Clinical Record keeping Policy and procedures

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• NHS Walsall records Management Policy 2010  
• NHSLA Risk Management Scheme for trusts  
• Information governance Tool kit  
• Generic Medical record keeping Standards (Royal college of Physicians 2007)  
• Guidelines on Patient records (the Society of Chiropodists and podiatrists)  
• Records management NHS Code of Practice  
• CQC Essential Standards of Quality and Safety  
• Verification of Adult Death Policy. |
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Changes since previous version:
- Addition of legal requirements
- Formatting
- Addition of references and further reading
- Addition of reference to CQC
- Changes to responsibilities
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1.0 Introduction

1.1 Purpose
This policy has been drawn up to guide NHS Walsall Community health’s clinical staff on the process of clinical record keeping and the underlying principles of accurate and safe record keeping.

Clinical records have three main functions:

- Communication
- Quality of care
- Medico legal purposes

Clinical records are central to the provision of safe and effective clinical care. They provide a description of the service user’s condition at a specific point in time for assessments, planned care or treatment, what care or treatment that has been provided and the evaluation of the outcome of care or treatment. In addition they are a tool to record the advice given to service users, and the service user’s wishes regarding their care or treatment (consent). Clinical records should be sufficiently comprehensive for a colleague to have a clear picture of a service user’s condition, treatment and wishes without a verbal handover. They are a vital communication tool for high quality professional practice.

Clinical records are often the only way to quantify the quality of care a service user has received. Records are used for audit to assess quality against predetermined standards of care such as national guidelines, policy or professional standards. By auditing the outcome of care or treatment it is possible to assess the clinical effectiveness and cost effectiveness of that care or treatment. Records are also used for research purposes (with consent).

There is also a legal requirement to keep records. Records provide a description of events and care provided to a service user. Where there is a dispute about events or care, the courts usually assume that if it is not written down it did not happen. The nearer the time an event is recorded, the more accurate the record of the event is considered. Therefore the PCT recommends records are written within 24 hours. Records may be requested by a court of law for either civil (usually associated with negligence claims) or criminal cases, or by a coroner. A coroner must be informed if someone dies in suspicious circumstances, suddenly of an unknown cause or a violent death (see verification of Adult death Policy).

The policy will outline the Organisational requirements with regards to record keeping standards and the audit of clinical notes. Although this is an organisational requirement our standards are not exhaustive and each service must expand on the audit with a service specific audit on the quality and content of the entries in the notes.

Record keeping is an essential requirement as part of the new Care Quality Commission Essential Standards of Quality and Safety. Regulation 20, Outcome
21 requires that records are fit for purpose and accurate and this policy will guide staff in ensuring that the Trust meets these requirements.

This policy must be read in conjunction with the most recent version of NHS Walsall Records Management policy.

1.2 Scope

To ensure good standards of record keeping across the PCT for all clinical staff, consistent with professional guidance.

• Provide guidance for staff (who may or may not belong to a professional organisation) on how to record clinical care.
• Promote a high standard of record keeping which demonstrates:
  o assessment
  o planned care or treatment
  o actions taken or care given
  o evaluation of interventions
  o Evidence of communication with clients, families/carers and colleagues
  o Service user consent and involvement in every stage of their care planning

The policy applies to paper and electronic Health Records.

The policy defines the process for clinical audit of health records and monitoring/action planning arrangements.

1.3 Legal and Professional Obligations

The Public Records Act 1958 sections 3 (1) – (2) state that all NHS records are public records (DH, 2006). It is stated within the Public Records Act 1958 that all NHS organisations have a duty to provide systems which support the safe keeping and eventual disposal of all types of records (DH, 2006).

The Organisation has the added responsibility to adhere to and comply with legal and also professional obligations as set out in the Records Management: NHS Code of Practice (DH, 2006), in particular:

• The Public Records Act 1958
• The Data Protection Act 1998
• The Freedom of Information Act 2000
• The Common Law Duty of Confidentiality
• The NHS Confidentiality Code of Practice
• Access to Health Records Act 1990

Any newly produced records management legislation must also be considered and adhered to if appropriate.

All staff must report any incidents regarding records (including the loss and theft of records). This applies to both electronic and paper records. Staff must ensure that all incidents are reported in line with the NHS Walsall Community Health Incident and Hazard reporting Policy.

2. Responsibilities

2.1 Chief Executive

- Chief executive has responsibility to provide adequate resources in order to ensure the implementation of this policy.

2.2 Heads of Service

- Ensure that arrangements are made for all services health records to be monitored through the annual Record Keeping clinical audit as outlined in this policy.
- Ensure that all services have action plans in place following the audit and that agreed changes are being made
- Ensure that all clinical team leads are aware of record keeping standards and the need to follow this policy.
- Report to Quality sub group.

