltd and to promote the best interests of clients.

Basic Record Keeping Standards:

- Any pieces of paper must be identified with the patient's full name and date of birth
- The record needs to demonstrate an accurate chronology of the patient's progress
- Completed in black ink/typed for all entries, do not use pencil, as must be readable on any photocopies
- Dated and timed, the 24 hour clock must be used. Entries should be contemporaneous i.e. made as soon as possible. If the time of recording varies significantly from the time of the contact this must also be noted.
- Accurately signed (validated) with the full name printed alongside each entry along with the designation / if electronic entries they need to be attributable to the author, including designation. When using paper records any entries provided by a non-registered professional staff member should be counter-signed by a registered professional.

- No use of erasers, liquid paper, or any other obliterating agents should be used to cancel errors; a single line should be used to cross out and cancel mistakes or errors and this should be signed and dated by the person who has made the error. For electronic records – follow the Writeupp procedure in the appropriate handbook.
- Do not include meaningless phrases and offensive subjective statements unrelated to the patient's care and associated observations
- The use of abbreviations should be kept to a minimum, if using abbreviations; they must be written out in full at the beginning of each entry.

5.3 Clinical Information Standards

Clinical Information will vary depending on clinical service provided and if relevant must:

- Include a record of initial assessment
- Include a record of any investigations and results
- Include a record of any medication being taken, including benefits and potential side effects
- Include a record of treatment
- Include a management / care plan with goals that are specific and measurable
- Include a record of the patient's comments and/or related expectations and goals related to their health and their perceptions of their anticipated treatment (which may influence treatment / management plan)
- Entries should be made for patients who are being cared for following every intervention (whether direct or indirect) by the health care professional and at any other time as necessary to record important facts. For intensive courses this may be an entry for each day.

Information given to patients will vary needs according to clinical needs and can include:

- Personalised care plan / goals
- Risks and benefits of treatment and relevant options where applicable
- Specific verbal advice and details of any discussion with patients /or authorised relatives and carers or representatives. Differentiation is required between information given to patients and carers and any other authorised representatives.

5.4 Filing

All paper files should include a cover sheet to identify the client.

All documentation in a paper record must be hole-punched and filed chronologically, according to the index.

5.5 Confidentiality & Information Security

All clinical information, whether created and stored as an electronic or paper record, must be kept secure. Each individual staff member is responsible for the information that is in their care and disciplinary processes will be followed if information is inappropriately accessed or lost.

Unavailable, mislaid or lost clinical records are a serious risk to Talking Out Ltd and it is therefore vital that tracking/tracing procedures are in place and followed at all times.

If, however, clinical records are unavailable, mislaid or lost, it is vital that appropriate action is taken to manage the potential loss of the information.

5.6 Patient Opt-out

Patients have the right, under Section 10 of the Data Protection Act, to request to "opt-out" of having an electronic patient record. This decision is based on clinical risk assessment, and impact on the individual.

5.7 Access to Electronic Patient Records (EPRs)

Staff must have a legitimate reason for accessing an EPR. This includes:

- Recording clinical information
- Reading clinical information of clients referred to the clinician / team where there is a legitimate relationship with the client
- Monitoring and auditing the completeness and quality of the record
- Undertaking reviews and investigations
- Providing support, assistance and guidance to staff
- Auditing clinical outcomes

5.8 Unqualified/non-registered staff using EPRs

All unqualified or non-registered clinical staff will have access to appropriate EPRs. The quality of their entries remains the responsibility of the Lead Clinician for the service, and clinical supervision should be used to ensure that the staff member has the competence to complete clinical records.

6. Subject Access Request – Access to Records

Under the Data Protection Act 1998 (DPA) and the General Data Protection Regulation 2018 individuals (data subjects, staff or patients) have the right to review and receive copies of their own records. Information about how to make a request to view records can be found in the privacy policy sent to all clients at when their record is created.

7. Litigation and Complaints Documentation

Clinical records must not contain information (inc. correspondence, reports, statements emails) relating to complaints, critical incident reviews or litigation. This includes inputting or uploading into electronic patient record systems. This information should be stored separately.

8. Policy Review

This policy will be reviewed in three years, or earlier if necessitated as a result of changes to legislation, codes of practice or national standards.

Associated guidance, procedures and templates will be updated as required, and signed off by the Records and Care Planning Work Stream, and the Information Governance Group (as required).

9. Supporting References

- The Public Records Act 1958
    - http://www.nationalarchives.gov.uk/
- NHS Code of Practice: Records Management 2016
- The Data Protection Act 1998
    - https://ico.org.uk/
- Access to Health Records Act 1990
- NHS Code of Practice: Confidentiality 2003
- NHS Health & Social Care Information Centre
    - http://www.hscic.gov.uk/
- Information Governance Toolkit
    - https://nww.igt.hscic.gov.uk/Home.aspx
- Common Law Duty of Confidentiality
- Human Rights Act 1998
- Freedom of Information Act 2000
- Royal College of Speech and Language Therapists