Clinical record keeping - Adult Mental Health Inpatient Services

Standard Operating Procedure

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1. AIM

The aim of this standard operating procedure is to set out the specific standards for clinical record keeping within the Adult Mental Health Inpatient Services, and is written in line with the Nursing and Midwifery Council record keeping guidance for nurses and midwives (2009) in which it highlights that good record keeping:

- Helps to improve accountability.
- Demonstrates decision making in relation to patient care.
- Supports the delivery of services.
- Supports effective clinical judgments and decisions.
- Supports patient care and communication.
- Promotes continuity of care.
- Provides documented evidence of the services delivered to a patient.
- Promotes improved communication and information sharing between members of the multi disciplinary team.
- Helps to identify risks, and enables early detection of complications.
- Supports clinical audit, research, allocation of resources and performance planning.
- Helps to address complaints or legal processes.

2. SCOPE

The contents of this standard operating procedure apply to clinical staff working within the Trusts' Adult Mental Health Inpatient Services.

3. LINK TO OVER ARCHING POLICY

This standard operating procedure is to be read in conjunction with the following Trust polices:

- Policy for health record keeping standards and health record management.
- Clinical risk assessment and management policy.
- Minimum standards for the physical assessment and examination of inpatients.
- Care programme approach policy.

In addition it is the responsibility of clinical staff to be aware of and adhere to the record keeping standards as set out by their professional body.

4. PROCEDURE

4.1 Structure of the clinical records.

Within the Adult Mental Health Business Division patients clinical records are electronic and therefore all clinical staff involved in a patients care are able to access them in a timely manner.
Each ward and community team have scanners which will enable them to scan into the patients electronic record copies of any letters or other correspondence which have not been provided electronically.

In the event that paper copies are to be retained on the ward these must be held in a ring binder file on the front of which will be the ward details and on the spine the following details are to be recorded.

- Patients name.
- The full name of their named nurse.
- The full name of their care coordinator
- For patients who are new to service and yet to be allocated a care coordinator staff should enter this onto the spine of the clinical record file.

All clinical record files within the Adult Mental Health inpatient services will be divided into the following sections.

Section 1 = Patients admission details.
- Blue admission form.
- Patients admissions record
- Carers pathway
- Access team information.

Section 2 = Mental Capacity Act documentation.
- MCA 1
- MCA 2.

Section 3 = Mental Health Act documentation.
- Copies of current MHA detention papers.
- Copies of expired detention papers.
- Copies of section 17 leave forms.
- Information relating to the reading of legal rights under section 132 of the MHA 1983.
- Consent to treatment.
- Absent Without Leave.
- Information relating to Mental Health Review Tribunals and managers’ hearings.
Section 4 = Risk Assessments’.

- Current FACE risk assessment.
- FACE weekly evaluations

And where clinically indicated the following are to be included in this section.

- Falls risk assessment.
- Moving and handling risk assessment.
- Choking risk assessment.
- Nutritional risk assessments.

Section 5 = Medicines reconciliation and side effects monitoring.

Section 6 = Care plans.

- Current care plans, including any which are specific to Occupational Therapy, Psychology or Physiotherapy services.
- Discontinued care plans.
- Care plan evaluations.

Section 7 = Evaluation /progress notes.

These are held on the electronic patient record and there is no requirement for printed copies to be held in the patients clinical records file. A laminated sheet is to be inserted into this section which informs anyone looking at the clinical record that the evaluation /progress notes are available to view on the electronic patient record.

The only time paper copies may be held in this section is in the event of an out of hour’s medical review if the Doctor doesn’t have access to the electronic patient record. The entry will be made on paper, and will then be scanned into the patients electronic by the ward clerk on the next working day.

Section 8 = Physical and other observation Charts.

- Drug screening.
- MRSA.
- Blood results.
- Lab reports.
- Investigation results.
NB. No investigation results are to be filed until they have been viewed and signed off on the result form as having been seen by a member of the medical team.

Section 9 = Copies of Mental health assessment tools.

Section 10 = Miscellaneous information.

- Third party letters.
- TTO and drug cards.
- Copy of the discharge summary.
- Copies of IR1 reports.
- Absent without leave information for informal patients.