2.3 Clinical Team Leads

- Monitor record keeping standards in their own service throughout the year
- Offer appropriate support and supervision to staff
- Ensure staff attend all relevant training
- Draw up action plans following the annual record keeping cycle and monitor actions throughout the year to ensure changes are made for the next cycle
- Ensure that an appropriate member of staff is attending all project group meetings
o Keep on top of new national, professional and local standards
o Ensure that the Trust record keeping audit is completed for their service annually
o Ensure that action plans are implemented following the annual audit.

2.4 Record Keeping group

o To monitor departmental record keeping audit action plans
o To receive reports from departmental project groups of progress on implementation of action plans
o To facilitate and oversee the annual Record Keeping Clinical Audit
o To ensure that staff receive awareness and training pertaining to the Record Keeping Clinical Audit
o To promote the publication of Record Keeping Clinical Audit findings and encourage translation of those findings into practice
o To agree the Clinical record keeping policy and procedure
o To identify new Record Keeping standards
o To submit reports to the NHS Walsall Information Governance Steering Group and the Walsall Community Health Risk Sub Group
o To highlight and share best practice in Record Keeping
o Keep up to date with professional standards

2.5 Task groups

o Monitor action plans
o Ensure all services are meeting deadlines
o Monitor non-compliance to standards
o Monitor those services who fail to complete the audit/action plans
o Provide a representative to report to audit and effectiveness group and record keeping group.

2.6 Audit and Effectiveness group

o Ensure that a Trust wide Record Keeping Clinical Audit is completed annually
o Take appropriate action for those who do not complete and escalate actions to quality sub group.

2.7 Professional Development Unit

o Provide up to date record keeping Training
o Advise teams on best practice and share best practice.

2.8 Governance Department
o Analyse all returned clinical audit data on a Walsall Community Health wide basis.
o Monitor, report and disseminate the results
o lead the record keeping project group
o Support teams through one to ones and in meetings to make and implement action plans
o Advise teams on best practice and share best practice through meetings, policies, training, alerts and support sessions.
o Support teams with the completion of the annual audit
o lead the record keeping project group

2.9 All staff

o Keep up to date with all record keeping standards and best practice
o Keep up to date on training
o Recognise own areas of difficulty and seek support
o Ensure that all standards and best practice are followed
o Support clinical team leaders as necessary with the annual Clinical Record Keeping Audit and action planning
o All staff have a responsibility to follow this policy and the standards laid out in the policy with regards to record keeping.
o This policy should be followed in addition to individual professional standards and legal obligations as outlined in section 1.3.

3. Definitions

3.1 Health Record
A Health Record as defined in section 68 (2) Data Protection Act 1998:
‘(a) consists of any information relating to the physical or mental health or condition of an individual’ and
‘(b) Has been made by or on behalf of a health professional in connection with the care of that individual’

All entries in the health records including external agency contracts are included.

3.2 hyper-sensitivity
This refers to known allergies or allergic reactions and can be defined as:
“allergic to a substance to which persons do not normally react.”
4. **Record Keeping Standards**

Please note that below are quotations from specific guidance so where it refers to medical records this would be referring to healthcare records for the purposes of this policy.

Please see footnote for reference. These are aligned with the audit proformas (see appendix 3)

4.1 Ink colour \(^1\)

- all notes should be written in blue or black permanent ink

4.2 Date and time \(^1\) \(^2\) \(^3\)

- this will indicate when the service user interaction occurred
- dates should include the day, the month and the year, in that order
- times should either be written in 24 hour clock format or clearly state ‘am’ or ‘pm’

4.3 Author of the entry should be easily identifiable, \(^1\) \(^2\)

- this will be done by ensuring that all entries have the following
  - the signature of the author
  - the printed name
  - the designation of the author

- all of this should be easily read and identifiable

4.4 The note should be legible and readable \(^1\)

4.5 Amendments \(^2\) \(^3\)

- All amendments should be clearly crossed through and countersigned by the author

4.6 Signature List \(^2\)

\(^1\) Risk Management Scheme for Trusts (NHSLA, 2005/06)
\(^2\) Information Governance Toolkit
\(^3\) Generic Medical Record Keeping Standards (Royal College of Physicians 2007)
• Copies of signatures of all healthcare professionals who make entries in the record should be retained by the PCT for the same period as the health record, together with the professional's registration number. The register of signatures should be reviewed and updated on a specified regular basis (at least annually).

4.7 Contemporaneous

Entries to the medical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded.

4.8 Chronological order

• Documentation within the medical record should reflect the continuum of service user care and should be viewable in chronological order.

