Health Records Audit Procedure

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Responsible Director:	Medical Director
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Health Records Audit Procedure

1 Introduction

The Trust recognises the patient safety and legal risks that it can face as a result of poor keeping and therefore is committed to the promotion of high standards of clinical record keeping across the Trust. This document sets out the standards for record keeping as agreed by the Trust and the process by which performance against the standards will be monitored, and the results of audits used to support action planning to continually improve performance of record keeping. Record keeping audit is undertaken for the following reasons:

- To support continual improvement of clinical record keeping (both paper and electronic) throughout the Trust
- To undertake a data quality control to verify entries between paper records and the Trust's electronic clinical database, Carenotes
- As a key part of the clinical Governance agenda for maintaining and improving quality in the Trust.
- To meet requirements of NHSLA risk management standards, HCC Standards for Better Health and internal auditors standards for data quality.

2 Purpose

This procedure establishes the Trust's minimum standards for clinical documentation in manual and electronic forms and details the processes for monitoring and improving the quality of patient's medical records.

3 Scope

The standards of clinical record keeping apply to manual and electronic records and are to be followed by all clinical staff and administrative staff that work with patient records

4 Definitions

5   Duties and responsibilities

5.1   Medical Director/ Clinical Audit Work stream lead

The Medical Director is the Clinical Governance Lead for the Trust and in this role is responsible for ensuring that audit take place to monitor quality of case not records.

The Medical Director has delegated day to day responsibility for clinical audit to the Clinical audit Work stream, who is responsible for:

- Commissioning audits of record keeping in line with Trust requirements, which will include:
    - An annual Trust wide audit against core record standards
    - An annual audit of clinical documentation in relation to risk assessment of patients
    - Ad hoc audits as required by External Agencies or as a result of risks identified (e.g. CQC requirement for suicide audit).

- Ensuring that the Trust resources the audit process with Appropriate professional and administrative expertise

- Receiving the audit reports

- Ensuring that appropriate action plans are drawn up and followed in the light of audit findings

5.2   Director of strategy and Development

The Director of Strategy and Performance is responsible for

- Managing the Trust's Carenotes system, and RiO system (from October 2010) (which is the Trust's patient computerised patient administration system)

- Advising the Medical Director of the requirements for the audit in respect of data quality of data on the administration system

- Advising the Trust in respect of action planning following the audit in respect of electronic data capture.

5.3 Clinical Audit Work stream Lead

The Clinical Audit Work stream Led is responsible for:

- Receiving the audit report and advising on the development of appropriate action plans

- Receiving, approving and monitoring completion of actions plans that result from audits of record keeping

- Ensuring that Clinical Governance Leads take back lessons learned to Directorates and supporting the implementation of an changes that are agreed following the audit

- Advising the Management Committee and the CQSG of any agreed changes in practice resulting from records audit that affect clinical and administrative service across the Trust and seeking their endorsement to these changes

- Clinical Governance Leads will be responsible for developing appropriate actions plans for their Directorate in response to the results of the audit.

5.4 Records Audit Project Coordinator (usually the Governance and Risk Adviser)

The Audit Project Coordinator is responsible for:

- Preparing the methodology for the audit to be approved by the Clinical Governance Committee (this will be revisited each year to ensure that is meets current requirements)

- Preparing data sheets for data collection based on current standards and data quality requirements

- Advising the Trust on data sampling size and methodology

- Coordinating the data collection, and undertaking data analysis

- Preparing the audit report to agreed format and submit the report to the Clinical Audit Work stream Lead

- Ensuring that the highest standards of confidential and record security are maintained through the audit process

5.5   Clinical Directors

Clinical Directors are responsible for promoting highest standards of record keeping within the Directorates and responding to situations where poor record keeping by audit, incident and/or practice.

