DRAFT RCP standards for record keeping – inpatients VERSION 6.0 (NCRS compliant)

Patient/Medical Records

Standard 1

When a patient is admitted to hospital with an acute medical or social problem, or for rehabilitation, the patient's complete medical record, including summaries of care, should be available at all times.

Hospital includes teaching, district general, community, or geriatric long stay hospital and any environment utilised for the care of patients with medical (acute and/or rehabilitative) needs

Standard 2

Documents within the record should reflect the continuum of patient care

Clinical records should be viewable in chronological order so that they can reflect the patient's experience of healthcare.

Standard 3

The following generic headings should be used to structure the clinical record.

Sources:

- Headings marked NCRS are from the National Programme for IT 'NHS Care Record Elements, version 1.1'
- Headings marked RCP are additional RCP headings for local use and information recorded under these headings will not be transferred to the spine

Clinical DocumentationNCRS	**Examples** Request documentation Report documentation Referral Documents Discharge documents e.g. the summary produced when a patient leaves hospital Transfer documents e.g. the summary produced when a patient is transferred from one team to another team. Clinical update documents e.g. clinic letters, domiciliary visit letters
Personal DemographicsNCRS *(Patient Details)*	**The identification and contact details that allow a patient to receive health care.**
Care EventsNCRS *(Encounter Details, Patient Location, Record Author, Responsible Clinician)*	**A Care Event is any occasion during which a health care professional, and/or the patient, and/or their carer, makes a material contribution to the health care of the patient, resulting in a change to a patient's NHS Care Record** A care event encompasses face-to-face consultation with the patient (such as a GP consultation), telephone conversations with the patient, or Multi-Disciplinary Team reviews where the patient is not present. It includes the addition of information by a patient

	or their representative. Each Care Event must reference the health care professionals who have participated in the Care Event. It also includes administrative actions such as a change in patient demographics. Amongst important data items which will be required as part of the care event record will be the Care Event Type (Physical, Virtual or Absent), Communication Method (telephone/email etc), and Reason for Care Event.
Review of Case[RCP]	***A brief narrative description of the case including main clinical features, course during hospital stay, occurrences since last review etc.*** *This includes the 'History of Presenting Complaint' that is recorded during an admission to hospital.* *Any new diagnoses, problems, medications etc should be specified under the appropriate heading.*
Problems and Issues[NCRS] *(Problem List)*	**Unmet needs or related requirements to be resolved or noted, and are perceived as a problem or issue by a patient or a HCP.** **Examples** Chest pain Poor mobility (due to fall) Pain in ankle High blood pressure
Diagnoses[NCRS]	**Decisions arrived at as a result of a synthesis of signs, symptoms, investigations, and theoretical knowledge. These include diseases, disorders, syndromes and physiological states such as pregnancy.** **Current confirmed diagnoses**[RCP] *(Current diagnoses)* ***Confirmed disorders, syndromes and diseases that the person currently suffers from. If there is uncertainty about a diagnosis then the most appropriate problem (symptom, sign or test result) should be used until the diagnosis is confirmed. If there is more than one confirmed diagnosis these should be recorded as a list, in order of importance, in terms of keeping the patient in hospital. Specific professional rules may exist for particular diseases being classified as diagnoses even if they have potentially resolved (e.g. treated cancer). On discharge, current diagnoses should include all adverse drug reactions and other problems that developed during the stay in hospital.*** **Significant Past Illnesses**[RCP] ***Includes previous disorders, syndromes and diseases that are not currently affecting the patient, but are considered significant by the most senior health care professional at the time of the care event. Dates should be given.***
Procedures[NCRS]	**Therapeutic, preventative, investigative, informative, curative or palliative actions or interventions delivered to or acted upon a person to determine, support, clarify or effect change upon, their health status.** This element includes a vast array of widely differing procedures so these have been sub-classified into Treatments, Investigations, Administrative Procedures and Information Provision to patients.