4.9 Identification of the service user

• The front page should include the following
  o Service user date of birth
  o Service user forename
  o Service user surname

• All Pages should include the NHS number

4.10 Blank spaces should all be scored through and initialled by the author

4.11 Abbreviations should only be used if they follow an approved list agreed by the Integrated Governance Sub Group

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1 Risk Management Scheme for Trusts (NHSLA, 2005/06)
2 Information Governance Toolkit
3 Generic Medical Record Keeping Standards (Royal College of Physicians 2007)
4 Guidelines on Patient Records (the Society of Chiropodists and Podiatrists)
5 NPSA alert NHS Numbers Ref: NPSA/2008/SPN001

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4.12 Records will be stored and bound so that loss of documents and traces are minimised \(^{(1)}\)

4.13 Storage arrangements allow retrieval on a 24 hour/7 day arrangement \(^{(1)}\)

4.14 There is a system for measuring efficiency in the recovery of records for in-patients and out-patients. \(^{(1)}\)

4.15 The patient record contains a designated place for the recording of hypersensitivity (allergic) reactions and other information relevant to all health care professionals. \(^{(1)}\)

4.16 The patient record contains clear instructions regarding filing of documents. \(^{(1)}\)

4.17 Operation notes and other key procedures (such as invasive diagnostic procedures) are readily identifiable. \(^{(1)}\)

4.18 Machine produced recordings are securely stored and mounted. \(^{(1)}\)

4.19 Handover information should be recorded using a standardised structure. \(^{(3)}\)

4.20 An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four days for acute medical care or seven days for long-stay continuing care, the next entry should explain why. \(^{(3)}\)

4.21 Advance directives and consent status statements must be clearly recorded in the medical record \(^{(3)}\)

4.22 There is a mechanism for identifying records that must not be destroyed \(^{(1)}\)

4.23 Notes will include the following \(^{(1)}\)
   - Assessment
   - Diagnosis
   - Treatment plan
   - Discharge arrangements
   - Frequency of entries
4.24 See records Management policy and NHS code of practice for Retention and disposal Schedules (1-6)

5. Clinical record Keeping Audit

As an organisation we are required to annually audit the record keeping practices of clinical services to give assurance for Information Governance and Risk Management.

The record keeping audit is comprised of two parts:
- Part 1 Patient record entries (paper and electronic)
- Part 2 Storage of records

The audit must be completed on an annual basis by 100% of services that creates Health Records within Walsall Community Health. There will be an organisational report written by the Governance department and all services must report on and action plan against their own services individually.

For the purposes of the audit, only corporate-held records should be included. This means that only records held by and used by trust staff are required for this audit.

See appendix 3 for audit proforma and inclusion criteria.

5.1 Aim of the audit

The purpose of the record keeping audit is to:-
- Establish a Walsall Community Health wide approach to record keeping as this enables the sharing of best practice across all service areas.
- Develop a multi-professional & multi-agency generic audit tool to maintain minimum record keeping standards.

5.2 Method for the audit

Record Keeping Audit Project Team:
- Each group member will provide a complete list of all services within their business unit including a named person as the Departmental Project Lead.

1 Risk Management Scheme for Trusts (NHSLA, 2005/06)
2 Generic Medical Record Keeping Standards (Royal College of Physicians 2007)
3 NHS Walsall Records management Policy 2010
4 Records management NHS Code of Practice (DH, 2006)
• An ID number will be attached to each service and sent to all project leads which will need to be included on all returns to the Governance Department.

Departmental Project Lead:

• Assign a project team for the audit; this should include representation from all relevant members of staff for example clinicians, administrators and the manager.
• Agree the population for the audit. For example the specialist areas can all be grouped as one set (population) of notes or individual sets of notes. The storage audit may involve various sites.
• Agree the method for sample selection - See Appendix 1. **Fill out form 1 - Inclusion criteria and sampling in the electronic spreadsheet.**
• If you need help from Information Services in obtaining your sample, please make sure that you contact them before the audit starts in line with their information requesting procedures.
• Agree who is going to be responsible for data collection. This may involve several people if you have multiple sites.
• Ensure that the method in this protocol is understood and followed by all staff involved in the audit.
• Agree the timeframe for data collection.
• Retrieve the health records in line with the agreed sample selection.
• **Complete Form 2.1 – Paper Health Records** for each paper health record in the required sample or **Form 2.2 Electronic Health Records** if applicable.
• **Complete form 3 Storage Audit Proforma** for each premise where paper health records are kept. (If the storage arrangements are consistent at each site then only one proforma needs to be completed)
• **Using the electronic template (attachment),** collate the data from the record entries proformas.
• If you have multiple storage proformas, collate the data.
• **Complete all other forms on the electronic spreadsheet and email to the Governance Department.** Please note that original forms need to be retained by project groups for future reference and for action planning purposes. **Ensure that you save the electronic spreadsheet and send a copy to the Governance Department.**
• Discuss and analyse the results for each audit and formulate a draft action plan, ensuring that timescales and responsibilities have been assigned to each action.
• **Send the results and action planning template (form 4) to the Governance Department**
• **Write up the audit report.** Reports should be written in the agreed format as outlined below(see report writing template for full outline)
• Review progress made against each action plan (form 5) on a regular basis. Ideally actions should be fully implemented before re-auditing. Progress against action plans should be reported to the Governance Department.
• Include these audits as part of your clinical audit plan

5.3 Report writing format outline

After completing the Trust Wide Record Keeping audit there is an organisational overview report written up by the Governance Department. All services must also write up their own report for their individual service, focussing on their own results. Both reports should follow the Trust’s report writing template which is outlined below, the full document can be found on the Intranet.

