1.7.5 Clinical Record Keeping Policy

Related guidance

England:

- **Regulation 36: Children's case records**
- **Regulation 37: Other records**
- **Regulation 38: Storage of records, etc.**
- **Schedule 3: Information to be included in the case records of children accommodated in children's homes**
- **Schedule 4: Other records with respect to children's homes**

Wales

- **Regulation 59: Records**
  https://www.legislation.gov.uk/wsi/2017/1264/regulation/59/made
- **Regulation 78: Duty to ensure there are systems in place for keeping records**
  https://www.legislation.gov.uk/wsi/2017/1264/regulation/78/made
- **Schedule 2: Records to be kept in respect of regulated services**
  https://www.legislation.gov.uk/wsi/2017/1264/schedule/2/made
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Additional Guidance

- **Health Care Professions Council – HCPC framework**
- **HCPC Standards of conduct, performance and ethics (2008)**
- **HCPC, Standards of proficiency Practitioner Psychologists (2015)**
- **HCPC, Standards of proficiency Art Therapist (2013)**
- **British Association of Counselling and Psychotherapy- BABCP Ethical Framework**
- **United Kingdom Council for Psychotherapy – UKCP Ethical Principles and code of conduct (2009)**
- **British Association of Behavioural and Cognitive Psychotherapy framework**
- **British Psychological Society - BPS, Code of ethics and conduct (2009), individual professional guidelines for supervision by division**
- **References**
  Dimond B. (2005) Legal aspects of documentation. Exploring common deficiencies that occur in record keeping. British Journal of Nursing, Vol.14, Issue 10, p.568-571.
- **Data Protection Act 2018**

Contents

1. Purpose of the Policy

This policy applies to both paper and electronic records and includes handwritten clinical notes, emails, telephone calls and letters to and from other health professionals, and any other activity carried out by members of the clinical team.

2. Introduction

Record-keeping is an integral part of clinical practice and is essential to the provision of safe and effective care. Records of care refer to a specifically planned process of care including chronological developments contributing to the decisions made about the process of care. Records of care should also refer to events that are unplanned but still significant to the period of care and planned but that have not taken place. Records of care should also refer to information that is effective for team communication.

Records include anything that refers to the care of children and young people. Any record can be called as evidence as part of Coroners' inquests or criminal proceedings, professional standards inquiries and organisational disciplinary proceedings.

The approach to record keeping should be that if it is not recorded, it has not been done'. Good record keeping helps to improve accountability and shows how decisions related to the care of children and young people have been made.

A number of common problems with record keeping have been identified (Dimond 2005). These are:

- Absence of clarity e.g. the meaning of 'Had a good day' and 'slept well' is not clear;
- Failure to record action taken when a problem is identified, e.g. 'is suffering increasing pain' then no record of action taken;
- Missing information, e.g. administration of a drug not documented;
- Spelling mistakes, e.g. error in name resulting in wrong diagnosis;
- Inaccurate records, e.g. changing a dressing or giving medication, when in fact the patient had not received the recorded treatment (leading to a nurse being removed from the Register);
- Failure to document conversations;
- Failure to document care given;
- Failure to document special needs;

- Failure to record telephone calls, e.g. on risk of suicide;
- Failures in communication between healthcare professionals;
- Too much jargon;
- Patient identification, e.g. entry of information on an identity band, clinical documentation.

3. Record Keeping Standards

The following standards of record keeping should be adhered to:

