POLICY INFORMATION (Policy no CS035)	
Subject	**Records Management Policy** *(This policy is non-contractual and is subject to periodic review and will be amended according to service development needs).*
Applicable to	All staff of Nottinghamshire Hospice
Target Audience	Others such as agents, consultants and other representatives of Nottinghamshire Hospice may be required to comply with the policy as a condition of appointment.
Date issued	16 July 2024
Next review date	16 July 2025
Lead responsible for Policy	Director of Care
Policy written by	Governance Lead
Notified to (when)	Quality and Safety Committee 16 July 2024
Authorised by (when)	Quality and Safety Committee 16 July 2024
CQC Standard if applicable	
Links to other Hospice Policies	Information Security and Data Protection Policy
Links to external policies	
Summary	Record-keeping is an integral part of Nursing, Allied Health Professionals and other Care Staff's practice and is essential to the provision of safe and effective care. This Policy provides staff with guidance on recording and records management.
This policy replaces	N/A

IMPORTANT NOTICE

Staff should refer to the Hospice website for the most up to date Policy. If the review date of this document has passed it is still valid for 3 months. After that staff should seek advice from their clinical lead or manager.

VERSION CONTROL		
Status	**Date**	**Review date**
Original policy written by Governance Lead	May 2024	
Policy reviewed by Director of Care	May 2024	
Policy notified to Quality and Safety Committee	16 July 2024	
Policy ratified by Quality and Safety Committee	16 July 2024	16 July 2025
Updated control sheet and published on website	July 2024	

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1.	**Introduction** Record-keeping is an integral part of Nursing, Allied Health Professionals and other Care Staff's practice and is essential to the provision of safe and effective care. Records include anything that refers to the care of the patient and records can be called as evidence as part of: • Coroners' inquests or criminal proceedings • Safeguarding and Local Authority investigations • Nursing and Midwifery Council Fitness to Practice Committee hearings • Hospice Incident and Patient Safety Investigations • Disciplinary investigations The approach to record keeping that courts of law adopt tends to be that 'if it is not recorded, it has not been done'. Good record keeping shows how decisions related to patient care were made, while poor record keeping increases the risk of harm when making decisions. All Hospice staff must comply with the Hospice Information Security and Data Protection Policy.
2.	**Policy Aim** The aims of this policy are: • to ensure that patient personal information is dealt with securely, and effectively • to ensure that the hospice follows legal and national guidance • to outline the governance arrangements for the record management function.
3.	**Scope** This policy applies to all Nottinghamshire Hospice registered and non-registered staff, and applies to both paper and electronic records including handwritten

	clinical notes, emails, and letters to and from other health professionals, as well as care plans, and observation charts etc. For Registered Nurses this guidance is intended to be used alongside the NMC Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (NMC 2018). For Allied Health Professionals and Care staff this guidance is intended to be used alongside the Health and Care Professions Council: Standards of Conduct, Performance and Ethics (HCPC 2016).
4.	**Definitions** **Health Record -** The Data Protection Act 1998 describes the health record as "consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual". **Paper Record -** Any of the following documents which record aspects of care of a patient or client can be required as evidence before a Court of Law or before any regulatory body, e**.**g. Diaries**,** Attendance books, handover books, referral forms, assessments, messages and any paperwork messages relating to the care of a patient. This list is not exhaustive. **Electronic Record -** The Electronic Patient Record is a secure, real-time, point-of-care, patient centric information resource. Electronic Patient Record (EPR) is an official health record for an individual that can be shared among multiple departments and agencies e.g. SystmOne. This may include "data" and is wider than just non-identifiable data used in business processes. This also includes all electronic information relating to a specific patient, e.g. activity; contracts; demographic information; care plans; assessments; carers/significant others. **Contemporaneous -** Means records should be written at the time of or as close to the event described in the record. **Confidentiality -** All staff have a duty to protect the confidentiality of the patient record. Access to a patient's records and the information contained in them must only be for an appropriate reason and by appropriate staff.

	Caldicott Guardian - The Hospice's Caldicott Guardian has a particular responsibility for reflecting patients' interests regarding the use of patient identifiable information by safeguarding the confidentiality of patient information. **Access -** Means the opportunity or right to see records. Under The Data Protection Act 1998, patients have the right to access their health records, subject to certain safeguards. **Duty of Candour -** A culture of openness within the Hospice ensures communication is open, honest and occurs as soon as possible following an incident, or when a poor outcome has been experienced. It encompasses the communication between patients, their families and carers, healthcare organisations, healthcare teams, and ensures that the Hospice supports staff in being open. **Records Lifecycle -** This describes the life of a record from its creation/receipt through the period of its "active" use, then into a period of "inactive" retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation. Refer to Code of Practice for Health and Social Care (2016) Records management for information on lifespan of records. **Audit -** Audit provides a method for systematically reflection on and reviewing of practice to ensure compliance with current standards. **NHS Number -** The NHS number is the only national unique patient identifier in operation in the NHS at this time. A ten digit number assigned to every individual registered with the NHS in England.
5.	**Responsibilities** **Director of Care** • Has overall responsibility for Patient Records Management within the Hospice. • Is the Hospice's Caldicott Guardian

