Introduction
This document sets out the standards which all clinicians within NHS Lothian, their assistants and students should apply when making any entry in clinical health records. They also apply to the managed services of NHS Lothian. Independent contractors or those working in community settings within NHS Lothian may feel that adherence to these standards is not part of the conditions of their contract; however they are required to abide by their own professional codes and standards.

The standards are a distillation of legal requirements, published standards and best practice statements referenced in Appendix 2 (page 20).

Aim of this document
The aim is to increase the quality of multidisciplinary record keeping to enhance patient care and patient safety and decrease NHS Lothian's exposure to risk (whether legal or clinical).

NHS Lothian provides inpatient and outpatient services for acute adult health, mental health, children and older people plus a wide range of specialist services, each with specific information to record.

The standards are not an exhaustive list but cover the basic principles of record keeping which are applicable to most service areas.

These standards therefore provide a set of guiding principles rather than an answer for every situation.
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Appendix 1  Glossary
Appendix 2  NHS Lothian policies
# Summary of general requirements for any entry made in clinical record by any clinician, assistant or student

*(section number in standards is given for further information)*

## Practical issues

<table>
<thead>
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<tbody>
<tr>
<td>• No loose pages / paper clips / staples / poly pockets</td>
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<tr>
<td>• Each page is clearly identified (patient CHI minimum)</td>
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<td>• The notes are in structured sections</td>
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<tr>
<td>• All entries are legible and could be photocopied (black ink)</td>
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## Admission to a ward or entry into a service

<table>
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<th>3.1</th>
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<tbody>
<tr>
<td>• Full patient identification information/ profile</td>
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<tr>
<td>• Full demographic information (including ethnicity)</td>
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<tr>
<td>• Details of presenting problem</td>
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<tr>
<td>• History of presenting problem</td>
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<tr>
<td>• Care plan/ management plan (including relevant assessments)</td>
</tr>
<tr>
<td>• Allergies, relevant social circumstances, impairment or disability</td>
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<tr>
<td>• Name of primary clinician responsible for patient’s care</td>
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<td>• Record of information given to patient</td>
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## Written continuation notes

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<tr>
<th>3.8, 3.9 (frequency)</th>
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<tr>
<td>• All entries are timed and dated</td>
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<tr>
<td>• All entries are signed (plus designation and printed name)</td>
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<tr>
<td>• Minimum use of symbols, abbreviations and acronyms</td>
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## Surgery

<table>
<thead>
<tr>
<th>4.1, 4.2 (obstetrics), 4.3 (dental)</th>
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<tbody>
<tr>
<td>• Documentation relating to surgery (including patient history, results of test or assessments, name of procedure, patient consent)</td>
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<tr>
<td>• Anaesthetists pre-operative report</td>
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<tr>
<td>• Intra-operative record</td>
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<tr>
<td>• Immediate post-operative record</td>
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<tr>
<td>• Post-anaesthetic evaluation</td>
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## Discharge

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<thead>
<tr>
<th>5.1, 5.2 (Immediate discharge document), 5.3 (letter)</th>
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<tbody>
<tr>
<td>• Full patient identification information</td>
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<tr>
<td>• Date of admission/entry to service and discharge</td>
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<tr>
<td>• Final diagnosis</td>
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<tr>
<td>• Name of clinician validating discharge</td>
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<tr>
<td>• Details of follow-up (including medications)</td>
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<tr>
<td>• Discharge information (e.g. form, letter, document)</td>
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<tr>
<td>• Instructions given to the patient</td>
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## Transfer

<table>
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<tr>
<th>5.5 to another institution</th>
<th>5.6 within a hospital</th>
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<tbody>
<tr>
<td>As for discharge plus:</td>
<td></td>
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<tr>
<td>• Reason for transfer</td>
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<tr>
<td>• Details of receiving service and receiving clinician</td>
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<tr>
<td>• Receiving clinician notes when they accept responsibility for the patient</td>
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## Alterations