**Allergies**

At admission all patients are to be asked if they have any allergies. If yes a RED laminated allergy warning sheet is to be inserted at the front of the patients’ clinical record and a care plan put. This care plan must give clear guidance on the type of allergy, what steps need to be taken to limit/prevent exposure and what treatment is required should the patient experience an allergic reaction. This will also need to be done if a patient develops an allergy during an episode of inpatient care.

It is important that staff still ask about any known allergies even the patients allergy status is already on record as they may have developed new allergies since their record was last updated.

**Ensuring that it is easy to identify which patient the paper records relate to.**

Due to the risk of paper records becoming detached from the patient’s clinical record it is important that the patient’s full name or a patient identification label is attached to every page or document.

4.2 Prior to admission

All patients who are admitted to one of the Adult Acute Mental Health Inpatient wards will have been seen and assessed by the access team. As part of this assessment the staff in the access team will complete the following documents either prior to the patients’ admission taking place, or as soon as possible after their arrival on the ward.

- A FACE risk assessment is to either be completed in the case of a patient not previously known to services, or updated to reflect current risks due to deterioration in mental state and need for admission to hospital in the case of a patient already known to services.

- An MCA 1 in relation to the patient’s capacity to consent to admission.

- Purpose for admission form. (see appendix 1)
• A completed clustering tool.

Within the Rehabilitation and Recovery wards the admissions are not arranged through the local access teams as admissions are pre-planned and subject to assessment by the inpatient clinical team. In these cases a full clinical picture including any risks will be obtained from the referring ward/service as part of the assessment process for transfer into one of the Trust Rehabilitation and Recovery wards.

4.3 On admission

It is accepted that admission to hospital can be a stressful time for patients and with this in mind clinical staff should determine on a case by case basis how much of the admission documentation it is appropriate to complete at the point of admission. In the event that sections of the admission documentation have to be left to a later time the admitting Nurse is responsible for handing this over to another member of the clinical team and then ensuring that all documentation has been completed within 48 hours of the admission.

Within the Adult Mental Health Inpatient wards the following must be completed as part of the patient’s admission process.

• The multi disciplinary admission assessment and physical health checks.

• Medicines reconciliation form. When completing this staff should as far as possible verify the information provided by the patient with their relatives, community workers, and General practitioner.

• An update to the FACE risk assessment to reflect any changes to the patient’s risk status in line with their admission to the ward.

• Consent to share information sheet. This is important as staff involved in the patient’s care need to know what information the patient is happy or not to be shared with their relatives/friends. In the event that a patient declines consent this must be recorded on the sheet and arrangements made for the decision to be revisited at regular intervals throughout their stay on the ward. Following each discussion with the patient about the sharing of information with their relative/friend an entry is to be made in the patient’s clinical record.

• Care plans are to be put in place for all identified needs and risks. Where possible these are to be formulated in conjunction with the patient and signed by them. The patient is to be offered copies of their care plans to keep in their “My care folder”. If the patient declines or is not well enough to be involved in the development of their care plans a record of this is to be made in their clinical record.

• MCA 1 and where indicated the MCA 2 for the prescribed treatment.

• MRSA risk assessment.
• Where clinically indicated a:
  o MUST
  o Choking risk assessment.
  o Falls risk assessment.
  o Moving and handling risk assessment.

For any patients who are known to have been under the care of another Mental Health provider ward staff are to make a request for copies of their clinical records to be forwarded to the ward so that they can be reviewed to inform decision making around future care and treatment.

4.4 Specific requirements for patients admitted who are subject to detention under the Mental Health Act 1983.

In the case of a patient admitted to the ward who is subject to detention under the Mental Health Act 1983 the Nurse in Charge of the ward at the time of the patients admission should be in receipt of the original detention papers which relate to that patient. Once the legality of these section papers has been confirmed the Nurse in Charge of the ward must complete a form H3 to formally receipt and accept the detention on behalf of the Hospital Managers. An attempt must then be made to explain the patients legal rights to them, and a form 14a completed. In the event that the patient refuses to have their legal rights explained to them or if they lack capacity at the time of admission arrangement must be made for further attempts to be made, and this will be recorded on the form 14a and an entry made in the patients clinical records to this effect.

