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Health Recordkeeping

Self-Directed Guidance Document and Trust Employee Declaration
Level 2 (Organisational) Tri-Annual Requirement

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Learning and Development
The Dudley Group NHS Foundation Trust

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Types of Health Records

Legally, a health record may be any form of record ***"which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection with the care of that individual."***

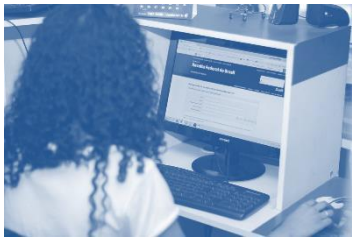
(Data Protection Act, 1998)

This allows for any type of media which may relate to the health and care of an individual, such as **Hard Copy Records**, **Electronic Data either held on PC or printed**, **Images or Media Recordings** and **Handwritten Notes**.

As we move towards increasing use of electronic data, all employees should remain aware these too legally constitute a health record.

Staff Records Creation and Use

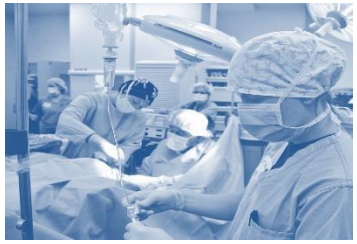
All Trust employees contribute to the health records of individuals:



Administrative staff through recording patient data electronically or in print.

Nursing and Therapies staff in logging patient care activities and information, or adding to existing data.

Clinicians in reviewing patients and documenting their assessments and plans for ongoing care.



Specialist or Multidisciplinary Teams in recording their interventions, in acute, outpatient or community settings.

Accordingly, all Trust staff are held individually accountable for their own recordkeeping and documentation, whether they are acting as the **originator** of the data, as a **user** of the data, or responsible for its **review**.

Health Recordkeeping – Clinical Risks

Incorrect, inappropriate or unsafe use of records and information can pose a genuine risk to the health and well-being of service users.

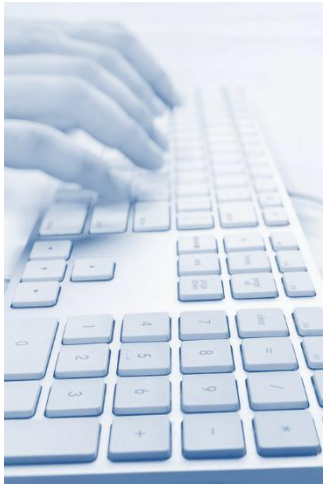
Errors, omissions and unnecessary delays can all arise where data is not **recorded promptly and accurately**, **stored securely**, and **available for use** when needed.

Poor health recordkeeping has the potential to contribute to the real deterioration of those in our care. An Ombudsman review of Hastings and Rother NHS Trust (Audit Commission, 1999) found the lack of documentation of concerns by the family of a patient with intestinal obstruction may have indirectly contributed to his death. In the case of *Prendergast vs. Sam and Dee Limited* (Magrath, 1988), an illegible prescription resulting in patient harm was attributed both to the prescribing General Practitioner and the dispensing Pharmacist involved.

Health Recordkeeping – Staff Risks

Where Trust employees are found to have been negligent in their recordkeeping, investigation through the channels of **Conduct** or **Capability** may be necessary in order to protect and reassure service users.

In the event of an **adverse incident**, **allegation**, or **complaint**, both your own recordkeeping and that of others relating to your work will need to be examined thoroughly and any concerns challenged accordingly.



For those staff with a professional regulatory body, malicious or negligent creation or use of health records may lead to **further investigation and potential sanctions**.

The General Medical Council (GMC, 2013) for Clinicians, Nursing and Midwifery Council (NMC, 2015) for Nurses and Midwives, and Health & Care Professions Council (HCPC, 2016) for Allied Professionals all provide clear guidance to registered practitioners to promote to safe and accurate use of health records.

Health Recordkeeping – Statute

The creation and use of health records, and access to them by others, is guided legally by the following main acts or statute:

- **Access to Health Records Act (1990)** allowing service users access to information held about them and their care. This must be submitted in writing in the first instance to **Health Records Requests, The Dudley Group NHS FT** to ensure the records contain no information relating to other identifiable individuals and to allow clinician consent to be established.

- **Data Protection Act (1998)** for all identifiable information, not only health care data, to ensure it is gathered appropriately, stored securely, not transferred or shared inappropriately or unsafely, and contains accurate and timely details.

Health Recordkeeping – Statute

- **Caldicott Report (1997, Updated 2016)** identifying key principles specifically for patient health care data, including avoiding unnecessary use, utilising as little as clinically necessary, and being accessible only on a *need to know* basis or amongst professionals in the justifiable best interests of the patient.

- **Freedom of Information Act (2000)** to allow the public access to non-identifiable information held by public authorities, taking into account potential public interest in disclosure, and the risk of security, legal or Data Protection Act breaches before it is provided.

