Generic medical record keeping standards

This document sets the standards for general medical note-keeping by physicians in hospital practice. This standards have been developed by the Health Informatics Unit (HIU), which is part of the Clinical Standards Department of the Royal College of Physicians (RCP), London and were supported by NHS Connecting for Health.

Purpose of the standards

The purpose of these standards is to:

- Maximise patient safety and quality of care
- Support professional best practice
- Assist compliance with Information Governance and NHS Litigation Authority (CNST) Standards

Development process

The process of developing records standards originated from a review, reported by Mann and Williams[1], and publication on the RCP website of draft records standards together with their evidence-base[2]. The evidence pointed not only to the benefits of standardised records but also identified large differences between hospitals in the way records are structured and organised[1,3,4].

Wide ranging consultation ensured that the views of clinicians were considered and represented in the development of the standards[5]. The HIU sought the views of the RCP's Acute General Internal Medicine Committee, the BMA's Speciality Sub-Committees, the Medical Directors and their nominees of NHS acute hospital Trusts and the DH Digital and Health Information Policy Directorate. The standards were reviewed and revised based on received comments and were approved at the RCP's Clinical Standards Board in March 2007.

Products in development

- An audit tool to support the implementation of these standards
- Standards for the structure of admission, handover and discharge records for incorporation into the electronic patient record

References

1. Mann R, Williams J. Standards in medical record keeping. Clin Med 2003; 3(4):329-32
2. Access at: http://hiu.rcplondon.ac.uk/clincialstandards/recordstandards/draft_std_5-0.asp
3. Audit Commission. Setting the record straight – a study of hospital medical records. London: HMSO, 1995
4. Audit Commission. Setting the record straight – a review of progress in health records services. London: HMSO, 1999
5. Carpenter I, Bridgelal Ram M, Croft GP, Williams JG. Medical records and record-keeping standards. Clin Med 2007; 4: 328-31

Developed by HIU and funded by NHS Connecting for Health

RCP Approved 'Generic Medical Record Keeping Standards'

Prepared by the Health Informatics Unit of the Royal College of Physicians

Generic medical record keeping standards define good practice for medical records and address the broad requirements that apply to all clinical note keeping. These standards were developed by the Health Informatics Unit of the Royal College of Physicians following review of published standards and wide consultation. They were first published in 2007 in Clinical Medicine.

Standard	Description
1	The patient's complete medical record should be available at all times during their stay in hospital
2	Every page in the medical record should include the patient's name, identification number (NHS number)[1] and location in the hospital
3	The contents of the medical record should have a standardised structure and layout
4	Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order
5	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma[2]
6	Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed
7	Entries to the medical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded
8	Every entry in medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made
9	On each occasion the consultant responsible for the patient's care changes, the name of the new responsible consultant and the date and time of the agreed transfer of care, should be recorded
10	An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why[3]
11	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital
12	Advanced Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney

1. The NHS number is being introduced as the required patient identifier
2. This standard is not intended to mean that handover proforma should be used for every handover of every patient rather that any patient handover information should have a standardised structure
3. The maximum interval between entries in the record would in normal circumstances be one (1) day or less. The maximum interval that would cover a bank holiday weekend, however, should be four (4) days
4. Last Updated November 2009