Staff should refer to the following Trust Procedure for the receipt and scrutiny of section papers and the procedure for informing detained service users of their legal rights under section 132 of the Mental Health Act 1983 for full details.

4.4.1 Guidance on the preparation of reports for Tribunal and Hospital Manager hearings.

Any reports submitted to either the Mental Health Review Tribunal or Hospital Managers will be used to inform decisions around the need for the patient to remain subject to detention under the Mental Health Act 1983 and so must be up to date and accurately reflect the patients current presentation and level of engagement /insight.

Whilst it is down to the judgement of the clinician preparing the report the following should be included as a minimum.

**Nursing Report**

This should be prepared by the patients named nurse and cover the following;

• Reason for admission and presentation.
• Identified clinical risks. Including incidents of self harm, and threats of harm to self or others.
• Medication.
• Compliance and level of engagement with treatment plan.
• Level of supportive observation.
• Section 17 leave /episodes of absence without leave.
• Incidents of seclusion or restraint.

**Medical Report**

This should be prepared by the patients Responsible Clinician and cover the following:

• Background history.
• Family history.
• Details around any reported use of drugs and/or alcohol.
• Forensic history.
• Physical health.
• Past Psychiatric history.
• Circumstances of admission.
• Progress since admission.
• Current medication.
• Risk Assessment with a particular focus on risk to self, others, and non-compliance.
• Psychiatric opinion.
• Recommendations, including what the arrangements would be should a decision be made to discharge the patient.

4.5 **Personalised care planning**

Care plans must be personal to each individual patient and written in a way which means that any reader of them will be easily able to understand what action needs to be taken to help address the patients identified needs. Wherever possible the patient and where appropriate their relative /carer are to be involved in the development of any care plans, and the patient should be asked to sign that they have been involved in the development of their care plan and agree with the content. If a patient refuses
or is unable to sign their care plan for any reason this is to be recorded in their clinical record with a date agreed for when further attempts will be made to gain the consent /engagement of the patient in their care plan.

All care plans are to be on the Business Divisions approved template and must:

- Reflect and be led by the patients identified needs, rather than by their diagnosis and where appropriate include the following.
  - Arrangements related to medication including information about choices, side effects and treatment concordance;
  - Arrangements for any identified physical health care needs;
  - Arrangements for aspects of care related to daily living e.g. help with meals, personal hygiene, domestic support;
  - Arrangements to support child care and visiting;
  - How the patient will be supported to develop self management skills around their illness.
  - Details of any other agencies involved in the patient’s care.

- Clearly set out how any identified risks are to be managed.

- Be recovery focused.

- Include the patient’s perception of their identified needs which is written in their terms.

- Be written in a way which is easily understood by the patient and their carer/relative.

- Use language which is user friendly, jargon and abbreviations are not to be used as abbreviations can mean different things to different people.

- Take account of all protected characteristics in equality law:
  - Ethnicity.
  - Gender.
  - Disability.
  - Religion or belief.
  - Sexual orientation.
  - Age.
  - Gender reassignment.
- Where appropriate show evidence of involvement by the patients care/relative. This is particularly important in respect of leave and discharge care plans.

- Contain goals that are SMART.
  
  - Specific.
  - Measurable.
  - Achievable.
  - Realistic.
  - Time limited.

  Be numbered, as this will be used to reference the care plan to which any evaluation entries refer to.

  Contain the full name of the staff member. This is needed in case there is ever an enquiry about the care plan at a later date.

  Each patient is to be offered a copy of their care plan.

**Admission Care Plans**

An admission care plan is put in place to cover the patients’ orientation to the ward and to allow clinical staff time to undertake a more detailed assessment of the patients clinical presentation and care needs. However it is only an interim care plan to cover the first 72 hours of a patient’s admission and after this time it is to be discontinued and more detailed care plans put in place.

**Obtaining specialist advice**

There may be times during a patient’s admission when staff need to put in place care plans for areas where the Trust employs specialist advisors. Examples of this could be manual handling, infection control, fire safety and adult or children safeguarding issues. In these cases staff should contact the relevant specialist within their locality to gain advise and support around the development and implementation of the agreed plan of care.