5.6   Clinical Governance Leads

Clinical Governance Leads are responsible for ensuring that their Directorate develops and implements a Directorate Action Plan in response to findings of record keeping audits. This plan will be received and monitoring by the Clinical Audit work stream reporting to the CQSG

5.7   Directorate Administration Managers

Directorate Administration Managers are responsible for:

- Advising on and supervising record keeping practices of all administrative staff within the Directorate, to ensure standards are maintained

- Ensuring that all new non-clinical staff are aware of record keeping standards

- Ensuring that all relevant staff receives appropriate training for accessing patient identifiable before using the Trust electronic database.

- Promoting feedback to clinical staff of any instances of poor or incomplete record keeping encouraging administrative staff to return records to clinicians for completion if required.

5.8   Clinical Staff

Clinical Staff are responsible for ensuring they are fully familiar with the standards for record keeping in the Trust and following these standards in respect of record keeping for their patients.

6   Procedures

The Clinical Audit Work stream Lead is responsible for setting and approving clinical standards for clinical record keeping. These standards will be reviewed and updated on an annual basis in line with receipt of feedback from the annual case not audit.

The current standards for record keeping are shown at Appendix B

6.1   Format of annual audit

The Trust will audit its standards of record keeping on an annual basis to assess both the quality of written record keeping and the data quality between written and electronic records.

6.2   Consistency between Electronic and Paper Records

On an annual basis a cross check will be made of all sample case files to compare data on the file with data held on Carenotes (RiO from October 2010) to review accuracy and completeness of data on the electronic system.

6.3   Audit Against Standards for Record Entries and Communication

The audit of files will cover the following:

- Content of files (e.g. filing instructions, loose papers, placing of documents)
- Completeness of records made at each stage of patient journey i.e. assessment; treatment; and discharge. This audit will be against current standards for record keeping.

6.4   Audit methodology for annual audit

The key steps in conducting the annual audit are shown below:

This will be undertaken by the Project Coordinator

  i.   Prepare data sheet for data collection based on current record keeping standards and data quality requirements

as determined by the Director of Strategy and development (data quality audit)

   ii.   Liaise with Speciality experts (clinical governance leads) during the development of data tools to ensure that local practices

  iii.   Agree data sampling size and methodology for selection

  iv.   Liaise with informatics re data sample to obtain case note numbers

   v.   Arrange for data sample records to be pulled and made available

  vi.   Allocating data reference numbers to sample to maintain confidentiality

 vii.   Train allocated administrative staff in data capture and recording

viii.   Monitor the quality of data capture through double checks

  ix.   Organise data into a suitable data package for analysis

   x.   Undertake the analysis and prepare the report

6.5　Data Sample for Annual Audit

The annual audit will be carried out on recent closed files. The reason for selecting closed files is as follows:

- Least disruption to clinical services
- High availability of files reducing time required to complete audit
- Files will have been completed by current staff and therefore feedback should be relevant to staff
- Files will be capable of review at each of three stages of treatment i.e. initial assessment, in treatment reviews, and discharge process.

6.6　Data Set

A core data set will be developed for all files based on standards for record keeping, and will be examined for all records, in addition directorate specific data sets will be collected to review local practices (eg record keeping for patients under 16 years of age)

The data set will as a minimum assess practice against the following core standards:

- *All notes, letters or summaries are typed or written legibly (preferably in __black ink__ because it photocopies well should case note copies be needed).*
- *Each case note entry are dated and signed.*
- *The full patient name and file number are on every page of a report/summary*
- *The date when the report/summary was written or typed is on every page*
- *The signature and printed name of author of each report / summary is recorded.*
- *The profession of the author is stated except on letters to clients/families (in some situations this may be considered inappropriate)*
- *All telephone messages stored in patient's files are signed, dated and timed with the patient's name clearly*

6.7   Reviewing Multiple Attendances

For many closed files the patient will have multiple attendances and therefore the data entries for a sample of these entries will be reviewed for each case. The sample will be randomly generated for each case file to ensure that data examined reflects the complete span of sessions.

6.8   Working with Directorate Administration Managers and Reducing Bias

In order that the annual audit is as relevant as possible all stages of the audit will be discussed with Directorate Administration Manager, and they will be involved in the data extraction, so that they have first-hand experience of the performance of those working in their team. To reduce the risk of bias a member of informatics staff and the audit coordinator will act as independent reviewers throughout the audit sampling data capture for each of the Directorate Managers.