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<tr>
<td>• Scored through with single line</td>
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<tr>
<td>• No correction fluid</td>
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<tr>
<td>• Signed and dated</td>
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<tr>
<td>• Reason for alteration stated</td>
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## Entries in notes by students

<table>
<thead>
<tr>
<th>2.10</th>
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<tbody>
<tr>
<td>• Countersigned by overseeing member of staff</td>
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## Research studies

<table>
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<tr>
<th>2.12</th>
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</thead>
<tbody>
<tr>
<td>• Summary of protocol</td>
</tr>
<tr>
<td>• Patient information sheet</td>
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<tr>
<td>• Patient consent</td>
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## Consent

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<th>3.4</th>
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<tbody>
<tr>
<td>• For a procedure</td>
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<tr>
<td>• To share information with family/others</td>
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## Adverse events

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<th>3.10</th>
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<tr>
<td>• Full details of event</td>
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<tr>
<td>• Correspondence relating to complaints or litigation must NOT be filed in the clinical record</td>
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## Electronic records

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<tr>
<td>The principles are the same as for paper records plus:</td>
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<tr>
<td>• Security issues (including access, passwords, virus control)</td>
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<tr>
<td>• Adequate back-up</td>
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## Death

<table>
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<th>5.4</th>
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<tbody>
<tr>
<td>• Summary of death in notes (including details of verification of death and details as for discharge)</td>
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These are the basic general requirements applicable to any service in NHS Lothian, whether hospital or community. In addition to these general requirements clinicians should follow their own professional guidelines regarding the frequency and content of their entries into the clinical record.
Section 1: Purpose of the clinical record

The clinical record is the legal record of all patient care-related transactions between any member of staff working in or for NHS Lothian and the patient; it is the property of NHS Lothian.

Each clinical record should include all significant clinical information relating to a patient to ensure that the maximum possible information about the patient is available to the other healthcare professional staff providing his or her care.

It should also protect the legal interests of the patient, NHS Lothian and the responsible professional(s).

The record should enable the professional(s) responsible for the patient’s care to provide appropriate, effective, efficient and safe care, including to:

a. identify the patient and the patient’s current eligibility for admission/ entry to a service and treatment
b. validate the patient’s diagnosis
c. justify the patient’s treatment
d. plan the patient’s care, including risk assessments
e. monitor the patient’s progress
f. identify the results of treatment
g. provide effective continuing care to the patient
h. provide a time related record of the patient’s condition
i. evaluate the patient’s response to treatment

The clinical record should also contain sufficient information to enable:

j. communication between the responsible professional(s) and all other healthcare/ social care staff who are involved in the patient’s care
k. a consulting clinician to document an opinion, intervention and plan following an examination of the patient and a review of the patient’s record
l. another professional to assume the care of the patient at any time without undue delay or the need to repeat unnecessarily previously carried out tests and investigations
m. any professional(s) treating the patient to know what has been said to the patient and to the individual(s) designated by the patient and the timing of communications with the patient or designated others
n. any professional(s) caring for a patient to honour the duty of care to the patient by ensuring that entries in the patient’s record or omissions from the record do not compromise the safety of the patient in any way
o. healthcare related processes, such as quality assurance and improvement, clinical audit, epidemiological studies, risk management, complaints handling, continuing education or planning activities

Correspondence relating to a complaint or litigation must NOT be filed in the clinical record.
Section 2: Structure of the clinical record

2.1 Identification of the primary clinician with responsibility for the patient’s care

The name of the primary clinician who is assuming overall responsibility for the current episode of the patient’s care must be clearly identifiable in the patient’s record (paper or electronic) at all times. If the designated primary clinician transfers responsibility for the overall management of the patient, the name of the clinician to whom responsibility is transferred must be clearly identifiable in the patient’s record.

In the event of two or more episodes of care running concurrently, it must be clear in the entries who has responsibility for which elements of care.

2.2 Sequence of content

Each clinical record should be organised in clearly labelled sections so that all staff can file or insert sheets into the appropriate sections.

Serial recording of communication sheets or clinic notes should be in proper date order [in reverse chronological order (most recent on top) for letters and chronologically forwards for continuous clinical recording].