**Leave care plans**

Prior to any patient commencing a period of leave from the ward a care plan is to be put in place which will detail what the leave arrangements are, where it is to be taken, what support is to be provided to the patient during the leave, and advice to the patient /carers as to who to contact or action to take if a Crisis arises.

The leave care plan must also detail how feedback in respect of the leave will be gained from both the patient and where appropriate their carer. This feedback is to be recorded in the patients’ clinical record and used to inform decision making around any further episodes of leave from the ward.
**Discharge Care Plans**

The discharge care plan should be agreed at the pre discharge meeting and must **include** details of the 7 day follow up arrangements, and action to be taken including who to contact if a Crisis arises.

**Involvement of Carers in care planning**

Carers should where possible be involved in the care planning process throughout a patient’s episode of inpatient care, and agreement for this involvement should be sought from the patient at a time when they have the capacity to provide informed consent. The involvement of carers is key to safe and effective leave and discharge planning.

4.6 **Reviewing care plans**

All care plans are to have review dates which are timed to suit the needs of each individual patient. However these review dates are the minimum time in which the plan of care is to be evaluated and it is expected that the care plans will form the basis of the ward multi disciplinary team reviews. In addition to this should there be a significant change to the patients’ presentation or social circumstances a review of the care plan must be undertaken, and it is also important that a review of the care plan is undertaken during any transition of care, for example when a patient is transferred to another service or discharged to the care of the community services.

The care plan review should be used to support the patient in seeing what progress they have made in respect of their recovery and to evaluate the effectiveness of the treatment programme.

When making an entry in the clinical record which relates to a care plan review the clinician must record the number(s) of the care plan which the entry relates to.

4.7 **Care planning when patients decline or lack the capacity to be involved**

There may be times during a patient’s episode of care when they either decline or lack the capacity to be involved in the planning of their care. In these circumstances staff are to clearly document in the patients clinical records why the patient has not been involved in the development of their care plan.

As a patient’s engagement/capacity can change at any point during an episode of care it is important that staff make ongoing attempts to involve the patient. All further attempts to engage the patient are to be recorded in the patients’ clinical records.

4.8 **Advance Decisions /Statements**

Some patients who have had previous involvement with the mental health services may have made an advance statement /decision of their wishes in-respect of their care and treatment should they ever require a future episode of inpatient care.
Staff should refer to the Trust Policy for Advance Directives and Advance Decisions for full details but below are the definitions.

**Advance Statements** – It is a general statement of a person’s wishes and views. People who understand the implications of their choices can state in advance how they wish to be treated if they suffer loss of mental capacity. It can reflect their religious beliefs or other beliefs that they have and allows the person to state how they would like to be treated should they not be able to communicate their wishes in the future. Advance Statements can be used to nominate a person to be consulted with at a time a decision has to be made although at present their view is not legally binding. However, if the nominated person has also been granted Lasting Power of Attorney to make personal welfare decisions, the decision of the person with Lasting Power of Attorney will be binding. Advance Statements can also be used to inform health professionals of how they would prefer to be treated medically. Whilst an Advance Statement does not bind doctors and professional staff to a particular course of action if it conflicts with their professional judgement or if the treatment preferences described are not considered appropriate or necessary (e.g. taking into account available resources), it is important to consider an Advance Statement when planning care and treatment.

**Advance Decision** – Advance Decisions are governed by the Mental Capacity Act 2005 and relate to refusals of specified treatment if specified circumstances arise in the future at a time when the person no longer has mental capacity. Advance Decisions are sometimes known as ‘advance directive’, ‘advance refusal’ or ‘living will’. However, the statutory term is “Advance Decision” and that is the term which is used within the Trust Policy. An Advance Decision to refuse treatment can only be made by an individual aged 18 and over with capacity to make Advance care and treatment Decisions. In the event of them losing capacity in the future, a properly made Advance Decision is as valid as a contemporaneous Decision (that is, one made at that time). There are no set formats for Advanced Decisions; they can be written, witnessed oral or written statements, printed cards or notes of a discussion recorded in the clinical record. All versions are acceptable but the important element is that the Advance Decision is clear and unambiguous. A valid Advance Decision which is applicable to the circumstances which arise is legally binding in the same way as a contemporaneous refusal by a person with capacity. Professionals may be legally liable if they treat a patient in the face of a valid and applicable Advance Decision.

