Record Keeping Policy and Procedure

Approved by: Candy Cooley, Chairman
Originator: Libby Mytton, Director of Care
Date of approval: August 2016

Introduction
The Primrose at Home Service provides support for adults at the end of life in their own homes. The team work to a care plan written by a referring nurse, usually the District Nurse or community palliative care Clinical Nurse Specialist (CNS (palliative care)).

Primrose Hospice recognises the need to ensure that the rights and best interests of patients receiving care from Primrose at Home are safeguarded by the maintenance of a record of key events undertaken in the home in relation to the provision of personal care. It further recognises the importance of appropriate sharing of information between agencies providing care.

Purpose of Policy
The purpose of this policy and procedure is to set out the steps by which records relating to the care delivered by the Primrose at Home team are created, managed, stored and subsequently destroyed.

Roles and Responsibilities

Chief Executive
The Chief Executive is responsible for determining the governance arrangements of the Hospice including effective risk management processes. They are responsible for ensuring that the necessary clinical policies, procedures and guidelines are in place to safeguard patients and reduce risk. In addition they will require assurance that clinical policies, procedures and guidelines are being implemented and monitored for effectiveness and compliance.

Director of Care
The Director of Care has overall responsibility for patient safety and ensuring that there are effective risk management processes within the Hospice that meet all statutory requirements and adhere to guidance issued by the Department of Health.

Primrose at Home Manager
The Primrose at Home Manager is responsible for ensuring that all carers working within the Primrose at Home have received appropriate induction into the role and have received training in the importance of good and accurate record keeping.

As line manager, the Primrose at Home Manager is also responsible for ensuring that:

- This policy is made available to all relevant staff
Primrose at Home

- The staff they are responsible for implement and comply with the policy
- That staff are updated with regards to any change in the policy

Procedure

Records within the Home

- The Primrose at Home team provide care within a patient’s home, and work within the district nurse’s written care plan
- A written care plan specific to Primrose at Home is also provided by the referring nurse, setting out exactly what tasks the Primrose at Home carer is expected to carry out (appendix 1)
- A communication sheet is also provided within the district nurses’ folder, specifically for the use of a Primrose at Home carer to record any changes or information to be passed on to the district nurse or CNS (palliative care) (appendix 2)
- If required a Medicines Administration Record will also be in the district nurses’ folder (appendix 3)

Clinical Records held at the Hospice

- A clinical record is also open for all patients receiving care from Primrose at Home on the electronic records system in use at Primrose Hospice
- Because this is a system shared by all parts of the wider palliative care team, records of patients known to the Primrose at Home team will usually already be open on the system due to the involvement of the community and/or hospital palliative care teams
- A referral to Primrose at Home will be opened up and a record made by the administrative and management staff at Primrose Hospice of all contacts with:
  - The referrer
  - Patient or family
  - Any Primrose at Home carers working with the patient
- These entries will provide a documented record of:
  - The receipt and administration of the referral
  - All telephone and face to face communications with the above people
  - Feedback from carers following a shift, and any action taken as a result of that feedback (this might include the passing on of information to the district nurse or CNS (palliative care)

Non-clinical Records held at the Hospice

- Non-clinical records held at Primrose Hospice include:
  - A referral form
  - Details of support provided

Document archiving

Records held within the home

All Primrose at Home records in a patient’s home are kept within, and as a part of, the district nurses’ records.
Primrose at Home

At the end of an episode of care, those records are removed from the home by the district nurse and archived according to the Worcestershire Health and Care Trust’s archiving policy.

If access were required to that element of the record pertaining to Primrose at Home, an application would be made to the Worcestershire Health and Care Trust by the Primrose at Home Manager or Director of Care at Primrose Hospice.

Clinical Records held at Primrose Hospice

Electronic Records
Primrose Hospice uses an electronic clinical records software system called SystmOne.

SystmOne data is held in a secure data centre accredited by the Health and Social Care Information Centre (HSCIC). It has both a primary data centre and a secondary disaster recovery centre. Patient data is not destroyed at the end of an episode of care, but is held securely by a central server.

Paper (non-clinical) records
All paper records are stored, managed, archived and ultimately destroyed in line with the Hospice’s Health Records Policy.

Review
This policy will be reviewed as a minimum every 3 years, and sooner if legislation, local or national guidelines change.

Policy Area
Primrose Hospice: Primrose at Home: Patient Treatment and Care

Staff Training Requirements
All Primrose at Home staff will be introduced to this policy and procedure at commencement into the role and as a part of their induction.
Appendix 1

PRIMROSE AT HOME CARE PLAN
Nursing Information for Primrose at Home Carers
(To be completed bully by the Referrer and inserted into patients notes)

Patient’s Name: ................................................................. Date of birth: ............
Address: ................................................................................ Date: ....................

<table>
<thead>
<tr>
<th>CARE REQUIREMENTS</th>
<th>DETAILS</th>
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<tbody>
<tr>
<td>1. Physical Symptoms and support needs</td>
<td></td>
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<td>2. Continence care Include Stoma or Catheter care</td>
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<td>3. Pressure area care</td>
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<td>4. Sight, hearing, communication</td>
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<tr>
<td>5. Dietary requirements and fluids</td>
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<tr>
<td>6. Oral care/Eye care Washing/Shaving</td>
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<td>7. Personal safety and risk management</td>
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<tr>
<td>8. Mobility/Transfers and Manual Handling Equipment available.</td>
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<tr>
<td>9. Medication requirements (Oxygen, Anticipatory meds?)</td>
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**Special requests from family/carers**
To include any specific details on care, cultural needs or preferences. Following the wishes of the patient and family members (with specific regard to any personal care or use of equipment)

**Form completed by:**
- Full Name: 
- Signature: 
- Team: 
- Contact Numbers:
Appendix 2

PRIMROSE AT HOME COMMUNICATION SHEET

Patient’s Name: ……………………………………

<table>
<thead>
<tr>
<th>DATE</th>
<th>COMMENT</th>
<th>SIGNATURE</th>
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Appendix 3

MEDICINES ADMINISTRATION RECORD

Page 1 of 2
### Depot Medicines

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Frequency</th>
<th>Prescriber/Pharmacist</th>
<th>Date</th>
<th>SD</th>
<th>Status</th>
<th>Days/Time</th>
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**As Required** Medicines (PRN)

Medicines that might not be needed on a regular basis, eg to manage symptoms that can change.

<table>
<thead>
<tr>
<th>Item</th>
<th>Route</th>
<th>Frequency &amp; Instructions</th>
<th>Date</th>
<th>SD</th>
<th>Status</th>
<th>Days/Time</th>
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### Variable Dose Medicines

Doses can change, but extent dose must be prescribed each time - no dose ranges

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<tr>
<th>Drug</th>
<th>Route</th>
<th>Instructions</th>
<th>Date</th>
<th>SD</th>
<th>Status</th>
<th>Days/Time</th>
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**Instructions:**

- Drug can be used in a procedure, record of administration, or both.
- Drug regimen design can only be completed by a pharmacist, licensed physician, or professional approved by, and FDA.
- Prescription must a maximum of 3 months (90 days for controlled drugs).
- To proceed in two clearly distinct through the details of remaining doses, the 2022 and the only.

- Do not administer anything more difficult to read or where instructions are not clear.
- The name must be given in the medication administration record in order and within 1.5 cm.
- POSING-PHS add the PHS code in the Order Qty box of the computer section, add that name and directions, and proceed through administrative administration process.
- Do not administer to the patient under 18 years of age in the emergency.