	Treatments and investigations would include invasive treatments and investigations, non-invasive treatments and investigations, psychosocial and cognitive treatments and investigations, aids, appliance, orthosis and prosthesis management, and medication management. **Treatments**[NCRS] *(Procedures and Investigations, Medications, Diets)* **Treatments are procedures that are intended to have a therapeutic, preventative, curative or palliative effect.** **Investigations**[NCRS] *(Procedures and Investigations)* **Investigations are procedures that are undertaken to find out more information about a patient's state of health or wellbeing.** **Administrative Procedures**[NCRS] **These are procedures, typically of a clerical nature, that support the investigation and/or treatment of a patient.** **Provision of Information to Patients and Carers**[NCRS] *(Information given to patient)* **The activity of providing information about a patient's health or social care, to the patient or to their specified carer.**
Medication Record[NCRS]	**The single record of all medications, dietary supplements, dressings and equipment that have ever been prescribed or ordered for a patient.** It is the master medical record consisting of a list of medicines, vitamins or supplements and other treatments that the patient is currently taking, together with a list of significant medications taken in the past as well as those prescribed but yet to be taken. It will contain all medications regardless of who prescribed them, including self medication. **Examples** Standard formulary drugs and therapies Complementary therapies (homeopathy, herbal, arnica etc.) Wound dressings, intravenous fluids and appliance items such as catheters
Risks and Warnings[NCRS] *(Alerts including allergies)*	**This is information that may be vital for a HCP to be made aware of quickly, concerning potential risks or warnings related to the presenting patient or the Health Care Practitioner or other third parties.** These are risk or highlighted issues that a HCP need to know before seeing/treating a patient. This would also include detentions under the Mental Health Act together with details of compulsory treatment orders. **Allergies**[NCRS] **A reaction to an allergen reported/experienced by the patient.** **Examples** Latex hypersensitivity Allergy to elastoplast Mild erythema on administration of intravenous contrast media for radiological examination **Risks To Patient**[NCRS]

	A potential risk to a patient which should be brought to the attention of Health Care Practitioners. **Examples** Legal status Patient has been previously sectioned under the mental health act **Risks To Health Care Practitioner or Third Party**NCRS **A potential risk to a Health Care Practitioner or third party which should be brought to the urgent attention of Health Care Practitioners.** **Examples** History of violent tendencies to others, HIV positive, known abuser of health care services
Family HistoryNCRS *(Family History)*	**Family History is a record of significant illness in family relations deemed to be significant to the care or health of the patient.** **Examples** Sister has breast cancer.
Social ContextNCRS *(Social Circumstances)*	**The social and environmental circumstances in which the patient has found/finds/or will find him or herself.** **Social and Personal Circumstances**NCRS *A description of a patient's social background, network, and personal circumstances including occupational history and specific habits.* **Examples** Socio-economic status Housing – patient lives on the 12th floor Occupation Religious / spiritual belief **Services and Carers**NCRS **The services received to support the social and personal functioning of the patient, by agencies other than health and social care.** Information that a patient or Health Care Professional needs to be aware of are the frequency of such service (e.g. once in the morning and evening), type of service (e.g. home help, shopping, personal care), intensity of service (e.g. level of personal care), provider of service (e.g. Aylesbury Town Council), and contact details for service provider. **Behaviour**NCRS **Behaviour displayed by the patient towards others and activities patient in which the patient participates.** The frequency and severity of such behaviour or activities need to be known as well as any legal status (e.g. conviction and subject to current compulsory order for GBH). **Examples** Examples may be excessive smoking and alcohol consumption, violence towards others or self, substance abuse, sexual habits (e.g. unsafe sex), and foreign travel such as to areas where malaria is prevalent.
	Level of social and personal functional capabilities or

Functioning and Wellbeing[NCRS] *(Functional Status)*	**wellbeing (social, mental, emotional or physical).** This is a record of information provided by the HCP, patient or carer during a consultation or is part of a procedure. These details are then documented and interpreted by the HCP. The information may be expressed as a text description or score. **Examples** The assessment of a patient's Activities of Daily Living upon transfer from secondary care to community care, e.g. mobility, capability of attending to personal care, ability to eat and/or drink independently.
Clinical Observations and Findings[NCRS] *(Examination findings)*	**Clinical observation is an observation made by a HCP or carer without specific examination. A finding on examination is the interpretation of a clinical examination of any sort.**
Personal Preferences[NCRS] *(Patient wishes)*	**Personal Preferences are statements of preferences provided by a patient, that influence or determine how health or social care is provided to them.** **Proactive Personal Preferences**[NCRS] **A proactive personal preference is a set of rules and/or guidance which direct care given by clinicians when provided by a patient or their authorised representative. A proactive personal preference applies to all current and future encounters or for a specific purpose.** **Examples** Legal/quasi-legal (Rules) such as: Living Wills Donor Status Consent to Record Sharing for provision of health care Consent to Record Sharing for secondary use of identifiable data such as third party use, research and education Other (Guidance) such as: Religious/Culturally dependent needs Written communication format (e.g. Braille, Large print, Audio Tape) Transport Preference **Reactive Personal Preferences**[NCRS] **A reactive personal preference is a specified choice in response to the attempt to deliver care (a procedure) offered by clinicians to a mentally competent patient. A reactive personal preference applies to the current encounter.**
Investigation Results[NCRS] *(Investigation results)*	**The results, or interpretation of the output, of an investigative procedure.** **Examples** Creatinine clearance – reduced Peak expiratory flow rate (PEFR) = 250 No abnormality detected on a chest X-ray
Overall Assessment[RCP] *(Overall Assessment / Clinical*	***The clinician's overall assessment of the patient's condition. If there is no change then 'no change' can be recorded.***