The exceptions to this are:

- That refusals of life sustaining treatment must be in writing (and must comply with a number of other requirements as set out in the Trust policy).
- Advance Statements and Advance Decisions to refuse medical treatment cannot be used when the patient has the capacity to consent to or refuse the proposed treatment.
- That the terms of the Mental Health Act 1983 take precedence and prevail over Advance Decisions when it comes to treatment for mental disorder.
In the event that a patient's wishes as stated in their advance statement / decision cannot be met, the Consultant Psychiatrist in charge of the patient's care is where possible to have a full discussion with the patient. The outcome of which is to be recorded in the patient's clinical record along with the reason for why the patient's wishes could not be respected.

4.9 WRAP (Wellness, Recovery, Action planning)

The Wellness Recovery Action Plan is a framework which allows patients to develop an effective approach to overcoming their distressing symptoms, and unhelpful behaviour patterns. WRAP was originally developed by Mary Ellen Copeland and a group of mental health service users who wanted to work on their own recovery and is increasingly being used by patients who are under the care of the Trust's Mental Health services.

A WRAP is developed and belongs to the patient, and it is up to them to decide how and when to use it. If a patient has a WRAP in place, clinical staff should discuss with them how best to use it to inform care planning during their inpatient stay.

For patients who are not familiar with WRAP, the occupational therapy staff in the localities run WRAP groups, and patients should be encouraged to attend these so that they can get the information to make a decision as to whether or not developing a WRAP would be useful for them.

4.10 Use of the Recovery STAR

Within the Rehabilitation and Recovery services, the Recovery Star is used throughout a patient's inpatient stay as it provides a tool for supporting and measuring change when working with adults of working age who experience mental health problems. When working with the Recovery STAR, patients can see a visual map of their journey to recovery and have the opportunity to plot their progress and plan any actions they need to take to aid their recovery.

The Recovery Star focuses on the ten core areas that have been found to be critical to recovery, which are:

- Managing mental health
- Relationships
- Self-care
- Addictive behaviour
- Living skills
- Responsibilities
- Social networks
- Identity and self-esteem
- Work
- Trust and hope
And measures the relationship the patient has with any difficulties they are experiencing in each of these areas and where they are on their journey towards addressing them.

4.11 Evaluation of care

The frequency with which evaluation entries are made into the patients clinical record are determined both within the individual care plans and by professional judgement. When making an evaluation entry onto MARICIS the system will automatically record the time of the entry using the 24 hour clock. However in the case of an entry being made in relation to a specific incident which needs to have the time noted staff should make it clear in the text at what time the incident occurred.

When making an entry in any patients clinical record staff must remember that it may at some point by viewed by the patient and with this in mind all entries made in a patient’s clinical record must:

- Be written as soon as possible after an event has taken place.
- Follow a logical sequence.
- Be factual, consistent and accurate.
- Provide current information on the patients care and response to treatment.
- Where possible show evidence of the patients involvement in the evaluation of their care.
- Be written in terms that the patient can understand.
- Clearly show the clinical decision making process.
- Provide an explanation for any actions /aspects of care not carried out.
- Not include abbreviations as these can be interpreted differently dependent on who is reading the record.
- Only contain meaningful statements.
- Clearly show where information has come from in the event that the entry relates to an event /incident not directly witnessed by the clinician making the record.

4.12 Recording 1-1 time

When recording 1-1 time this may include an evaluation of the care plan(s) but staff should also record an assessment of the patients’ presentation and mental state by using the following headings as a guide:

- Appearance.
- Behaviour
• Mood.
• Cognition.
• Speech.
• Abnormal thoughts.
• Abnormal beliefs.
• Self harm/suicidal ideas.
• Harm to others.
• Insight.
• Patients’ perception as to their progress/recovery.

There should also be a clear record of any agreed actions and where necessary the patients care plans should be reviewed to take account of these.

4.13 Recording a multi disciplinary team review

When any multi disciplinary review takes place the following must be recorded in the patient’s clinical record.

• The name and designation of everyone present, including the patient and their carers/relatives.
• Details of anyone invited who was unable to attend.
• Details of the discussion which took place.
• Details of the patient and where appropriate their carer/relatives’ feedback.
• The agreed treatment plan, including any changes to observation or leave status.