- The Clinical recording paper provided by the organisation should be used;
- Handwriting should be legible;
- Entries should always be written in black ink;
- Do not leave spaces between lines or entries. Any spaces in notes need to be crossed through and signed;
- Any client-related contact should be recorded. This includes face-to-face contact, consultations with other professionals, telephone contact with young people and professionals etc. Records should be made for non-attendance as well as attendance, noting reason for non-attendance if known;
- Clinical records should show clear evidence of assessments undertaken and goals / action plans for work to be undertaken. Where appropriate, there should be a clear formulation of the difficulties being experienced. There should be clear records of outcome monitoring to monitor progress;
- For each contact, record the date and time of the session, who was present, where it took place and, as a minimum, key points discussed and outcomes and action plans;
- Recorded notes should be an accurate summary of the contact undertaken and suitable as an aide memoir;
- A record should be made within notes of supervision that has been received;
- After each entry, sign your name and print your name & designation;
- Always write up notes on the same day or as soon as possible after each contact / session;
- Avoid jargon and acronyms. When using abbreviations, ensure their meaning is clearly identified when initially used;
- Sign and date alterations. Errors should be crossed through with a single line only so the original can be seen. Do not use correcting fluid;
- Avoid taking client files (or copies) ‘off service premises’ or home in order to write up in your own time. If this is necessary, ensure that they are kept safe, and are not left in cars whilst you are away from your car or overnight;
- Send letters / reports out within the agreed timescales for Bryn Melyn Care;
- Destroy any recordings (audio, visual, digital) when they have been listened to/watched or otherwise achieved their purpose;

- Give back work that belongs to the client (materials they have produced for your work together whether writing, drawings, etc.) before discharge, taking photocopies, photographs of therapeutic work for storage within the clinical files as necessary;
- Where necessary a new volume is created to avoid over filling records and damage. When a second volume is created the relevant indexing system is created which refers to volume 1 of 2. Volumes should be separated by date rather than contents and all volumes should be stored together;
- Records of clinical consultation, clinical sessions/ therapy sessions and professionals meetings should be recorded on the forms provided by the company and a copy should be returned to the home in a timely manner;
- Record forms should be referred to in the main body of the clinical notes, which should act as a chronology of care provided. Each record form should then stored in the appropriate section of the case notes;
- Each case file should have identified sections which are indexed. Information should be stored according to the index system;
- Electronic records should be saved on the shared drives provided and not on individual laptops, pen drives or desktops.

4. Roles and Responsibilities

4.1 The Organisation

- Provide adequate storage facilities for both electronic and paper records;
- Provide record keeping standards;
- Provide training where required;
- Provide materials for the recording and maintenance of record keeping e.g. suitable IT equipment, relevant paperwork templates and access to office space and equipment.

4.2 Clinical Staff

- Follow the record keeping standards;
- Identify when systems are not in place to support their recording of clinical work;
- Work within their professional boundaries and codes of conduct;
- Ensure that the policy is followed and support the use of audit.

4.3 Clinical Lead

- Ensuring that the policy is implemented and audits followed;
- Ensuring that audits are reviewed and action plans implemented as a result of record keeping audits.

5. Confidentiality

All Health Care professionals are obligated to protect information (obtained in the course of their professional practice) concerning their clients/ service users as confidential. Disclosures concerning such information can only occur either with prior consent, or as required by the order of a court, where the disclosure can be justified in the wider public interest or under legislation.

6. Storage and Security

Disclosure of information can occur by poor record storage. The Data Protection Act 1998 states that:

“Records storage conditions must provide environmentally safe protection for current and archived records. Records must be protected by effective information security management and records management staff members should be aware of and comply with measures put in place.”

Clinicians should ensure that they follow record keeping procedures for both electronic and paper records and where the transmission of documents is outside the organisation all efforts to protect the security of the information must be taken, this includes the use of encrypted emails/ reports/ letters, encrypted data storage/ pen drives. The company’s electronic records should be saved on the server shared drives and not on individual computers.

Archiving should take place once a young person leaves the companies the care. Archiving of paper records should be as follows:

All records placed in order into a secure envelope and sealed with a closed case file sticker stating the relevant identifiable information and date of closure.

Electronic records will be archived in accordance with the company’s policies for handling electronic information.

Please also see **Archiving Procedure**.

7. Arrangements for Monitoring and Evaluation

Clinical Record Keeping practice will be monitored through audit and review. Regular evaluation will take place and actions implemented as required. A copy of the audit procedure is included in **Appendix 1: Clinical Record Keeping Standards**.

Appendix 1: Clinical Record Keeping Standards

Click here to view Appendix 1: Clinical Record Keeping Standards.

Revision History

Date last updated: May 2020

Date of next review: May 2021

Date of release: December 2018

End