**Clinical record keeping**

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **1** | **Record-keeping complies with good practice and GMC guidance** | | | |
| All records are accurate, legible, unambiguous, signed, dated and timed. |  |  |  |
| Where records are not written contemporaneously, this is clearly documented with reasons where necessary. |  |  |
| IT log-ins are secure to ensure confidentiality is maintained and audit trails are accurate. |  |  |
| Information is recorded consistently and appropriately to facilitate risk alerts *(e.g. known allergy, contraindications).* |  |  |
| If records are amended or deleted, the reason for this is clear and transparent and the audit trail maintains a record of deleted information. |  |  |
| If records are later considered to be inaccurate, a note is appended to reflect this which shows the reason, along with the date, time and author of the entry; the original record should not be changed. |  |  |
| There are policies in relation to confidentiality and appropriate use of records that all staff are required to comply with. |  |  |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **2** | **Records are created for every patient consultation** | | | |
| If the record is unavailable on a house visit, the consultation is documented and the patient record updated as soon as possible thereafter. |  |  |  |
| The system allows the clinician to clearly note the nature of the consultation *(e.g. house visit, telephone consultations).* |  |  |
| Advice to patients given by telephone is recorded within the patient record. |  |  |
| Clinically relevant third party encounters are recorded within the medical record, including when correspondence is received from a third part. |  |  |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **3** | **Records are sufficient to provide insight into diagnosis, rationale, management and follow up** | | | |
| The record includes details of information provided by the patient, in particular in relation to “red flags”. |  |  |  |
| The record includes details of any observations and clinical findings, whether significant or not. |  |  |
| The record includes details of any decisions made and any instructions or advice given to the patient, including medications prescribed and side-effects discussed. |  |  |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **4** | **Records are sufficient to provide evidence of patient consent in relation to treatment planning** | | | |
| Any discussions in relation to consent for a proposed treatment are fully documented in the patient record *(see Consent checklist for further details)*. |  |  |  |
| Concerns or wishes the patient has in relation to proposed treatment are fully documented. |  |  |
| Any determinations in relation to capacity are recorded. |  |  |
| Any best interests decisions made for patients lacking capacity are documented, including details of factors and individuals involved in making these decisions. |  |  |
| Chaperones are offered if appropriate and details documented within the consultation. |  |  |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **5** | **Patient results and letters are recorded effectively** | | | |
| Results received are evident and results accessible within the records. |  |  |  |
| Actions taken in relation to results are documented, with rationale where necessary. |  |  |
| Urgent results notified by telephone are clearly documented in the patient’s record. |  |  |
| There is a system in place to ensure any required actions are implemented and documented as appropriate. |  |  |
| There is a system to ensure actions associated with results, hospital letters and referrals are tracked and actions taken. |  |  |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **6** | **Referral to other healthcare professionals is documented** | | | |
| The reason for the referral is clear. |  |  |  |
| Patient consent to referral is documented. |  |  |
| Appropriate information is included in the referral including urgency level. |  |  |
| A copy of the referral is documented within the patient record. |  |  |

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|  | **Action Points** | **Yes** | **No** | **Action Required** |
| **7** | **There is an incident reporting system in place to record problems encountered in relation to record-keeping** | | | |
| Misfiles are identified and rectified as appropriate. |  |  |  |
| Records access is audited to confirm appropriate access to records. |  |  |
| Significant issues with record keeping should be dealt with as a significant event. |  |  |
| Any breaches of record keeping policies should be handled appropriately. |  |  |