5.3.1 What to include

Front page
The first page of the template is set to a standard format for a title page.
  □ Project Title
  □ Service/Department Name – Replace this text with your services details
  □ Project Lead Name – Replace this text with the name of the person/people leading on the project.
  □ Project start date
  □ Final report date
  □ Date action plan agreed - When the action plan was agreed
  □ Date of proposed re-audit - When the re-audit is planned

Contents table
If the report is very lengthy it may beneficial to include a contents table, however this may not be needed if the report is less than 5 pages long.

Sub-Headings for Inclusion
The following sub-headings should make up the body of your project report.

Audit Project Team Membership
This should include the identified lead for the project along with other team members working on the project containing their name, job description, telephone number and email. Also include the assigned facilitator from the clinical audit department if assistance was given with the project.

Background
Include details of why the audit was undertaken. Try to answer the following questions in this section:
What has prompted this project? How was this topic selected? Why is this topic important? Why do you want to do this project?

**Summary of previous audit and Progress against actions of previous audit (if applicable)**

Summarise details of the previous audit if applicable detailing the time period this was undertaken. Use the table to record any progress against actions of the previous audit (if applicable) in the next section. If no previous cycle then delete this heading.

**Aim**

This section should include your main aim or what you are trying to achieve. This may be expressed as *to improve / to ensure / to enhance / to increase.*

**Objectives**

List all aspects be examined and measured.

**Standards and Criteria**

Criteria are definable measures of healthcare which describe quality and can be used to assess the quality of healthcare. Standards are statements about what should be expected in a specific aspect of care – the expected level of the quality of care. Both standards and criteria should be evidence-based and explicit.

Standards and criteria are listed above and are included as part of the audit proforma (attached as appendices).

**Population**

The population will be how many sets of notes you chose your sample from in the given time period of one year.

**Sample**

If you have taken a sample from your entire population then include an explanation of how this sample was selected and what your final sample size is. The sample should be no less that 20, unless your entire population is less than 20.

**Method**

To ensure that you have a comprehensive account of the method used for your project you may wish to answer the following questions:

What data was collected? 
Wote any methods used to engage other staff in the service area? 
How was the data collected? 
Where was it collected from? 
Who collected it? 
How was the data analysed? 
Have ethical and confidentiality issues been considered?
Make this section as detailed as possible. The principle idea being that anyone could repeat the methodology of the project just by reading this report. The simplest way to do this is by bullet pointing each process of the project.

**Ethical Considerations**
Include details of ethics approval, confidentiality statements, and Caldicott considerations if applicable to your project.

**Findings**
If the report is lengthy include a summary of the main findings and issues raised as result of the project.

**Results**
Results are displayed per question and per service in the overall report.

Individual reports should display results per question. Judgement should be used on how to display the results, graphs are preferred but this is subject to the data, the most appropriate method should be used.

**Action Plan**
It is important that you include your action plan in the final report. This may be displayed in any format; however a table is often the simplest method. The Report Writing Template includes an action plan that can be filled in (see appendix 5), however this shouldn’t be viewed as a form filling exercise. Use the form as a guide but ensure that anything added is meaningful and is planned on being implemented.

The action planning table within the template includes a “Barrier to change” column. This is so that for each finding, barriers can be considered which may stop an action from being implemented. It’s good to consider these potential barriers at this stage so as not to be stopped by them.

The “Risk” column is provided so as to assess the risk to the department if an action is not carried out.

**Appendices**
The following should be considered to be included as appendices to the report creating a new page for each one:
- Data collection tool
- Details of the tool pilot (if applicable)
- Minutes of audit project team meetings (if applicable)
- Details of approval gained from ethics committees (if applicable)

**5.3.2 Formatting**
The Clinical Audit Report Template can be used as a pre-formatted document to add the report to.
The first page has been set with font sizes suitable for a project title and can be replaced by highlighting the existing text and typing over with the actual name of your project. This can also be performed for the service and project lead name.

The rest of the report mainly consists of sub-headings that have been set for “Heading 1” style. If these heading names are not applicable or do not reflect your project they can be replaced or removed as appropriate.

It is good practice to include headers and footers in a report that has several pages. The template includes a header on each page except the first page, which contains the filename. You may wish to use the project title instead. The footer is set to display the number of pages. This should automatically change as you add more pages to the document.

Ensure that you check the formatting of the template before sending out the final copy to your team. Although the template has been designed to make the task of report writing easier for you, it’s inevitable that the formatting will be effected after you’ve added more information.