4.14 Recording a change of diagnosis for a patient already known to mental health services

As a change of diagnosis can lead to the patient being reclustered and coming under the care of another community team and care coordinator a full multi disciplinary team review must be held, and the following recorded in the patients clinical record:

• Details of the clinical staff who have been involved in the discussion around the change of diagnosis.
• A review of the patients past history to demonstrate that this has been taken into consideration.
• The clinical reasons for the change of diagnosis.
Details of the discussion with the patient and where appropriate their carer about the change of diagnosis, and what this means in relation to their future care and treatment including transfers to another community team/care coordinator.

The above will also be provided to the patient in writing and a copy sent to their General Practitioner.

4.15 Recording third party information

It is important that the source of any information contained within a patient's clinical record can be identified, therefore when recording any information which has been provided by a third party clinical staff are to state at the start of the entry who has provided the information to them and whether or not the information was provided face to face or over the phone.

4.16 Principles of good record keeping for handwritten records

Although the Adult Mental Health Inpatient services are using the electronic patient record there may be times when clinicians have to make handwritten records. An example of this may be in the case of a new staff member who has not been logged onto the electronic patient record.

If handwritten records are being made the following additional record keeping standards are to be adhered:

- All entries are to be made using black permanent ink.
- All entries are to be dated and timed using the twenty four hour clock.
- Handwriting should be legible.
- All entries are to be signed and include the clinician's name and job title.
- Tipex is not to be used.
- In the event that an error is made in the record the clinician is to draw a single line through the entry so that the entry can still be seen, write “written in error” and then sign and date the amendment.

4.17 Information which is for none disclosure

There may be occasions during the course of a patient's episode of care when sensitive information is disclosed to staff. Sometimes this information is provided with express instructions that it is not to be disclosed to the patient i.e. if it forms part of a police or safeguarding investigation, or the clinical team may feel that disclosure of the information could be detrimental to either the mental health of the patient or safety of another person. In these situations staff should.

- Information provided with the express instruction that it is not to be disclosed - Record at the start of the entry in bold that the information
contained in the entry is not for disclosure. The clinician should then detail who provided the information and the reason why it is not to be disclosed.

- **Information that could be detrimental to the mental health of the patient** - Record at the start of the entry in **bold** that the information contained in the entry is not for disclosure without discussing with the patient's lead clinician first. This is due to the fact that information which may be detrimental to the patient at the point of care when the entry is made may not be detrimental at a later date so the decision needs to be kept under review. The clinician should then clearly state why the information could be detrimental to the patient.

- **Information provided which if disclosed could pose a risk to the safety of another person** - Record at the start of the entry in **bold** that the information contained in the entry is not for disclosure. The clinician should then detail who provided the information, the reason why it is not to be disclosed, who would be at risk should disclosure occur, and what the nature of the risk is.

4.18 Entries made by Nursing Assistants

Clinical record keeping can be delegated to Nursing Assistants to enable them to document the care they provide to patients. However as with any delegated activity the Ward Sister / Charge Nurse must be assured that the person to whom they are delegating the task is competent to safely undertake the task.

Within the Adult Mental Health inpatient services Nursing Assistants will not make entries in the patients’ clinical records until they have completed the Trust:

- Information Governance training.
- Clinical record keeping training.
- Training in the use the electronic patient record.
- And been provided with a copy of this standard operating procedure and the record keeping guidance issued by the Nursing and Midwifery Council.

Once the Nursing Assistant has completed the above training the Ward Sister / Charge Nurse will meet with them and agree the period of time during which each entry made by the Nursing Assistant will be checked and counter signed. It is not possible to state a definitive time for the checking and countersigning of each entry as people will achieve competency at differing rates. However the Registered Nurse who is countersigning the clinical entry made by the Nursing Assistant should only do so if they have witnessed the activity which took place.

Whilst the Ward Sister /Charge Nurse retains professional accountability for the appropriateness of delegating clinical record keeping to the Nursing Assistant ,the Nursing Assistant is personally accountable for the content and quality of any records they make.
Once the Nursing Assistant is deemed to be competent there will be no requirement for the records to be countersigned and the ongoing monitoring of the staff members adherence to the clinical record keeping standards will be undertaken as part of their clinical supervision.

