**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. |[ ] [ ]   |