If you wish to develop your own format then it is recommended that all project reports follow a similar format. This retains consistency, enables project reports to be identified from other documents and makes it easier for you next time you produce a report.

The NHS has standards for professional documents which can be applied to all documentation so that information is displayed in a professional manner. The NHS Identity website (www.nhsidentity.nhs.uk) contains detailed guidelines on how to use the NHS logo and appropriate fonts to use.

5.4 Action planning and review

All services must complete an action plan following the Record Keeping Audit. The Template in Appendix 4 can be used but is not necessary as long as all relevant headings are covered.

All action plans must highlight areas for concern following the audit, actions for improvement and timescales for improvement.

The action plans will be monitored via the record keeping group and Task groups and any issues escalated via these groups to the Quality Sub group and the Integrated Governance Sub Group.
It is the responsibility of each individual service to ensure that action plans are implemented. Any high risk issues must be added to the service specific risk register and escalated via the risk sub group to the Integrated Governance sub group where necessary.

Action plans will be reviewed every quarter by the Project lead for each service.

6. Training

All staff should attend any relevant training as identified by their manager and in line with NHS Walsall Community Health’s Training Needs Analysis.

7. Monitoring

This policy will be reviewed annually by the Clinical Governance Team and will be monitored via the record keeping Project group, the Audit and Effectiveness group and the Clinical governance Task groups. The policy will be reviewed sooner if necessary in order to keep up with any new legislation or guidelines.

The organisation undertakes an annual clinical record keeping audit. Action plans are made at service level following this and monitored via Clinical Governance Task groups and Quality Sub group. Proactive changes are made from these action plans and this is then monitored via the 12 monthly re-audit.

The effectiveness of the policy is reviewed on an ongoing basis at the record keeping project group but on a 12 monthly basis it will be reviewed for effectiveness after the clinical record keeping audit has taken place.

8. References


2. DH, (2006); Records Management: Code of Practice. Department of Health: London

3. NHSLA Risk management Scheme for Trusts http://www.nhsla.com/home.htm


5. NPSA http://www.npsa.nhs.uk/
Appendix 1: Sample Sizing

Inclusion Criteria

For this audit the population is defined as one of the following

a) All health records for patients / service users discharged from the designated service area for the period from the month following the last audited month to the last complete month.

b) All health records for patients / service users seen by clinical staff within the designated service area for the period from the month following the last audited month to the last complete month.

If there is no previous audit cycle, then the last 12 complete months should be used as a timeframe.

Exceptions: None

Note that the method you choose for calculating the population should remain the same for all subsequent cycles.

Methods for Sampling Data

The inclusion criteria (above) specify which cases are to be included in the record keeping audit (the population). Once you have determined the population, you need to consider how many cases to examine with the data collection tool. This is done by sampling the population.

We would suggest a sample size of 20 cases or the whole population (whichever is smaller). However if your population size is a considerably large number and the service is divided into numerous sites across the borough then you may wish to increase your sample size to a more representative figure (Option 5 below may be most the appropriate method for this).

Note that the method you choose for sampling the population should remain the same for all subsequent cycles

For the purposes of this audit protocol, the statistical significance of the sample is not calculated. This audit employs non-statistical sampling methods, using samples for the purpose of obtaining information that need not be attributed to the entire population with measured reliability.

As the process of record-keeping (and not the population characteristics) is being measured, large amounts of data collection to establish statistical significance are not required.

Note that when identifying case notes that are retrieved from health records libraries, use the sampling methods to identify additional cases, as all records may not be available

1: Entire Population Sampling

Use this method where the identified population is less than 20 cases.
All of the cases within the population should be assessed using the data collection tool. Do not use any of the other sampling methods below if the population numbers less than 20 cases.

2: Random Sampling

*Use this method where each of the cases in the population is or can be easily numbered. Every case in the population then has an equal chance of being selected.*

A useful site is [http://www.randomizer.org/form.htm](http://www.randomizer.org/form.htm) which has an easy to use random number generator.

A random sample is selected by matching random numbers generated by a computer or selected from a random number table with, for example, the document number. With this method, every item in the population has the same probability of being selected as every other item in the population.

3: Interval Sampling

*Use this where items are not or cannot be easily numbered.*

A method by which items are selected from the population in such a way that there is a uniform interval between sample items. The first item in the series must be chosen at random and then every "n"th item is chosen to result in the desired sample size.

4: Consecutive Sampling

*Use this only where the above types of sampling are not possible*

A method by which items are selected in order – e.g. the last 20 cases, or a selection of 20 consecutive cases between two time intervals. Caution should be when using this method of sampling, as it is potentially far more susceptible to the Hawthorne effect than the other methods of sampling.*

5: Stratified sampling

*Use this method when the service provided is subdivided into further groups/teams or if the service has numerous sites and it is believed that more reliability would be achieved by sampling equally from each site/team.*

A method by which items in the population are segregated into two or more classes or strata. Each stratum is then sampled independently. The results for the several strata may be combined to give an overall figure.