**Countersigning paper records** - The Registered Nurse is to record their full name, and job title then sign the record.

**Countersigning entries in the electronic patient record** – As passwords cannot be shared the Registered Nurse will need to log onto the electronic patient record and make a note on the entry that they have viewed and countersigned the entry.

4.19 **Entries made by Students**

As part of their training it is important that students who are placement have the opportunity to make entries in clinical records. Arrangements are to be made with the IT department for any students who do not have access to be given the necessary authorisation to use the electronic patient record. In addition to this as part of their induction to the ward they are to be provided with a copy of this standard operating procedure and the record keeping guidance issued by the Nursing and Midwifery Council.

During the first two weeks of placement all entries made by the student will be countersigned by a Registered Nurse. Following this as with the Nursing Assistants the need for and frequency of countersigning will be determined by the level of competency displayed by the Student. This will be agreed between the Student and their mentor.

Please see above for details of how to provide a countersignature.

4.20 **Making an entry in the clinical records on behalf of someone else**

If a student or other staff member does not have access to the electronic patient record ,and have witnessed an incident or have information which needs to be entered onto the record a registered nurse can do this on behalf .When doing so they must state who it was that made the observation.

4.21 **Risk assessment and risk management**

The identification and effective management of clinical risk is key to the provision of safe care and within the Adult Mental Health services the FACE risk assessment tool is used. As the risk assessment will inform care planning and decisions around leave and discharge planning it must be current and reflective of the patients’ presentation taking into account both past and present risks.

For all patients the risk assessment will be reviewed and updated as follows as a minimum:

- At admission.
- Weekly for all acute patients during the first month of their admission then monthly thereafter.
• Prior to any periods of leave.
• Following periods of leave.
• Prior to discharge.
• Following any significant change to the patients' mental state, or social circumstances.
• In the event of any new and significant information coming to light.

When completing the risk assessment it is important that all sources of information are identified.

Where a current risk has been identified a risk management care plan is to be put in place.

The FACE risk assessment provides clinicians with a range of modules and for patients with a dual diagnosis the decision as to which module to use will be based on the patients' primary presenting need.

4.22 Frequency of medical reviews by the patients Consultant Psychiatrist

The frequency of reviews by the patients Consultant Psychiatrist will be determined by each patients clinical presentation but as a minimum will be undertaken no less than;

• Weekly on the acute admission wards.
• Twice weekly on the Psychiatric intensive care wards
• Every two months on the Rehabilitation and Recovery wards.
• Every two weeks on Coral Lodge.

These times are stated as a minimum and it is acknowledged that there will be occasion when the clinical presentation of the patient requires more frequent medical reviews to be undertaken.

4.23 Retrospective entries

Retrospective entries should not be routinely made in patients clinical records as it is important that they provide a contemporaneous and chronological record. However if circumstances arise whereby a retrospective entry can not be avoided the entry must be made within 24 hours of the incident occurring and staff must:

• Record at the start of the entry that it is retrospective.
• Clearly record the date and time of the patient contact/ incident to which the entry refers.
• Provide an explanation as to why a retrospective entry has been made.
4.24 Recording of information provided to patients and their carer

The provision of written information to patients and their carers helps to inform their decision making so it is important that they are provided with up to date and relevant information. When an information leaflet is given to a patient and, or their carer it is to be recorded in the patients clinical record and a note made of the leaflet number/reference number. This will enable the service to track the leaflet should there ever be a query raised around it at some point in the future.

4.25 Recording of Safeguarding Children information

It is important that staff identify any children that a patient may have parental responsibly for or access to. This is to be documented on the health and social needs assessment and any risks posed taken into account on the clinical risk assessment and in the case of identified risk a risk management plan is to be put in place.

In addition to this where there is regular contact with a child this needs to be taken into account in the planning of the patients care, with particular attention to:

The arrangements for children to safely visit whilst the patient is receiving a period of inpatient care. (staff should refer to the Trust Policy on the visiting of patients on the inpatient areas ).

- A care plan is to be put in place to provide guidance to staff around the arrangements for when a child visits.
- Any increased risk to the child if the patient is being considered for leave from the ward.
- Any increased risks/ required support when plans are being put in place for the discharge of the patient.