6.9   Format and content of Audit report

The Project Manager will supply an audit report and recommendations to the Clinical Audit Work stream Lead on an annual basis on completion of the audit

The audit will be prepared to a standard template

The minimum content of each audit report will be as follows

- Date of Final Report

- Background: *Why the project was undertaken*
- Services Audited
- Objectives and scope of the audit
- Methodology and Standards: *The standard(s) against which practice was compared*
- Key results: *Main results arising from the project*
- Recommendations
- Feedback findings
- References Contact details of author

7   Training Requirements

Completed audit reports will be presented at the Clinical Audit work stream lead who will invite each Directorate to consider the results and develop local plans to address any deficiencies in compliance with standards.

The Clinical Audit work stream lead will then monitor progress on action plans from reports form the clinical governance leads and report these to the CQSG via the action tracker

Any risks that cannot be mitigated will be added to the operational risk register and monitored by CQSG on a quarterly basis.

Where the audit shows evidence of lack of training in record keeping directorates will be directed to incident local training in their action plans and if indicated to conduct local repeat focused audits to demonstrate that lessons have been learned.

8   Process for monitoring compliance with this Procedure

The Clinical Audit Work stream Lead will monitor compliance in the following ways:

- Ensuring receipt of an annual Trust wide audit report against record keeping standards
- Requesting and monitoring Directorate action plans following the audit
- Reporting up to the CQSG on a quarterly basis
- Escalating any risk identified by the audit to the Trust's Risk Resgister.

9   References

- Audit Commission. (1999). *Setting the Record Straight: A Review of Progress in Health Records Services*
- Department of Health. (2006). *Records Management: NHS Code Of Practice* London: Department of Health.
- Department of Health. (2000). *The Essence of Care. Patient-Focused Benchmarking for Health Care Practitioners.* London: Department of Health.
- NHS Executive. (1999). *Quality and Performance in the NHS: Clinical Indicators.* London: Department of Health.
- NHS Executive. (1998). *Information for Health. An Information Strategy for the Modern NHS. 1998-2005.* London: Department of Health.

10   Associated documents[1]

Health Records Procedure
Clinical Risk Assessment Procedure
Discharge and Closure Procedure

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[1] For the current version of Trust procedures, please refer to the intranet.

Appendix A : Equality Impact Assessment

1. Does this Procedure, function or service development affect patients, staff and/or the public?

YES

2. Is there reason to believe that the Procedure, function or service development could have an adverse impact on a particular group or groups?

NO

*3. If you answered **YES in section 2,** how have you reached that conclusion? (Please refer to the information you collected e.g., relevant research and reports, local monitoring data, results of consultations exercises, demographic data, professional knowledge and experience)*

4. Based on the initial screening process, now rate the level of impact on equality groups of the Procedure, function or service development:

Negative / Adverse impact:

Low…….

Positive impact:

Low………

Date completed 26.8.15

Name Jonathan McKee

Job Title   Governance Manager

Standards for Record Keeping Treatment records   Appendix B

Directorate	Stage in Treatment	Target/ Time	Record content standard: Individual case records
All	All Stages	All written clinical records	• All notes, letters or summaries are typed or written legibly (Preferably in black ink because it photocopies well should case note copies be needed). • Each case note entry are dated and signed • The full patient name and file number are on every page of a report/summary • The date when the report/summary was written or typed is on every page • The signature and printed name of the author is stated except on letters to clients/families (in some situations this may be considered inappropriate) • All telephone messages stored patient's files are signed, dated and timed with the patient's name clearly stated.
All	During assessment	ASAP after each session	• As a minimum a brief written entry in record assessment with date and signature • If patient does not attend a note to be made in the record of this fact with reasons if known (e.g. CBP)
All	Completed assessment	Within 3 weeks of end of assessment	• Assessment summary prepared on Trust assessment proforma, (under 16 or 16+ as appropriate), with all section so the proforma completed • Summary should be signed and dated by the author • The summary should be counter signed by the lead clinician of clinician is a trainee