---

* In essence, the Hawthorne Effect can be summarized as "Individual behaviours may be altered because they know they are being studied." In the Hawthorne experiments, an increase in worker productivity was produced by the psychological stimulus of being singled out, involved, and made to feel important.
Appendix 2: Guidance for completing Records Entry Proforma

Paper Health Records

1. Service / Contact Details

These details can be entered onto the electronic spreadsheet but it may be useful to ensure that you add the date onto the individual forms for your reference. They relate to contact details of the person completing the form and not the patient’s details.

2. Patient Identification

All responses to section 2 refer to information that can usually be found on the front page, main page and summary or key details page of the record.

3. Health Care Professional Identification

This relates to the last entry in the record

The standards that relate to these questions dictate that the signature and designation of staff is written alongside each entry made in the record and that a signature list is also held by the service.

4. Case Note Entries

This relates to the last entry in the record

The timing of entry relates to the time that the entry was made in the notes. If this was not the same as the time of contact, then the time of entry and the time of contact must be recorded in the text.

Please refer to the standards on page 5 when completing question 4.5. The entry should be made as soon as possible after the contact with the patient or reflected in the entry as to the reasons why if this is not the case.

Question 4.6 – If abbreviations are used and they also appear on an abbreviation list then tick ‘Yes’. If they are used but do not appear on an abbreviation list then tick ‘No’. If abbreviations have not been used in the entry then tick ‘None used’.

5. Records/Notes

Question 5.3, relates to each patient record as a whole. All papers within the record must be secured so that loose papers cannot fall out. Records that are constructed using plastic wallets should also follow this principle and loose papers are secured together within the wallet.

6. Key Procedures/Information

The information required for this section may not be applicable to all services.

Question 6.3 relates to any allergies of the patient.

Question 6.4 relates to an area on the record where information can be recorded which may be useful to other health care professionals and that can be quickly and easily identified.
Electronic Health Records

Complete this form if your service uses electronic health records as the main system for recording patient contact and treatment information.

The standards mirror those used for paper health records with the principle that electronic records must also contain these standards as a minimum data set.

As electronic systems may vary it cannot be assumed that the date and time of entries is always recorded and visible to the user which is why these questions are also asked.
Appendix 3: audit criteria

Form 1: Inclusion criteria and sampling

Complete details and transfer to the electronic spreadsheet to return to the Governance department via email.

Inclusion Criteria

Please choose the definition to use for defining the population:

a) All health records for patients / service users discharged by clinical staff within the designated service area for the period from the month following the last audited month to the last complete month.

b) All health records for patients / service users seen by clinical staff within the designated service area for the period from the month following the last audited month to the last complete month.

If there is no previous audit cycle, then the last 12 complete months should be used as a timeframe. Exceptions: None

Note that the method you choose for calculating the population should remain the same for all subsequent cycles.

Enter A or B _____
Number of cases in the population _____

Sampling

We would suggest a sample size of 20 cases or the whole population (whichever is smaller). However if your population size is a considerably large number and the service is divided into numerous sites across the borough then you may wish to increase your sample size to a more representative. Note that the method you choose for sampling the population should remain the same for all subsequent cycles.

Please choose the method for sampling the population: (tick one only)

- Entire population
- Random sampling
- Interval sampling
- Consecutive sampling
- Stratified sampling
## Form 2.1: Paper Health Records Entry Proforma

Complete one form for each set of paper health records in your sample. Transfer information to the Results spreadsheet and email to the Governance department.

### 1. Patient Information
1.1 Date __/__/____
1.2 Contact Name
1.3 Tel No
1.4 Department ID
1.5 Base

### 2. Patient Identification (front page / main page / summary / key details page)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(2.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>NHS Number (clearly &amp; correctly documented)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>2.2</td>
<td>Forename (clearly &amp; correctly documented)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>2.3</td>
<td>Surname (clearly &amp; correctly documented)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>2.4</td>
<td>Date of Birth (clearly &amp; correctly documented)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>2.5</td>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

### 3. Health Care Professional Identification (Last entry in the record)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(3.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Signed (identifiable signature)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>3.2</td>
<td>Printed Name</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>3.3</td>
<td>Designation of staff in record</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>3.4</td>
<td>Signature contained within signature list</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No signature list</td>
</tr>
<tr>
<td>3.5</td>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Case note Entries (Last entry in the record)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(4.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Dated (day, month, year)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.2</td>
<td>Timed (hour and minute, 24hr clock or am/pm specified)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.3</td>
<td>Legible entry (Can you read the entry?)</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.4</td>
<td>Was the entry in black or blue ink?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.5</td>
<td>Was the entry written contemporaneously?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.6</td>
<td>Are abbreviations, if used, contained within an agreed abbreviations list?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.7</td>
<td>Is this standardised abbreviations list easily accessible?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.8</td>
<td>Are blank spaces scored through?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.9</td>
<td>Are any alterations/deletions countersigned?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>4.10</td>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