2.3 Format and forms

Forms and charts used in the record (e.g. fluid balance charts, SEWS charts, assessment forms, ICP documents) should be the approved version of NHS Lothian unless specialised for a particular service area.

All forms and charts to be included in the clinical record must be capable of being bound into the record. There must be no poly-pockets in the case-note folder and no loose sheets of paper.

2.4 Patient identification

All inpatient, outpatient and emergency records of an individual patient must bear the same unique record number - the CHI number.

2.5 Page identification

Every page in the clinical record must include the patient’s full identification information (patient’s name and their CHI number). Every healthcare professional making an entry in the patient’s record should ensure that the page on which s/he is making an entry includes the date and the patient’s CHI number.

2.6 Requirements for all entries in the clinical record

Every time a healthcare professional observes or treats a patient, details of the observation or treatment should be noted in the patient’s record.

When several members of a team are present during the observation, treatment or discussions about the care of a patient (such as at ward rounds), a member of the team, (as designated by the most senior member of the team) should make the entry in the patient’s record of observations made, actions decided or taken and the specific information given to the patient or others designated by the patient.

The entry should identify the most senior doctor/dentist, nurse and/or other healthcare professional present at the time, as well as the author of the entry.
2.7 Sharing patient information
The clinician responsible for the admission/entry to a service should note in the patient’s record whether or not the patient has agreed that members of the team can discuss the patient’s condition, treatment and/or prognosis with members of the patient’s family, carer or others. The record should specify the names the patient has given as people with whom his or her condition can – or cannot - be discussed.

2.8 Practical issues relating to clinical documentation
All entries in the clinical record should:
be written, dictated or entered into the clinical record or an electronic information system at the time of, or as soon as possible following, observation of the patient or completion of a patient care-related activity.

Should it become necessary, or desirable, to add an entry in the patient’s notes sometime after an examination or observation of a patient was carried out, the retrospective entry should be entered in the place in the notes where current notes are to be written, and not retrospectively inserted in an earlier date or time in the notes other than an indication to read the later contemporaneous note. Also, the reason for the retrospective entry must be noted.

a. be clinically relevant, accurate, clear and unambiguous, concise and comprehensive
b. be in the English language, using plain English
c. use the CHI number
d. represent appropriate observations of the patient’s condition and response to treatment , avoiding value judgements about the patient or the patient’s family
e. be legible by all others who may need to rely on the information entered
f. be written in permanent black ink (which would permit accurate photocopying)
g. be dated using the dd.mm.yy format
h. be timed, using the 24-hour clock (retrospective entries should be timed at time of writing, indicating what time period the record relates to)
i. be signed by the author (paper records only – name must be attributed in electronic records)
j. be identified by printing the name (at least last name and first initial) and professional designation (paper records)

Where there is a pre-printed signature/initial sheet, such as is part of many Integrated Care Pathway documents, each healthcare professional must ensure that their details are included on this sheet.

The clinician’s name entered in any clinical record should be the exact name recorded with the appropriate registration body; it can be contracted or amended only if consistent and unambiguous.

Information and advice given to the patient, for example, by direct verbal explanation or leaflet or other written material, should be noted.

As much as possible the goals and intended outcomes should be developed in collaboration with the patient.

2.9 Symbols and abbreviations
a. Scientific symbols may be used in clinical records if they are clear and there is no possibility of ambiguity of their meanings.
b. Abbreviations and acronyms should not be used when there is any possibility of ambiguity and never on a drug prescription and record.
2.10 Supervisory responsibility for documentation by student grades of clinicians

When an entry is made by student grade of clinician, the entry also should include the name of the professional supervisor as appropriate.

a. medical or dental discharge summaries, or letters prepared by student grades, should be countersigned by the responsible consultant, specialist registrar or registrar as appropriate.

b. written requests for consultation / investigations are made by trainee grades will be authorised by the responsible consultant and this will be indicated in the case record.

c. entries made by students in any formal academic training programme related to direct patient care must be countersigned by a registered individual who is assuming responsibility for their supervision.