Issues of Data and Recordkeeping are also covered in **Information Governance and Data Training**, which is an annual legal requirement of **all** NHS employees, regardless of role or area of practice. Please access the Learning and Development team intranet site for details of how to complete this awareness requirement, either as an e-Learning or face-to-face session.

Health Recordkeeping – Standards

The following standards should be followed by all staff in relation to healthcare-related documentation and recordkeeping:

- **Black or blue indelible ink** for handwritten records, to both aid copying or scanning and reduce the risk of removal or amendment by others;
- Handwriting must be **legible by others**, including potential the service user themselves if they formally seek access to their own information;
- **A correct date, and a time in 24-hour format** must accompany the entry, to clearly identify when the record was made and reduce the risk of miscommunication;
- All entries should be **signed**, with the **printed name and role** of the individual making the entry. Staff provided with identification ink stamps may also use these, but a signature should be provided also to reduce the risk of fraudulent use of a stolen or mislaid identity stamp.

- Jargon, slang terminology, irrelevant, inappropriate or offensive information should be avoided in health records. **Details should be relevant to the care and well-being of the individual service user** only.
- Records should be made and stored **chronologically**. Post-dated entries should be avoided wherever possible, but a justification for the delay included where it was unavoidable due to clinical or safety issues.
- Any errors or amendments should be **crossed through but remain visible**, and **countersigned** as correct. It is not acceptable to deface entries or remove them entirely from the remainder of the record.
- All patient entries should contain their **correct name**, **patient identification number** and their **current location** in the Trust. The details of adhesive labels should also be confirmed as correct if these are used.
- **Omissions as well as actions** must be recorded, with an explanation documented where a planned or intended activity or intervention is not completed or there is any deviation from required support or care. In the event of a error, incident or allegation, you may be reliant on your records to justify your own practices.

Health Recordkeeping – I.T. Standards

- For information inputted or accessed electronically, all staff requiring access are provided with an individual secure login for Trust PCs and relevant information programs. **You should contact your Line Manager or Trust IT Services if you require a login or require a password reset**.
- **You must not disclose your passwords to others for their use, or expect them to disclose theirs to you**. Any electronic materials, including patient information, staff information, e-mail or messaging platforms, or Internet access is logged against the individual employee. As such, any errors, breaches or malicious actions will also be logged against you.
- **You must not leave a Trust PC or piece of ICT equipment logged in and accessible when unattended**. Any malicious or accidental access, amendments or accidents made by another individual while you are not present will be logged against your own employee details. Even if the other individual can be identified, you will still be called to account for unintentionally providing them with access through your omission.

Health Recordkeeping – Abbreviations

Abbreviations should be avoided wherever possible as they carry a risk of misinterpretation by others who may be unfamiliar with the term. Where clinically necessary, the following abbreviations only are approved by the Trust:

AIDS	ACQUIRED IMMUNODEFICIENCY SYNDROME
CCF	CONGESTIVE CARDIAC FAILURE
COPD	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CVA	CEREBRO-VASCULAR ACCIDENT
DVT	DEEP VEIN THROMBOSIS
HIV	HUMAN IMMUNODEFICIENCY VIRUS
MI	MYOCARDIAL INFARCTION
MRSA	METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS
PE	PULMONARY EMBOLUS
STAPH	STAPHYLOCCUS
TB	TUBERCULOSIS
UTI	URINARY TRACT INFECTION
#	FRACTURE
VE	VAGINAL EXAMINATION / VENTRICULAR ECTOPIC

AxR	ABDOMINAL X-RAY
Ba	BARIUM
CT	SCAN COMPUTERISED TOMOGRAPHY
CXR	CHEST X-RAY
MRI	MAGNETIC RESONANCE IMAGING
U/S	ULTRASOUND
CPR	CARDIOPULMONARY RESUSCITATION
D&C	DILATATION AND CURETTAGE
PEG	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY
TENS	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION
TPN	TOTAL PARENTERAL NUTRITION
TPR	TEMPERATURE PULSE RESPIRATION
MEWS	MODIFIED EARLY WARNING SCORE
NEWS	NATIONAL EARLY WARNING SCORE

Ext	EXTERNAL USE
IM	INTRA MUSCULAR
Inh	INHALATION
IV	INTRAVENOUS
Neb	NEBULISATION
O	ORAL
PO	BY MOUTH
PR	PER RECTUM
PV	PER VAGINA
SC	SUB CUTANEOUS
S/L	SUB LINGUAL
Top	TOPICAL
OD	ONCE A DAY
OM	EACH MORNING
ON	EACH NIGHT
BD	TWICE A DAY
PRN	AS REQUIRED
QDS	FOUR TIMES DAILY
TDS	THREE TIMES DAILY
MANE	IN MORNING / NEXT MORNING
NOCTE	NIGHT
CD	CONTROLLED DRUG
IVI	INTRAVENOUS INFUSION
TTO	TO TAKE OUT / HOME (DRUGS)
Appt	APPOINTMENT
ASAP	AS SOON AS POSSIBLE