Conclusions)	
Care Plans[NCRS] *(Management Plan)*	**The provisionally or actually planned procedures and encounters intended to be completed in the future for a specific patient as part of a sequence of activity, planned by single discipline, or by a multi-disciplinary team.** **Example** The planned activities for a patient attending an asthma clinic will probably be prepared in advance, perhaps subject to a local protocol. The plan may include such procedures as chest X-ray and peak flow test as well as the face-face consultation.
Projected and Actual Outcomes[NCRS] *(Outcomes)*	**Projected Outcome is the recorded aim or expectation as evaluated by the patient, care professional or carer. Actual Outcome is the actual consequence as a result of one or more procedures/interventions, or the lack of, as evaluated by the patient, care professional or carer.** This element relates to the Projected and Actual Outcomes associated with one or more problems and/or interventions. **Examples** A patient may undergo an operative procedure to have their patella realigned; the projected outcome may be that they could resume full normal activities with no further intervention, the actual outcome could be that the abnormality could not be resolved and that the patient will walk with a limp unless they undergo further surgical correction.

Standard 4

The clinical record should consist of entries made by individual healthcare professionals. There should be an admission entry (clerking), follow-up entries, and a discharge entry (copy of discharge/transfer communication)

An entry includes any set of comments entered into the record by a physician. Entries made by other healthcare professionals are not included, although similar principles should apply.

Follow-up entries are considered to be those between admission and discharge. Outpatient entries are not included, although similar principles should apply.

In addition to admission, follow-up and discharge entries, there may be special entries (e.g. patient information, consent forms, death) with additional requirements).

All entries

Standard 5

Entries should be made as soon as possible after the event

Standard 6

Every entry should be legible and contain record author (name and signature) patient details, location of patient and the following encounter details:

- Date
- Time
- Care Event

The patient's full name date of birth and identification number must be recorded clearly on every sheet of paper in the paper record

Care Event should give details of the patient's location (can simply be the ward number if the hospital name and address is recorded elsewhere) and the administrative reason for the care event (e.g. 'ward round', 'asked to review' etc.)

Abbreviations used in the record should be avoided and, if used, must conform to agreed local protocols

Standard 7

Every record entry should identify the doctor responsible for decision making at the time of the care event for which the entry is made.

The responsible doctor is sometimes identifiable at the beginning of the record entry, next to the reason for the care event. It may be in the form of 'ward round Dr X'.

If the full name and grade of the most senior doctor is not given it should be possible to determine this from previous entries. (e.g. if 'ward round SpR' is used then the full name of the SpR should be identifiable from previous entries)

Standard 8

There should be an entry in the record at least once every 24 hours for acute medical care, and at least twice a week for rehabilitative care.

Acute medical care includes medical care given/received whilst on an acute ward or unit regardless of specialty

Patients who are receiving acute medical care should be reviewed as frequently at the weekend as during the week.

Admission entry

Standard 9

For acute medical admissions, the record entry on should include information under the following headings:

- Clinical Documentation
- Care Event
- Problems and Issues
- Review of Case
- Current Confirmed Diagnoses
- Significant Past Illnesses
- Procedures: Treatments
- Risks and Warnings
- Social and Personal Circumstances
- Functioning and Wellbeing
- Family History

- Clinical Observations and Findings
- Investigation Results
- Overall assessment
- Care plan
- Projected Outcomes
- Provision of Information to Patient and Carers
- Personal Preferences

Other headings from Standard 3 may also be used.

Follow-up entries

Standard 10

Every follow-up entry should clearly record what has happened or been done to the patient since the previous entry, the assessment of the patient's condition, state the new management plan, and document any information given to the patient

- Review of case
- Overall assessment
- Care Plan
- Provision of Information to Patient and Carers

New problems, procedures, findings, etc. should be recorded under the relevant headings.