2.11 Deletions or alterations to the clinical record

a. Should an entry in a clinical record have to be deleted or altered because it represents an error, the entry must not be erased nor should correction fluid be used. The original documentation and alterations should be clearly legible and auditable.

b. The deletion or alteration should be scored out with a single line.

c. The reason for amendment shall be noted.

d. The correct entry must be signed, dated and timed by the person making the amendment.

e. Alterations to electronic records will be in accordance with the relevant E-health policies.

f. When appropriate, the deletion or alteration should be countersigned by the author’s clinical supervisor, with the supervisor’s profession and grade.

2.12 Research studies

Patients participating in any research study should have in their notes a signed copy of the patient consent form, a summary of the protocol and the patient information sheet. There should also be a contemporaneous written note in the record stating at what point the patient was recruited to the study and by whom.

2.13 Deadline for completion of clinical record for inpatients

Records of discharged patients should be completed within 10 working days following discharge. A clinical record shall be considered complete when transcribed and signed reports and discharge summaries are present. All healthcare professionals are responsible for completion of the parts of the record that are attributable to them.

Loose-leaf sheets of discharged/ transferred patients may arrive days after that patient has left the clinical area or even the hospital. This ‘orphan’ paperwork should be locally collated for filing or forwarded to the patient’s new clinical area for filing there with that area’s agreement.

2.14 Electronic records

The principles of electronic record keeping are the same as for paper records. In addition there must be procedures to ensure the following:

a. Security: restricted access to computers/ effective use of passwords

b. Data is held on a network drive with regular back-up and adequate virus control

c. Adequate training for all users

d. Data must not be transferred to home computers, unencrypted data sticks etc or e-mailed to unapproved recipients by unapproved means

Where both computer and paper systems are maintained, the information held must be consistent.
Section 3: Entry into a service / hospital admission

3.1 Standard documentation for entry to a service

Documentation at entry to a service (first appointment) / admission to in-patient services should include the following:

a. patient demographics, including name, date of birth, CHI number
b. date and time of admission / entry to service
c. name of ward / service
d. reason for clinical encounter/ admission
e. chief problem or presenting problem
f. history and details of the presenting problem
g. current diagnoses – including physical and mental health
h. present medicines/ (including herbal and ‘over the counter’ medications) treatments, if any
i. known allergies – including details of response and known sensitivities
j. source of history information.
k. name of the clinician who is responsible for the patient’s management
l. date and time of admission or first appointment

The following should also be recorded for admission to in-patient services or out-patient services or community based services where appropriate to the area of patient care:

m. functional state – recorded as a validated score where appropriate
n. relevant details of ability, impairments or disabilities – such as hearing or visual impairment, dentition, manual handling assessment, communication needs (including the need for an interpreter) and any aids used or required
o. past history of illness(es)
p. dates of previous hospitalisations, operations or significant procedures
q. family medical history
r. social circumstances – including known carer situation, advocacy, ability to manage own care, religion, language / dialect, input by social services etc, known to other agencies
s. smoking and alcohol use and/or substance misuse
t. patient weight, nutritional screening tool assessment and diet (including any special or modified diets the patient may be on
u. orientation status and mental test score, as appropriate
v. psychological, psychiatric and social factors as relevant, including justification for intervention and audit of non-medical variable, as appropriate
w. single shared assessment where part of managed care, as appropriate
x. ‘Do Not Attempt Resuscitation’ (DNAR) status, as appropriate
y. a note or copy of an Advance Directive/ Living Will (as appropriate) should be filed at the front of the record behind the DNAR form (if there is one)