### 5. Records/Notes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(5.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Do all the records in the folder belong to the correct patient?</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>5.2</td>
<td>Is the folder in a good state of repair? (e.g. no tears or excessive user of sticky tape or staples etc)</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>
5.3 Are all papers filed in the notes? (i.e. nothing loose)  
Yes [ ] No [ ] (5.3)

5.4 Is the patient’s NHS number or trust ID number on every page?  
Yes [ ] No [ ] (5.4)

5.5 Comments:  

---

6. Key procedures/information

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes [ ]</th>
<th>No [ ]</th>
<th>Not applicable to this service [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Are operation notes and other key procedures (e.g. Anaesthetic charts/operation records/ECT records) readily identifiable (e.g. Colour border/specific filing area/specific sheets)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2 Are machine produced recordings securely stored and mounted?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.3 There is a designated place for the recording of hyper-sensitivity reactions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.4 There is a designated place for the recording of other information relevant to health care professionals?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.5 Are advanced directives / consent status statements clearly recorded?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.6 Is there a standardised structure for the recording of handover information?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.7 If the patient is part of long-stay continuing care and there is no entry in the records for more than 7 days, does the next entry explain why?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.8 Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Page 28 of 37
Form 2.2: Electronic Health Records Entry Proforma

Complete one form for each electronic health record in your sample. Transfer information to the Results spreadsheet and email to the Governance department.

1.1 Date __/__/____ _________________ 1.2 Contact Name ________________________________
1.3 Tel No ________________________________
1.4 Department ID ____________________ 1.5 Base ________________________________

2. Patient identification
2.1 Is the patient NHS number recorded? Yes☐ No☐ (2.1)
2.2 Forename correctly recorded? Yes☐ No☐ (2.2)
2.3 Surname correctly recorded? Yes☐ No☐ (2.3)
2.4 Date of Birth correctly recorded? Yes☐ No☐ (2.4)
2.5 Comments

3. Author Identification
3.1 Has the author of all entries been recorded? Yes☐ No☐ (3.1)
3.2 Can the designation of the author be identified? Yes☐ No☐ (3.2)
3.3 Comments

4. Record Entries
4.1 Has the time of entries been recorded? Yes☐ No☐ (4.1)
4.2 Has the date of entries been recorded? Yes☐ No☐ (4.2)
4.3 Was the entry written contemporaneously? Yes☐ No☐ (4.3)
4.4 Are abbreviations, if used, contained within an agreed abbreviations list? Yes☐ No☐ None used☐ (4.4)
4.5 Is this standardised abbreviations list easily accessible? Yes☐ No☐ None used☐ (4.5)
4.6 Do alterations or deletions remain logged on the system so they can be reviewed if needed? Yes☐ No☐ (4.6)
4.7 Comments

5. Security
5.1 Is the record password protected? Yes☐ No☐ (5.1)
5.2 Comments
6. Other Information

6.1 There is a designated place for the recording of hyper-sensitivity reactions

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
|   |     |    | (6.1)

6.2 There is a designated place for the recording of other information relevant to health care professionals?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
|   |     |    | (6.2)

6.3 Are advanced directives / consent status statements clearly recorded?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
</table>
|   |     |    | (6.3)

6.4 Is there a standardised structure for the recording of handover information?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
</table>
|   |     |    | (6.4)

6.5 If the patient is part of long-stay continuing care and there is no entry in the records for more than 7 days, does the next entry explain why?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
</table>
|   |     |    | (6.5)

6.6 Comments
Form 3: Storage Audit Proforma

Section 1-Contact and Health Records Details

Please complete the information below for your department/service area. Transfer information to the Results spreadsheet and email to the Governance department.

1.1 Department/Service ____________________________________________________________

1.2 Base ________________________________________________________________

1.3 Name of lead person completing this assessment: ________________________________

1.4 Tel No ________________________________

1.5 Date of this audit: _____ / _____ / _____

1.6 Date of the last audit: _____ / _____ / _____ (or tick if no previous audit ☐)

To identify the records used by your service, please fill in the table below listing each type of record separately.

<table>
<thead>
<tr>
<th>Type of record (e.g. paper, electronic, patient held)</th>
<th>Number of records for this type</th>
<th>Specialities/services using these records</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

For all corporate held paper records, please fill in section 2, completing one form for each separate data store.
Form 3: Storage Audit Proforma

Section 2-Individual Record Stores for paper records

One form should be filled in for each separate data store for health records. Transfer information to the Results spreadsheet and email to the Governance department. Continue comments on a separate page if required.