DOB	DATE OF BIRTH
FU	FOLLOW UP
S/A	SAME ADDRESS
S/B	SEEN BY
SOS	SEE IF IN TROUBLE
TCI	TO COME IN
CPN	COMMUNITY PSYCHIATRIC NURSE
GP	GENERAL PRACTITIONER
HO	HOUSE OFFICER
HV	HEALTH VISITOR
RMO	RESIDENT MEDICAL OFFICER
REG	REGISTRAR
RSO	RESIDENT SURGICAL OFFICER
SALT	SPEECH AND LANGUAGE THERAPIST
SHO	SENIOR HOUSE OFFICER
SPR	SPECIALIST REGISTRAR
SR	SISTER
S/M	STAFF MIDWIFE
S/N	STAFF NURSE
ST/N	STUDENT NURSE
ST/M	STUDENT MIDWIFE
ENT	EAR NOSE AND THROAT
GI	GASTROINTESTINAL
GYNAE	GYNAECOLOGY
HDU	HIGH DEPENDANCY UNIT
NNU	NEONATAL UNIT
DNA	DID NOT ATTEND

OPD	OUT PATIENTS DEPARTMENT
OT	OCCUPATIONAL THERAPY
PAEDS	PAEDIATRICS
FBC	FULL BLOOD COUNT
FFP	FRESH FROZEN PLASMA
FSH	FOLLICLE STIMULATING HORMONE
HB	HAEMOGLOBIN
IgA.	FRACTION OF IMMUNOGLOBULIN
IgG.	FRACTION OF IMMUNOGLOBULIN
IgM.	FRACTION OF IMMUNOGLOBULIN
K	POTASSIUM
PCV	PACKED CELL VOLUME
PT	PROTHROMBIN TIME
Rh	RHESUS FACTOR
U/E	UREA AND ELECTROLYTES
WCC	WHITE CELL COUNT
X-MATCH	CROSS MATCH
BMI	BODY MASS INDEX
BP	BLOOD PRESSURE
CNS	CENTRAL NERVOUS SYSTEM
CVP	CENTRAL VENOUS PRESSURE
H/O	HISTORY OF
Ht	HEIGHT
NAD	NO ABNORMALITY DETECTED
NBI	NO BONY INJURY
NOK	NEXT OF KIN
SOB	SHORTNESS OF BREATH
TPR	TEMPERATURE PULSE RESPIRATIONS
Wt	WEIGHT
BCG	BACILLE CALMETTE- GUERIN
C&S	CULTURE AND SENSITIVITY
CSF	CEREBRO-SPINAL FLUID
CTG	CARDIOTOCHOGRAPH
ECG	ELECTRO CARDIOGRAM
EEG	ELECTRO ENCEPHALOGRAM
HVS	HIGH VAGINAL SWAB
LP	LUMBAR PUNCTURE
MC&S	MICROSCOPY CULTURE AND SENSITIVITY
MSU	MID STREAM URINE
LA	LOCAL ANAESTHETIC
Na	SODIUM
NBM	NIL BY MOUTH
POST OP	AFTER OPERATION
PRE OP	BEFORE OPERATION
RTA	ROAD TRAFFIC ACCIDENT
ROS	REMOVAL OF SUTURES
UV	ULTRA VIOLET
VE	VAGINAL EXAMINATION
ET	TUBE ENDOTRACHEAL TUBE
FG	FRENCH GAUGE
IUCD	INTRA UTERINE CONTRACEPTIVE DEVICE
NGT	NASO GASTRIC TUBE
TEDS	THROMBO EMBOLIC DETERRENT STOCKINGS

Further Information and Resources

In addition to the hyperlinks within this document, for further information and guidance regarding appropriate recordkeeping and standards, we recommend you utilise the following free resources, in addition to Trust policies and key staff contacts available via the organisational intranet:

Royal College of Nursing – Recordkeeping Guidance (2017)
https://www.rcn.org.uk/get-help/rcn-advice/record-keeping

Royal College of Physicians – Generic Medical Record Keeping Standards (2015)
https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards

Department of Health Records Management Code of Practice (2016)
https://www.gov.uk/government/publications/records-management-code-of-practice-for-health-and-social-care

Medical Protection Legal Service – Medical Records (2015)
http://www.medicalprotection.org/uk/resources/factsheets/england/england-factsheets/uk-eng-medical-records

Employee Confirmation

You must confirm your review and understanding of this document through one of two methods most convenient to you:

1) You may print this page, complete the details below manually, and return the page to use via **Learning and Development Department, 1st Floor Clinical Education Centre, Russells Hall Hospital, Dudley, DY1 2HQ**

Name:	
Ward / Area / Department:	
Date of Review:	

2) From your own .DGH or .NHS e-mail login, click dgft.learning@nhs.net to send an e-mail confirmation of your completion, identifying your name and Ward, Department, or Area of practice.

Once received, your confirmation will be automatically accessed by the Learning and Development team and your completion of this requirement updated for a further three years.