3.2 Nursing assessment on admission to hospital

In addition to the details above, a nursing assessment should be carried out as soon as possible and within 24 hours of admission. This should include the following:

a. patient demographics, including marital status, occupation, religion/ faith
b. general practitioner name and contact details
c. emergency contact names and details
d. Patient’s understanding of the reason for admission/entry to the service

e. Patient’s mental state on admission/entry to the service

f. Any problems at home because of admission/entry to the service

g. Full assessment of the patient based on the activities of daily living, or another suitable assessment framework, including (as appropriate):
   - Admission temperature, respiration rate, blood pressure, skin integrity, Waterlow (or equivalent) score, communication (including pain status), elimination, personal cleansing and dressing – including ability to care for teeth, eating and drinking (including body mass index, nutritional status as appropriate), falls, working and playing, nutrition (MUST), maintaining a safe environment, spiritual needs, expressing sexuality, sleeping

h. Oxygen saturation, urinalysis and blood sugar, if appropriate

i. Infection control checklist (including pyrexia of unknown origin, history of methicillin-resistant staphylococcus aureus (MRSA), vancomycin-resistant enterococcus (VRE) and vomiting and/or diarrhoea – informing Infection Control Team as appropriate)

j. Presence and status of any wound dressings, cannulae, catheters present on admission/entry to the service (as appropriate)

k. Possessions and removable items – including jewellery, orthotics, aids (as appropriate)

3.3 Midwifery entries

Narrative notes should be written frequently enough to give a picture of a woman or baby’s condition to anyone reading them.

Cardiotocograph traces (CTG) should have the woman’s identification information clearly written at the beginning of the trace. If the CTG machine has an automatic timer on it, this should be checked against the actual time and any errors noted and rectified. The midwife should record the maternal pulse once at the beginning of the trace and document it on the trace. Any interruptions in the trace should be explained. At the end of the trace, a note should be made of either delivery details or why the trace was stopped. All reviews of the trace by a midwife or doctor should be documented.

3.4 Consent forms

For routine procedures such as venepuncture, physical examination or the following of simple instructions, the patient’s willingness to comply usually provides adequate indication of consent. However, practitioners must get specific written consent for:

a. Any procedure that carries a significant risk

b. Any procedure to be carried out under general anaesthesia, sedation or utilising local anaesthesia other than topically or by simple infiltration (i.e. nerve blockade/regional anaesthesia)

c. Any procedure which could be considered new, novel or experimental

d. Any medical photography

e. Any situation where there are implications for ‘third parties’ e.g. relatives and insurance companies in relation to genetic studies or HIV testing.

All writing on the consent form must be

- legible
- unambiguous
- contain no abbreviations or acronyms
- be signed and dated by the patient and practitioner

Alterations are not permitted after the patient has signed the consent form. If alterations are needed, a new form should be used.
3.5 **Patient readmitted for the same problem**
If readmission of a patient has been planned for ongoing management of the same problem and the readmission is within 30 days, the history and physical examination from the previous admission should be updated with any recent changes. If the patient is readmitted after 30 days, the history and physical examination must be repeated.

3.6 **Dental patient admitted by a dentist or an oral surgeon**
A dentist or oral surgeon should carry out the dental history and the physical examination related to dentistry. The medical history and physical examination and the evaluation of overall clinical risk should be done by a qualified doctor or dentist.

3.7 **Patient refusal of physical examination**
If a patient refuses a clinical intervention of any sort, the refusal and any reasons offered must be documented in the clinical record. In the event of such refusal, the referring clinician should be informed as appropriate. Legal exemptions can allow treatment of the patient at the doctor’s, or referring clinician’s, discretion.

3.8 **Progress notes (continuation sheets)**
The clinical record includes notes on the patient’s progress that provide a complete chronological report of what has happened or been done to the patient since the previous entry, the assessment of the patient’s condition, the new management plan and any information given to the patient and/or others designated by the patient. Progress notes should be written at the time of observation of the patient or completion of a procedure or treatment or as soon thereafter as can be achieved as a priority.

If, in the clinician’s judgement, there is no change, then ‘no change’ could be recorded. If the management plan is not changing since the last entry, then ‘continue with previous management plan’ could be recorded, as long as the previous management plan is clearly documented. Only relevant and significant clinical information should be noted.

The progress notes will include specific information given to the patient or others designated by the patient and all assessments completed where requested by a member of the multidisciplinary team. As an interim step toward fully integrated multi-professional progress notes, there may be separate clearly identified sections of progress notes for doctors, nurses/midwives and allied health professionals.