	Care Leadership Team • Are responsible for ensuring staff are competent in recording and day to day management of Patient records. **All Staff** • Are accountable for ensuring that they are aware of and know how to use SystmOne and/or Iizuka. • Are accountable for entries they make to a patient record, including ensuring that all entries are timely and clearly identifiable and that each entry has been checked for accuracy prior to signing (written or electronic equivalent) in accordance with this policy and the Information Security and Data Protection policy.
6.	**Guidelines** Health care professionals have a duty to keep up to date with, and adhere to, relevant legislation, case law, and national and local policies relating to information and record keeping. • Records must be accurate and written in such a way that the meaning is clear. • Records must demonstrate a full account of the assessment made, and the care planned and provided, and actions taken, including information shared with other health professionals. • All entries in a record must be dated (date / month / year), timed accurately, and signed. • All entries in a record must be made, wherever possible, with the involvement of the patient / carer and written in language that the patient can understand. • Records must demonstrate any risks identified and / or problems that have arisen and the action taken to rectify them.

- Abbreviations, jargon, meaningless phrases, or offensive statements must not be included in any records.
- Records must never be falsified. Changes must not be made after they have been written and signed.
- All staff must develop communication and information sharing skills, as accurate records are relied upon at key communication points, especially during handover, referral, and in shared care.
- Legal requirements and local policies regarding confidentiality of patient records must always be followed.
- In line with the Data Protection Act and General Data Protection Regulations, care records and information concerning patients must not be left accessible, or in public places, and must not be unlawfully shared with anyone not directly involved in the patient's care.
- Health care professionals remain professionally accountable for ensuring that any duties delegated to non-registered practitioners are undertaken to a reasonable standard, and records made by pre-registration Nurses / or Care Support Workers are countersigned.

Guidance for Non-Registered Staff

Entries may be made to patient records in line with Hospice policy. Entries in patient records must be to the standard as outlined above.

Supervision and countersigning of care records completed by non-registered staff must take place until the worker is deemed competent.

All new starters undertake a minimum of two 9 hour shadow shifts with an experienced RN which covers several "competencies" **including** demonstrating an understanding of the principles of record-keeping and confidentiality (shift one) and the quality of record-keeping and understanding of confidentiality (shift two). If the RN does not feel the new starter displays appropriate behaviour or

	level of skill, they can request they complete another shadow shift until they are deemed competent.
7.	**Confidentiality** Staff must act in accordance with Nottinghamshire Hospice Information Security and Data Protection Policy which details its approach to confidentiality.
8.	**Paper Records** Handwriting must be legible and written in black ink to enable legible photocopying or scanning of documents if required. First entries on each page of the record must include the printed name and signature of the person recording the information. In the event of an error being made, entries must be corrected by striking the error through with one line, and applying the author's initials, time, and date alongside the correction. The original entry should still be able to be read clearly. Errors must not be amended using white correction fluid, permanent marker, scribbling out or writing over the original entry.
9.	**Storage and Disposal** **Storage** All paper records must be stored within Nottinghamshire Hospice unless it is required for the proper performance or your duties. Confidential information/files will be stored in lockable cabinets and employees responsible for keys should not pass them to unauthorised individuals. **Archiving** Hospice paper records archiving is held within the Hospice and a log of all files held and retention timescales is held by the Facilities and Transport Manager. **Disposal** Upon the expiry of the data retention periods as detailed in the Data Retention

	Policy, or when an individual exercises their right to have their personal data erased, personal data shall be deleted, destroyed, or otherwise disposed of as follows: • All Personal data stored electronically (including any and all backups thereof) shall be deleted. • All Personal data stored in hardcopy form shall be shredded and recycled.
10.	**Electronic Records** The principles of confidentiality of information apply to electronic and digital records as they do with other records. Whilst it is no longer common practice to fax records the same principles of confidentiality apply. Staff must use their own log-in details when accessing electronic / digital records and must log-out when not in use. Registered Nurses, Midwives, and Allied Health Professionals are accountable for any entry they make to electronic held records and must ensure that any entry made is clearly identifiable in accordance with Hospice policy.
11.	**Data Retention** All records will be retained as laid out in the Information Security and Data Protection Polic**y**.
12.	**Equality Impact Assessment (EIA)** An EIA has been completed.
13.	**References** 1. NHSE Records Management CoP 2023 (england.nhs.uk) 2. NMC (2018) The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates 3. HCPC (2016) Standards of Conduct, Performance and Ethics. 4. General Data Protection Regulations.

	Data Protection Act (2018).