



PATIENT SAFETY TOOL BOX TALKS®

EFFECTIVE CARE & SUPPORT

HEALTHCARE RECORDS DOCUMENTATION REQUIREMENTS



v1.1

Introduction

Healthcare records are legal documents and are designed to provide an **overview** of the service user's state of health before, during, and after a particular therapy. The healthcare record should contain sufficient information to identify the service user, support the diagnosis, justify treatment, document the treatment course and results and facilitate continuity of care among healthcare providers.



General Principles

Correct identification of service user- every page should have the forename and surname, identifiable number (MRN) and date of birth. Service user identification should be on every sheet including reverse of double sided sheets and should be verified with the service user on each entry.

Chronological, accurate and complete records- records should be accurate and recorded so as the meaning is clear and intelligible. Records must not be falsified. They must be factual and should not include unnecessary abbreviations, jargon, irrelevant speculation, coded expressions, sarcasm or meaningless phrases to describe service users or care providers. Opinions should be noted as opinions.

Communication with service users and families – the date, time and detail of all communication i.e. face to face meetings, letters and phone-calls must be documented in the service user's healthcare record.

Specific Requirements

Out-patient/Service user consultations

Entries must be made in the history sheet stating at least any procedures undertaken and the outcome of the consultation (including referrals).

In-patient care

- The admission must be clearly documented both in terms of the requirements of the service user registration, the referral, past medical history, social circumstances, current drug prescriptions, known allergies, physical examination, details of tests ordered and information provided to service users or their carers.
- A working diagnosis and care / treatment plan which should be signed by the appropriate clinician/care professional.
- Any risks or problems that have arisen should be identified and the action taken to deal with them documented.

For nursing records

- Appropriate risk assessments carried out at pre defined intervals post admission and recorded in the nursing care documentation. Care plans, which are prescriptions of care, and evaluation sheets plus any additional documentation



General requirements in relation to making an entry into a Health/Social Care Record

Registration - all aspects of this record must be completely filled in and rechecked on each admission/referral

Legibility - writing is legible, signed by entry maker and using **permanent black ink**

Date and Time – every entry must be dated & timed using 24hr clock

Author Identification- all entries **must** clearly signed with a PRINTED NAME, job title & bleep number and in the cases of doctors and nurses their registered identification number (IMC or N&MBOI). Where students make entries, they must be countersigned by the supervising healthcare professional.

Corrections, deletions or alterations of contents should be crossed through with a single line, signed, plus name in capitals, dated and time of correct entry and reason for amendment. Entries other than in exceptional circumstances, should be made contemporaneously and before the relevant staff member goes off duty.

Documenting evidence of care - Records should provide information regarding service user's holistic wellbeing, including any observations or information noted. All entries must be attributable to a healthcare professional. Entries relating to a clinical ward round must identify the most senior doctor present. Where multidisciplinary meetings or assessment forms are documented all members of the MDT present should be identified, since responsibility is shared.

Transfer of responsibility – when the care of a service user is transferred to another consultant the named consultant responsible, time and date of transfer of care must be recorded.

Frequency of records- an entry should be made each time a service user is seen by a clinician. Where there is a time lapse of entries (due to weekend or holiday periods) the next entry should give a reason as to the lapse.

Retrospective entries – these must be dated, timed (24 hr) and signed and also contain a printed name. Reasons for retrospective entry must be clearly stated.

Abbreviations – should not be used on documents for communications, medications sheets, consent forms, death certificates or transfer letters.

Verbal instructions via telephone - should be documented, dated, timed and signed. (Where appropriate countersigned by colleague within an agreed timeframe).

Test results- should not be filed before they are signed and dated. Results should be signed within twenty four hours of their availability to the clinician. Where abnormal results are evident, it must be documented who was informed and what actions were taken or planned in the health care record.

Medication Prescription and Administration Record – this should comply with clear unambiguous documentation regarding medication management and in keeping with the medication policy.

Language- all records must be written in English, clearly phrased and respectful.

Advice - all advice given by any healthcare professional to service users, including leaflets and education should be documented.

Referral letters- only opened by authorised staff, immediately stamped on receipt, triaged and date recorded and returned to relevant staff within five working days.

Consent – this should be clearly documented in accordance with hospital policy.

Advance Decisions and DNARs - these should be recorded and be in keeping with the service users wishes.

Acknowledgements: HSE Standards and Recommended Practices for Healthcare Records Management, QPSD-D-006-3 V3. An e-learning foundation training programme developed to support the Healthcare Records Management Programme can be accessed at www.hseland.ie