Nursing entries should include details of specific nursing actions provided for the patient and the patient’s response to these, a re-assessment of activities of daily living (as appropriate), a nursing evaluation of the patient’s status (including equipment and accessories in place), details of doctors’ visits or rounds, instructions or counselling provided to the patient and/or family regarding patient self-care or follow-up care and evidence of the patient’s or family’s understanding of these instructions.

3.9 **Frequency of entries into the patient record (hospital in-patients)**
For hospital patients, as a minimum, doctors/dentists should write medical progress notes at least once every 24 hours for patients who are acutely ill. For all other patients who remain in a hospital, or similar healthcare institution, even though they are not acutely ill, doctors/ dentists should write medical progress notes at least twice in seven days for as long as the patient remains the focus of healthcare intervention. Some departments or specialties may require more stringent standards for medical progress notes.

Nurses should write notes at least once every nursing shift and more frequently for patients who are acutely ill or are in intensive care units.
Midwives should write notes as frequently as needed to provide a clinically current description of the patient’s condition, whether in main or locally held notes.

Pharmacists and Allied Health Professionals should make appropriate notes on every occasion when they assess, observe or treat a patient. More detailed notes of individual therapies may be kept separately, to the appropriate professional standard, until such time as the professions agree that this is no longer needed.

Health care assistants and technicians are permitted to make notes in a patient’s record only when they have completed formal training to do so and have been assessed formally by a designated supervisor to be competent in recording in a clinical record.

3.10 Note of any incident or adverse event

Should a patient or patient’s carer/family experience an incident or adverse event while in the healthcare system, any healthcare professionals involved in the patient’s care should ensure that the full details about the adverse event are noted in the patient’s record as quickly as possible after the event has occurred, including that the patient and/or individuals designated by the patient have been told about the incident or adverse event. Such adverse events should also be recorded as incidents on the appropriate Risk Management reporting system (DATIX) as per NHS Lothian policy.
Section 4: Documentation relating to surgery

4.1 Basic items the surgical documentation must include

The record of a patient who undergoes surgery must include:

a. preoperative diagnosis recorded and signed by the responsible doctor prior to surgery
b. reports of the patient’s history and physical examination and the results of any examinations required available in the clinical record prior to surgery
c. properly executed consent for surgery prior to surgery
d. operative report prepared immediately after surgery, typed in the approved operative format where applicable, signed by a member of the surgical/dental team, including:
   • patient identification information
   • date and start and finish times of surgery
   • names of the primary surgeon, anaesthetist, any surgery or anaesthetic assistants, and the nurses present in the operating theatre
   • preoperative diagnosis
   • name of operation and technical procedures used
   • findings
   • narrative description of procedure(s) performed, which shall include the operative diagnosis, intraoperative complications and estimated blood loss, if any
   • patient condition at the end of the procedure(s), for example, stable
   • specimens removed
   • presence of any dressings, tubes, catheters and drains
e. a progress note entered in the clinical record by the surgeon or his designee immediately following surgery sufficiently comprehensive to provide relevant information to any healthcare professional who is required to attend the patient
f. the diagnostic report of the gross examination of any specimen removed in surgery by the pathologist entered in the clinical record ordinarily within 72 hours of surgery.

4.2 Obstetric procedures requiring an operative report

An operative report as described above must be prepared and signed by the responsible obstetrician for any of the following obstetric circumstances:

a. instrumental or breech delivery
b. caesarean section
c. unusual or complicated deliveries, including multiple births if any of the deliveries are unusual or complicated
d. third and fourth degree perineal tears and vaginal or cervical lacerations requiring regional anaesthesia for repair
e. any procedure done under general anaesthesia.

