HSC Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref:	Our Ref:	Date:
BPC-0148-12	HYP B04/01	26.03.12

Mr B Cullen
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to the above and your letter of 22nd February 2012. I note that you are seeking confirmation as to the existence in 1995 of any policy or guidance which informed clinicians as to the required standard of note and record making which was expected in preparation for and during the conduct of major paediatric surgery. For the sake of clarification the Trust has asked that I advised you that the 2008 Records Management Policy to which you refer is of little relevance to this issue. Furthermore for the avoidance of doubt I am instructed that had a similar policy existed in 1995 it would not have addressed the question asked in your aforementioned letter.

I am instructed that the Royal Group of Hospitals Trust had no policy or guidance in 1995 to inform clinicians of the standard of note and record making which was expected in preparation for and during the conduct of major paediatric surgery, although the enclosed Belfast Health and Social Care Trust Policy "Clinical Record-Keeping" 2008 covers the situation today.

Yours faithfully,

Joanna Bolton
Solicitor Consultant
Email: [redacted]
Tel: [redacted]

Belfast Health and Social Care Trust

Standards and Guidelines Committee

Clinical Record - Keeping	
Summary	Policy to be followed for keeping the general clinical notes by the multiprofessional team in hospital practice.
Purpose	The purpose of these standards is three-fold: • To maximise patient safety and quality of care; • To support professional best practice; • To assist compliance with DHSSPSNI medical record keeping requirements; *Quality Standards for Health & Social Care* and *Good management, Good records*.
Operational date	April 2008
Review date	May 2013
Version Number	V2
Director Responsible	Medical Director
Lead Author	Dr Cathy Jack
Lead Author, Position	Deputy Medical Director
Additional Author(s)	NA
Department / Service Group	Medical Directors Office
Contact details	Dr Cathy Jack, Deputy Medical Director, Royal Hospitals site, Ext [redacted] cathy.jack[redacted]

Reference Number	SG025/08
Supersedes previous	V1

Version Record

Date	Version	Author	Comments
29/04/2008	0.1	Cathy Jack	Initial Draft
26/06/2008	0.2	JR Johnston	Amendments
5/8/2008	0.3	JR Johnston	Amendments
13/10/08	1.0	C Murphy	No changes – version for dissemination
14 Jan 09	1.1	JR Johnston	GMC number addition
18 Feb 09	1.2	JR Johnston	+ Multidisciplinary PIN number
28 Mar 11	V2	C Murphy	Change term "Medical record" to "Clinical record", to reflect that guidance applies to all clinical notes. . Add NMC reference. Next Review date 2013.

Policy Record

		Date	Version
Author (s)		March 2011	V2
Director Responsible		March 2011	V2

Approval Process – Trust Policies

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval	21/04/2011	V2
Policy Committee	Approval	16/05/2011	V2
Executive Team	Authorise	18/05/2011	V2
Appropriate Director	Sign Off	20/05/2011	V2

Full Description

Reference No: SG025/08

1. **Generic Clinical Record-keeping Standards.**

2. **Introduction:**
The need for improved communication and record keeping is one of the key themes emerging from incident reports across Northern Ireland. Following the publication of generic medical record-keeping standards for physicians in hospital practice by The Royal College of Physicians in London, the DHSSPSNI indicated that organisations should be aware of this best practice guidance in order to assist in complying with the *Quality Standards for Health & Social Care* (implementation of evidence-based practice through the use of recognised standards and guidelines).

3. **Policy / Guideline description – Summary**
This document outlines the BHSCT policy to be followed for the general clinical notes by the multiprofessional team in hospital practice.

4. **The purpose.**
These standards ensure maximum patient safety and quality of care, support professional best practice and assist with compliance with DHSSPSNI medial record keeping requirements; *Quality Standards for Health & Social Care* and *Good management, Good records.*

5. **The scope**
This policy will apply throughout the Belfast Health and Social Care Trust hospitals and to all healthcare professional staff working within these hospitals.

   The clinical record in this context, also known as the clinical notes, is the operational record of clinical information relating to the hospital care. The scope covers all healthcare professionals who use these notes.

   It will not cover primary care.

   Although these standards are set in a medical context the practice is equally beneficial in a social care setting and these standards complement current guidelines in relation to *Good management, Good records.*

6. **The objectives.**
The aim of this document is to ensure standards in general medical note-keeping by healthcare professionals in hospital practice by promoting good record-keeping and is based on the Royal College of Physicians generic medical record-keeping standards.

7. **Roles and Responsibilities**
All healthcare professional staff of all grades must be familiar with this policy within the hospital site.

8. **The definition and background of the policy or guideline.**
The General Medical Council, in its *Good Medical Practice (2006)* document, advocates that physicians keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment. The GMC indicates

that when providing care physicians must make records at the same time as the events they are recording or as soon as possible afterwards.