Due to the sensitive nature of the information which is shared between agencies around safeguarding children it is important that any entries made in the patients clinical record relating to safeguarding investigations or case conferences are very clearly marked as highly confidential and sensitive

4.26 Recording of safeguarding adults information

With regards to clinical record keeping and safeguarding adults it is essential that staff:

- Maintain contemporaneous records of all observations, actions and discussions. It is important that all records are based on factual observation and not opinion.
- Develop a care plan in conjunction with any other services involved in the investigation to address any concerns and immediate risks to the vulnerable adult or others.
• The care plan should clearly state what the risks are and clarify who can visit and any specific arrangements needed to safely facilitate the visit.

4.27 Recording of patient related incidents

If an incident occurs which involves more than one patient an entry relating to the incident is to be made in each of the patients clinical records. However whilst it is important that the service is able to track back as to which patients were involved for confidentiality reasons staff should only use initials and not the full name of the other patient when making each of the entries. The full names of any other patients involved in the incident are to be kept in on a separate sheet for future cross referencing purposes.

When a patient related incident occurs an IR1 will also need to be completed and staff must give a clear and factual account of the incident but not use any patient identifiably information in the main text. Therefore if more than one patient was involved in the incident staff should record them as the victim, the aggressor or patient A and patient B. Names and initials are not to be used. An IR1 is a legal document so staff need to use appropriate terminology.

4.28 Clinical Record Audit Process within the Adult Mental Health Inpatient services

In addition to participating in the Trust annual clinical record audit the Adult Mental Health Inpatient services have the following ongoing system of audit in place.

Each week the ward Sister / Charge Nurse will complete an audit on 5 sets of clinical records ( 2 on the PICUs ). The results of these audits are reported to the Modern Matron each week and the Modern Matron collates these results into a monthly report for discussion at the Senior Managers meeting.

4.29 What can constitute poor record keeping

When making entries in patients clinical records staff must:

**Not make inappropriate comments**

Staff must remember that any entry they make in respect of a patient can be viewed by the patient and in some circumstances submitted as evidence in court.

**Not base the entry on their opinion**

Entries within clinical records are to be factual

**Not use abbreviations**

The use of abbreviations in clinical records can make it difficult for the patient to fully interpret what the entry means in relation to their care and treatment. In addition to this even for clinicians who are reading the records abbreviations can mean different things dependent on the clinical area.

**Not make assumptions**
It is important that staff only record what they have actually witnessed and don’t base their entry in the clinical records on their own assumption as to what has taken place.

**Avoid the use of meaningless or vague statements**

Statements such as “patient appears anxious” should not be used as it doesn’t tell the reader anything. Instead staff should record exactly how the patient is presenting i.e. “patient has been pacing the ward, wringing their hands, and seeking reassurance form staff that they will get better.”

4.30 Completing and Entering Assessment tools onto the electronic patient record.

Assessment tools are used as a way to both identify areas that a patient may need to work on in relation to their recovery and to measure progress. They should form part of the patients agreed plan of care, and once completed the outcome is to be discussed with the patient, their plan of care amended accordingly, and agreement reached as to when the assessment tool will be revisited.

Using these tools as a one of without discussing the outcome with the patient or following it through serves no benefit to the patient.

Completed assessment tools should be scanned into the patients’ electronic clinical record.

4.31 Process for introducing new documentation or changing existing clinical record documents.

Work has been undertaken within the Adult Acute Mental Health Inpatient services to standardise the clinical documentation across the three localities. This has been done for consistency purposes and to enable the monitoring of record keeping standards through audit.

In order to maintain this consistency if any of the agreed documentation needs to be amended or new documentation introduced it is to be forwarded to the locality Matron who will then take the request to the weekly Senior Managers meeting for consideration.

If the change /new documentation is agreed it will then be emailed out to the ward managers for implementation.

4.32 Documentation relating to complaints made by or on behalf of patients

Any documentation relating a complaint made by or on behalf of a patient does not form any part of their clinical records and therefore is not to be stored as part of the patients clinical records. All complaint investigations are to be submitted to the Trust complaints manager who will hold them on a central file.