4.3 Dental surgery

The number of teeth and fragments removed should be noted in the operative report using standard dental charting, in addition to other relevant content as described above. Recording should be as per best practice: e.g. should a tooth fracture on removal, the operator will clearly identify in the operation record whether the fractured portion was surgically removed or left.
4.4 Anaesthetist’s preoperative evaluation

Except in extreme emergencies, this evaluation must be recorded on the approved preoperative assessment form prior to the patient’s transfer to the operating area and before preoperative medicine has been administered. Documentation includes:

a. patient identification information (including CHI)

b. date

c. evidence of the anaesthetist’s review of the patient’s history and physical examination of the patient, including previous illness, previous anaesthetic experiences and complications, anaesthetic family history, drugs the patient is taking and has been taking, allergies, smoking habits and condition of teeth and airway

d. patient’s drug history and current medicines – including those stopped prior to surgery and instructions about if, when and how they are to be re-started

e. evidence of review of laboratory, diagnostic imaging and other examinations performed as part of the anaesthetic evaluation of the patient’s suitability for anaesthetic

f. any potential anaesthetic problems, including allergies and drug sensitivities

g. choice of anaesthetic, that is, general, spinal, regional or local

h. ASA (American Society of Anaesthesiologists) rating

i. evidence of preparation of the patient for anaesthetic

j. name and signature of anaesthetist.

The time of administration and dosage of pre-anaesthetic medicine should be documented in the drug chart in the patient’s record.

4.5 Intraoperative record

The following must be recorded by the anaesthetist and designated nurse on the approved forms:

a. date

b. patient identification information (including CHI)

c. vital signs, including blood pressure, pulse rate and respiration and electrocardiogram interpretation

d. induction and maintenance technique used, including times

e. dosage and duration of all anaesthetic agents used

f. intravenous fluids, medicines, blood or blood components or oxygen administered, including doses and time of administration

g. relevant equipment monitoring such as oxygen flow and pressure alarms

h. patient monitoring used

i. time based chart recordings of relevant physiological parameters from induction depending on patient stability, but not less frequently than every 15 minutes for pulse, blood pressure and oxygen saturation

j. fluid balance including evidence of venous cannulation and record of fluids administered and blood loss

k. mechanical ventilation, when used, with tidal volume, rate and pressures

l. intra-operative anaesthetic complications, if any

m. postoperative analgesic and other orders, including oxygen therapy and immediate postoperative fluids and monitoring

n. name and signature of anaesthetist and designated nurse(s).
4.6 Immediate postoperative record

This evaluation will take place in the recovery room and includes:

a. date and time
b. observations
c. vital signs
d. level of consciousness on entering and leaving the recovery room
e. status of infusions, surgical dressings, tubes, catheters and drains when they are in use
f. blood, blood components, intravenous fluids, oxygen and medicines administered in the recovery room
g. presence or absence of complications
h. evidence that the patient is safe for discharge from the recovery room
i. name and signature of anaesthetist and/or recovery room nurse assuming responsibility for transferring the patient to and from the recovery area
j. medication

4.7 Post-anaesthetic evaluation

Postoperative visits to the patient by an anaesthetist should be made when deemed necessary. The anaesthetist will note the date and time of the visit, along with relevant findings, including the presence or absence of anaesthetic-related complications, and will sign the note.
Section 5: Discharge information

5.1 Basic items the discharge record must include

At the time of discharge, a final clinical progress note shall be written in the casenote that is sufficiently comprehensive to provide relevant information to another clinician who may be seeing the patient in another healthcare setting before the discharge summary is available. The discharge note shall include at least

- the date and place of discharge
- final diagnoses, with the principal diagnosis listed first
- dosage and quantity of any medications (if applicable)
- instructions to the patient or individuals designated by the patient and follow-up arrangements.