Discharge/transfer Communication

Standard 11

A clinical communication must be provided for all doctors involved in the care of the patient when care is transferred out of the hospital.

All doctors involved in the care of a patient includes the general practitioner and any secondary/tertiary care consultant who either regularly cares for the patient or that the patient has been referred to.

Standard 12

The patient must be informed as to what information will be communicated to which other doctors involved in their care, and given the opportunity to object, in accordance with GMC guidance.

Consent should be obtained for disclosure of clinical information and documented.

Standard 13

A copy of the clinical communication must be kept in the record.

Standard 14

The Patient should be given a copy of the clinical communication, unless it is clinically inappropriate to do so.

It should be recorded that the patient has been given a copy of the clinical communication unless it is clinically inappropriate to do so, in which case the reason should be documented.

Standard 15

If the communication is duplicated using carbon copy paper then the duplicate sheets must be legible.

Standard 16

The clinical communication should be dispatched so that it is available to the receiving doctor when the patient is next seen.

Standard 17

The transfer or discharge communication should contain information under the following headings:

- Clinical Documentation
- Care Event
- Review of case
- Current Confirmed Diagnoses
- Significant Past Illnesses
- Risks and Warnings
- Procedures: Treatments
- Problems and Issues
- Care Plan
- Projected and Actual Outcomes
- Provision of Information to Patient and Carers
- Personal Preferences

Other headings from Standard 3 may also be used.

Standard 18

Discharge summary information should be validated by a responsible clinician

Standard 19

Discharge Summaries should be multidisciplinary where multidisciplinary care is to be continued

Special entries: Patient information

Standard 20

If information is given to anyone other than the patient, then consent should be obtained from the patient for the disclosure and recorded as patient wishes. If consent has not been given or obtained, then the reason must be documented. The GMC's guidance on confidentiality must be followed.

Standard 21

Subject to the conditions in standard 20, all patients and/or their relatives/carers should be given information about the patient's illness, treatment and further management. The information given, and to whom, should be documented in the record as information given to the patient/relative.

Standard 22

Patients have a right to be fully involved in decisions about their care. Their involvement should be documented in the record as patient wishes.

Standard 23

The existence of advance directives must be clearly recorded in the notes, alongside any resuscitation statements under Alerts (including allergies). Advance directives should be recorded under patient wishes.

Special entries: Consent forms

Standard 24

Consent forms should be included within the record under patient wishes.

Special entries: Death

Standard 25

The entry made when death is confirmed should contain the following information:

- Date and time of entry
- Name of clinician confirming death in block capitals
- Designation of clinician confirming death
- Examination made establishing death
- Time and date patient certified dead
- Signature of clinician confirming death, followed by full name in block capitals

Remember that confirmation of death is very difficult in severely hypothermic patients. Advice should be sought if there is any doubt.

Standard 26

When the death certificate is completed, an entry should be made in the record stating: The cause of death as appearing on the death certificate; whether a cremation form has been completed; whether and how the deceased relatives have been or will be

informed; and whether and how the general practitioner has been or will be informed.

The death certificate must be completed according to the guidance provided with the pad of death certificates.

Informing the general practitioner is important because it gives them the opportunity to offer counselling and support to the relatives of the deceased.

Standard 27

Deaths should be reported to the coroner if:

- It is not possible to readily certify that the death was due to natural causes
- The cause of death is unknown
- The deceased was not seen by the certifying doctor either after death or within the 14 days before death
- The death was violent or unnatural or suspicious
- The death was due to self neglect or neglect by others
- The death may be due to an industrial disease or related to the deceased's employment
- The death may be due to an abortion
- The death occurred during an operation or before recovery from the effects of an anaesthetic
- The death may be a suicide
- The death occurred during or shortly after detention in police or prison custody

There is no statutory obligation for doctors to inform the coroner: this duty rests with the registrar of births and deaths. However, the processes involved can be accelerated and be made less uncomfortable for the relatives if the coroner is informed directly.

Standard 28

If a post-mortem is undertaken, then a copy of the post-mortem report must be filed in the record.

Medical records management

Standard 29

Doctors should ensure that processes are in place to ensure that their patients' health (and other sensitive) information is safeguarded against loss, damage or unauthorised access and kept confidential in accordance with the latest legislation, and guidance.

Documents of importance:

- *Data Protection Act 1998*
- *Information Commissioner's guidance on health information*
- *ISO 17799 / BS7799 – Security of confidential patient information*
- *Computer misuse act 1990*

Standard 30

Doctors should participate in auditing medical records against evidence-based standards.