Department __________________________

2. Records storage area

2.1 Is the storage area secure / lockable?   Yes□ No□ (2.1)
2.2 Is the storage area fireproof?   Yes□ No□ (2.2)
2.3 Where are these records stored (e.g. filing cabinet)? __________________________
2.4 Do you have a safe working space in this area? Yes□ No□ (2.4)
2.5 Are any paper records kept loose? (Papers not bound together and kept in a pocket or flap) Yes□ No□ (2.5)
2.6 Can the confidentiality of records be assured so that no unauthorised persons have access to or can see them? Yes□ No□ (2.6)

Authorised = Professional who the patients could reasonably expect to have access to their records, for the purposes of their care and for have given their explicit permission.

2.7 Comments (for 2.1-2.4):

3. Availability of records

3.1 Are the records routinely available during office hours (e.g. mon-fri 9am-5pm)? Yes□ No□ (3.1)
3.1a If your service delivers care to patients 24 hours a day is there 24 hour access to records? Yes□ No□ Not Applicable□ (3.1a)
3.1b If other specialities use these records are there provisions to make them available? Yes□ No□ Not Applicable□ (3.1b)
3.2 Are there provisions for emergency access when records are not routinely available? Yes□ No□ (3.2)
3.3 Comments (for 3.1-3.2):

4. Destruction and tracking and handling

4.1 Is there a mechanism for identifying which records can and cannot be destroyed? Yes□ No□ (4.1)
4.2 Do you have a tracer system when records are removed from the store? Yes□ No□ (4.2)
4.3 Are the Records Management Code of Practice retention periods adhered to? Yes□ No□ (4.3)

(See the Records Management NHS Code of Practice Part 2, Health Records Retention schedule)

4.4 Do you have documentation that contains instructions on filing/handling arrangements? Yes□ No□
4.4 Comments (for 4.1-4.3):
Form 4: Results and Action Planning Template

Date___/___/___
Dept.__________________________ Base__________________________
Name of Lead__________________________ Tel No__________________________

Use this template to plan actions as a result of clinical audit reports. The resulting action plan should be ratified and then monitored by a formal group/meeting

<table>
<thead>
<tr>
<th>Standard</th>
<th>Result</th>
<th>Main Finding</th>
<th>Risk 7</th>
<th>Action to improve</th>
<th>Person(s) or Committee(s)</th>
<th>Complete by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

7 Please assess the risk to the trust of not responding to the main finding (high/medium/low). Your full audit report should include details of the rationale for the risk score you choose.
**Appendix 6: Equality Impact Assessment tool**

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Title of the policy/guidance:</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Does the policy/guidance affect one group less or more favourably than another on the basis of:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>2 Is there any evidence that some groups are affected differently?</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>3 If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</strong></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>4 Is the impact of the policy/guidance likely to be negative? (If no, please go to question 5.)</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Can we reduce the impact by taking</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
different action?  

<table>
<thead>
<tr>
<th>5 Health inequalities</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6 Please consider the following questions relating to Human Rights Act:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will it affect a person’s right to life? No</td>
</tr>
<tr>
<td>Will someone be deprived of their liberty or have their security threatened? No</td>
</tr>
<tr>
<td>Could this result in a person being treated in a degrading or inhuman manner? No</td>
</tr>
<tr>
<td>Is there a possibility that a person will be prevented from exercising their beliefs? No</td>
</tr>
<tr>
<td>Will anyone’s private and family life be interfered with? No</td>
</tr>
</tbody>
</table>

If you have identified a potential discriminatory impact of this procedural document, please complete Impact Assessment Action Plan identifying the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Equality and Diversity Manager.

**Is further detailed impact assessment required? No**

If yes, please detail how this is to be processed and by whom

**Details (names and roles) of staff involved in this impact assessment**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Date completed</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>Caroline Townsend</td>
<td>Healthcare Governance Facilitator</td>
<td>3/3/10</td>
<td>No action required</td>
</tr>
</tbody>
</table>
## Impact Assessment Action Plan

<table>
<thead>
<tr>
<th>Issue</th>
<th>Proposed Action</th>
<th>Rationale</th>
<th>Person Responsible</th>
<th>By When</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
## Appendix 7: Procedural Document Checklist

<table>
<thead>
<tr>
<th>Standard</th>
<th>Comments (e.g. paragraph where can this be found)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the document presented in the agreed corporate style (e.g. numbered paragraphs)</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there a clear introduction?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there a definition section to explain terms used?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there evidence that consultation has taken place?</td>
<td>Yes</td>
</tr>
<tr>
<td>Has an appropriate review period been identified?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is the monitoring of compliance identified within the document?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does it state how the document will be disseminated and is this appropriate?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have arrangements been made for retrieval and archiving?</td>
<td>Yes</td>
</tr>
<tr>
<td>Are associated documents cited and referenced correctly?</td>
<td>Yes</td>
</tr>
<tr>
<td>Has the document been impact assessed and any necessary action taken as a result of this?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Append to procedural document.**

**HINT:** Many of these items should be on the Metadata page or in the first few paragraphs of the policy