This will ensure that their work is carried out with maximum efficiency without having to waste time searching for information, that there is an "audit trail" which enables any record entry to be traced to a named individual at a given date/time with the secure knowledge that all alterations can be similarly traced and that those coming afterwards can see what has been done, or not done, and any decisions made can be justified or reconsidered at a later date and the records are secured against tampering or unlawful deletion.

It is therefore vital that physicians and indeed all healthcare professionals always record any important and relevant information, making sure that it is complete, ensure that it is legible so that it can be read easily and reproduced when required, that it is put it where it can be found when needed and is kept up to date.

More details regarding the standards to be applied to multiprofessional clinical records can be obtained from the Royal College of Physicians "*A Clinician's Guide to Record Standards – Parts 1 & 2*" which can be obtained from

http://www.rcplondon.ac.uk/clinical-standards/hiu/medical-records/Documents/Clinicians-Guide-Part-1-Context.pdf

http://www.rcplondon.ac.uk/clinical-standards/hiu/medical-records/Documents/Clinicians-Guide-Part-2-Standards.pdf

9. Policy Statement(s):
The 12 clinical standards and their description are stated below:

9.1 The patient's complete clinical record should be available at all times during their stay in hospital.

9.2 Every page in the clinical record should include the patient's name, identification number (hospital number) and location in the hospital (e.g. ward or theatre).

9.3 The contents of the clinical record should have a standardised structure and layout.

Where possible, medicines should be identified using their generic name.

9.4 Documentation within the clinical record should reflect the continuum of patient care and should be viewable in chronological order.

9.5 Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma.

This standard is not intended to mean that a handover proforma should be used for every handover of every patient. Rather that any patient handover information should have a standardised structure.

9.6 Every entry in the clinical record should be dated, time (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. It is also *recommended* that the unique registration PIN number e.g. General Medical Council reference number should be given with the signature. Deletions and alterations

should be countersigned.

9.7 Entries to the clinical record should be made as soon as possible after the event to be documented (e.g. change in clinical stage, ward round, investigation) and before the relevant staff members goes off duty. If there is a delay, the time of the event and the delay should be recorded.

9.8 Every entry in the clinical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made.

9.9 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.

9.10 An entry should be made in the clinical record whenever a patient is seen by a doctor or any healthcare professional. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for a long-stay continuing care, if possible, the next entry should explain why.

The maximum interval between entries in the record would in normal circumstances be one (1) day or less. However, the maximum interval that would cover a bank holiday weekend for example should be four (4) days.

9.11 The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital.

9.12 Advance directives, consent and resuscitation status statements must be clearly recorded in the medical record.

10. Implementation

All healthcare professionals of all grades must be trained in the practice of keeping good clinical records. This training should be combined with Queen's University, Belfast. These generic clinical record-keeping standards will be available on the BHSCT intranet.

Generic clinical record-keeping will be included within the induction packs of all new doctors, locums and healthcare professionals employed by the Trust.

11. Source(s) / Evidence Base

These standards have been developed by the Health Informatics Unit (HIU) which is part of a clinical standards department of the Royal College of Physicians in London and were supported by the NHS Connecting for Health.

1. Access at:
   http://www.rcplondon.ac.uk/clinical-standards/hiu/Documents/GenericRecordKeepingStandards.pdf

2. *"A Clinician's Guide to Record Standards – Parts 1 & 2"*

   http://www.rcplondon.ac.uk/clinical-standards/hiu/medical-records/Documents/Clinicians-Guide-Part-1-Context.pdf

   http://www.rcplondon.ac.uk/clinical-standards/hiu/medical-records/Documents/Clinicians-Guide-Part-2-Standards.pdf

3. Guidance for doctors on using registered name and GMC reference numbers – available in leaflet form.
http://www.gmc-uk.org/doctors/information_for_doctors/doctors_registration_number.asp#2

4. Audit Commission. Setting the record straight – a study of hospital medical records. London: HMSO, 1995.

5. Audit Commission. Setting the record straight – a review of progress in health records services. London: HMSO, 1999.

6. Carpenter 1, Bridgelal Ram M, Croft GP, Williams JG. Medical records and record-keeping standards. Clin Med 2007; 4: 328-31

7. Royal College of Physicians – Guidance – Generic medical record-keeping standards

8. Mann R, Williams J. Standards in medical record-keeping. Clin Med 2003; 3(4):329-32.

9. Nursing Midwifery Council. Record Keeping: Guidance for Nurse/Midwifes and midwives. July 2009.

12. The references including relevant external guidelines.
See sources

13. Consultation Process
Service groups and Standards and Guidelines Committee

14. Equality screening
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, the Belfast Trust has carried out an initial screening exercise to ascertain if this policy should be subject to a full impact assessment.

Screening completed
No action required.

Director: Dr A Stevens
Date: May 2011

Author: Dr C Jack
Date: May 2011