All	Completed assessment	Within 4 weeks of completed assessment	Letter to GP and referrer (if different) The communication describing the assessment process should: • Be written in letter form (i.e. not be a set of bullet points). • Include the patient's name, current address and date of birth. • Give the date of the first session. • Give the date of the original referral. • State the number of times the patient has been seen so far. • Give an outline of the main presenting problems* • Give the formulation of the patient's difficulties* • State the likely length and frequency of treatment • State the level of Care Programme Approach (as appropriate) and the degree of any risk the patient may prose to themselves or others
All	During Treatment	ASAP after each session	• As a minimum a written entry after each attendance containing brief note of nature and content of session and commenter any changes to circumstances, or changes to risk, or disclosure • If relevant a record should be made or any external agencies alerted following session • If patient does not attend a note is to be made in the record of this fact with reasons if known (i.e. DNA, CBP)
All	Termly Summary	Patients who have been in treatment for 2 or more months at term end	Termly summary on Trust assessment proforma, (under 16 or 16+ as appropriate) with all section so the proforma completed • Summary should be signed and dated by the author • The summary should be counter signed by the lead clinician if clinician is a trainee

All	Termly	At end of each term	Updating letter to GP and/or referrer as appropriate This should be in letter form and contain: • The patient's name, current address and date of birth. • The date of the previous letter sent to the referrer. • The regularity with which the patient attended the Clinic • The main issues arising from the treatment. • The process of the treatment (e.g. if it's to continue or an end date) • Any change in the degree of risk the patient poses to themselves or others and any change in Care Programme Approach Level
All	Closing Summary	Within 28 days of completion of treatment	Closing summary prepared on Trust assessment proforma, (under 16 or 16+ as appropriate with all section so the proforma completed • Summary should be signed and dated by the author • The summery should be counter signed by the lead clinician if clinician is a trainee
All	At closure	Within 1 month of closure	Closure letter to GP and for referrer containing: This should be in letter form and contain: • The patient's name, current address and date of birth. • The date of the original referral. • The length of time the patient was seen and the frequency of sessions • The patient's condition on termination (clinical outcome and current formulation) including a note of any residual areas of difficulty, or risk and, where appropriate, possible actions should there be a need. • An indication of the patient's use of treatment and their benefit • The availability of re-referral in the future • When the patient is continuing in treatment with another agency a note of this plus, where appropriate, their level on that agency's CPA

Directorate	Stage in Treatment	Target time	Record content standard: group case records
All	All		Each patient being seen in a group has an individual file containing all patient specific data including: • Assessment • Assessment summary on Trust proforma • Correspondence • Termly summaries on Trust proforma • Closure Summary on Trust proforma • Letters to GP/referrer (post assessment, termly and at closure)
All except Portman	Group sessions	Before first group session	A group file will be maintained for each group • Each patient will be assigned a letter of the alphabet which will also be noted in their individual file. • Should any patient leave a group and be replaced, a different letter of the alphabet must be assigned, for each group only one patient must be assigned each letter • Where there are long standing groups and the alphabet has been exhausted coding should continue as A1, B1, and C1 etc. • A confidential record will be maintained by group leader of patient identity by alphabet letter.
Portman only	Group sessions	Before first group session	As above except that f**irst initials may be used instead of the ABC coding**
All	Group session	Following each Group session	• The register should note who came to each session, using the patient's alphabetic coding not their name. Session content: a brief paragraph on the theme, mood and progress of the session. • Areas of concern should note those patients for who you feel increasingly concerned and any action taken. • Enhanced level patients should have note written after every session, including any follow-up action deemed necessary.

Template for Audit Reports   **Appendix C**

Date of Final Report	
Services Audited	
Background Why the project was undertaken	
Objectives and scope of the audit	
Methodology and Standards The standard(s) against which practice was compared	
Key Results Main results arising from the project	
Recommendations	
Feedback Findings	
References	
Contact	