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| **DOCUMENT TITLE:** | **Record Keeping Protocol** |
| **CATEGORY:** | Governance and Quality |
| **LAST REVISED:** | February 2023 |
| **VERSION:** | V2.1 |
| **DUE FOR REVISION:** | February 2024 |
| **OWNED BY:** | Head of Governance and Assurance - Syncora |
| **RELATED DOCUMENTS:** | NMC Code GMC Code |

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| **OUR PRINCIPLES:** | With passion and excellence, Delphi makes a  difference to people’s lives by providing innovative and specialist addiction services that lead the way from dependence to freedom. |
| **OUR VALUES:** | We all commit to and care about: going one step further with our clients; our wellbeing as individuals and as teams; and improving and strengthening ourselves and our organisation. |

# Introduction

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| NMC Code | The **NMC & GMC Code** has been adopted by Delphi Medical Consultants and Delphi Medical Ltd as a baseline for the record keeping standards that Delphi staff must uphold.  All staff must follow the principle of record keeping whether they are providing in-direct or direct care to individuals, groups or communities or bringing their professional knowledge to bear on practice in other roles, such as leadership, education, or research. The principle set out can be applied in a range of different settings and are not negotiable or discretionary.  Delphi staff members are responsible for exercising professional judgement and are accountable for individual record keeping.  The Code is useful for everyone who cares about good care and can be seen as a way of reinforcing professionalism. The Code contains a series of statements regarding record keeping that taken together signify what good practice looks like. |
| Statement | Delphi Medical is committed to the principle of continuous improvement with the purpose of achieving high standards in record keeping which evidence excellence in client care and professional decision making. |

**Principle**

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| Record Keeping from a litigation and regulatory perspective | Keep clear and accurate records relevant to your practice.  This applies to the records that are relevant to your work; it includes but is not limited to patient records.  To achieve this, you must:   1. Complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event 2. Identify any risks or problems that have arisen, and the steps taken to deal with them, so that colleagues who use the records have all the information they need 3. Complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements 4. Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation 5. Take all steps to make sure that all records are kept securely 6. Collect, treat and store all data and research findings appropriately |
| Record Keeping from a litigation and regulatory perspective  Purpose of medical records | Medical records include any electronic or paper records and also include email/text/WhatsApp messages, MDT minutes, etc.   1. Part of your duty of care to your patient. 2. For patient care. |

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| Record keeping must be  Wish list | 1. To make life easier for your colleagues. 2. For your benefit – best source of evidence of the care provided. 3. Clear, legible, accurate, professional. 4. Concise/detailed - proportionality. 5. Corrections: do not delete – cross through, leaving underlying words legible. Add corrected entry alongside it. Sign, date and time the amendment – with an explanation for it if appropriate. 6. Additions: Make additional note – signed, dated and timed, with an explanation of why it was not made contemporaneously. 7. Be particularly careful amending consent forms. 8. Electronic records: audit trail. 9. Beware proforma/drop downs. 10. Check notes written by others on your behalf. 11. Date and time patient seen/records written. 12. Name of clinician – printed – with signature. 13. Who else was present –   partner/relative/staff?   1. Review of previous records/referral – salient points. 2. Full history – including relevant negatives, particularly red flag symptoms. 3. Examination – nature and purpose of exam and purpose of examination explained to patient, patient agreed to examination. 4. Reason for examination? |

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| Consent | 1. Examination findings including relevant negatives (especially red flags). 2. Discussion with patient of findings, investigations required/results of investigations. 3. Diagnosis including differential diagnosis and reasons for excluding. 4. Discussions with any colleagues/seniors. 5. Management/treatment options including consent process. 6. Document advice given and any specific concerns/wishes/any refusal of treatment. 7. If the patient refuses your advice, document your explanation of the possible consequences, and the information given to the patient about what to do if their condition worsens or does not improve. 8. If you make a referral you should make the degree of urgency clear– a copy of the referral to be given to patient, 9. Follow-up or safety netting. 10. Information given to patient orally or in writing? 11. Information repeated back to you by patient. 12. Risks and benefits/pros and cons of all options including doing nothing. 13. Ideally patient should go away and think about it. 14. If you agree to go ahead without   that breathing space – document your reasons. |

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|  | 1. When they return for treatment – check and document that consent remains valid. 2. Any change in circumstances or request for information will require consent re-visiting to confirm agreement. |

# Appendix 1 – HMPs

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Blank Delphi Consent Form - B Ha

Blank Delphi Consent Form - Mch

Blank Delphi Consent Form -Gart

Blank Delphi Consent Form -Wym

# Appendix 2 – Blackpool

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Confidentiality & consent.pdf

GP consent to share information.docx