5.2 Immediate discharge document

When a patient is discharged (including where the discharge criterion is death) an immediate discharge document should be prepared in accordance with current guideline (SIGN 65: The Immediate Discharge Letter). It may be given to the patient and should be sent to the patient’s GP on the day of the patient’s discharge in order to enable the safe transfer of clinical responsibility for the patient. The document includes the following information:

- hospital/ service name
- patient identification information (including CHI)
- General Practitioner (GP) details
- consultant name and contact details
- ward / clinic / department/ specialty issuing the discharge document
- dates of admission, transfer and/or discharge
- date of death, if applicable
- reason for admission and transfer, if applicable
- mode of admission: for example, elective, emergency, transfer
- source of referral for the admission
- diagnosis(es) and/or problem(s)
- significant investigation(s), operation(s), procedure(s) or treatment(s) carried out, including chemotherapy or radiotherapy, with dates
- relevant investigations
- complications that occurred during treatment and their current status
- medicines on discharge, including the name of the drug(s), formulation, current dose, frequency, duration of treatment – as per ‘Safe Handling of Medicines’ policy
- any adverse reactions experienced by the patient during treatment, including known allergies
- warfarin status (where applicable to the service)
- discharge and action plans, including destination upon discharge, whether or not care arrangements have been made and whether or not a member of the community healthcare team should review the patient soon after discharge
- information given to the patient and/or family or others
- investigation results pending, if relevant
- name, signature, professional designation and job title of the person completing the immediate discharge document.
5.3 Discharge summary/letter

For each patient admitted to the hospital or assessed or treated as an outpatient, a discharge summary/letter should be prepared and checked by a senior responsible clinician within 10 days following a patient’s discharge. The letter should be in a style that the patient may be able to understand.

The discharge summary/letter should include:

a. patient identification information (including CHI)
b. dates of admission and discharge
c. date of discharge summary
d. final diagnosis
e. serious incidents, adverse events or unusual occurrences that happened to or involved the patient during the time the patient was with the service and had a significant consequence on the patient’s care, such as a serious fall, infection or injury
f. allergies
g. significant investigation(s), operation(s), procedure(s) or treatment(s) carried out, including chemotherapy or radiotherapy, with dates
h. the provisional diagnosis or reason for clinical encounter; significant findings from history, physical examination and investigations; management of the episode; and treatment rendered
i. patient’s condition upon discharge, stated in terms that permit comparison with the condition upon admission
j. instructions to the patient and/or others designated by the patient regarding medicines, diet or consistency of diet to be followed, physical activity or use of aids or prosthetic devices, as relevant
k. the dosage and frequency of any medicines, therapies or diets prescribed
l. mobility / falls risk
m. results of investigation left pending in the immediate discharge summary, if relevant
n. information given to the patient and carer, or others designated by the patient, concerning the patient’s condition
o. plans for follow-up care and any ongoing concerns for the community healthcare team, including any risk assessments they should be aware of
p. sick leave recommendation, if any.

5.4 Death summary

A summary of death must be completed in the casenote for each patient who dies in the hospital. The summary should include the required contents of a discharge summary and the following information:

a. date and time the patient was certified dead
b. date and time of verification of death
c. date and time of the entry in the record
d. name and designation of the doctor certifying the patient’s death in block capitals
e. examination made establishing death
f. events leading to death and cause(s) of death
g. signature of the doctor certifying death

The consultant responsible for the patient’s care shall ensure that the patient’s GP is notified of the patient’s death as soon as possible following the death.
5.5 Transfer from a hospital to another institution

All staff involved in the patient’s care have a responsibility to ensure appropriate, timely and full communication with staff in the receiving unit.

When a patient is transferred from a hospital to another institution, the responsible clinician should document in the patient’s progress notes as appropriate:

a. date of the transfer
b. reason for the transfer
c. name and location of receiving institution
d. note of agreement to accept the patient
e. name of receiving clinician
f. statement of the patient’s condition and fitness for transfer, including whether or not the patient requires a doctor and/or nurse escort during transfer
g. clinical information accompanying the patient, which shall include a letter to the receiving doctor/dentist, a copy of the discharge summary/letter and copies of other relevant material, which may include information about current treatment(s) and care needs, serious infection risks, results of investigations, copies of radiological impressions or relevant tracings, risk assessments, nutritional status etc
h. note of risk assessments, mobility, nutritional and tissue viability status
i. mode of transportation (ambulance, car, etc) and how much assistance required
j. information given to the patient and/or others designated by the patient about the transfer, including if the patient’s choices are limited due to legal instructions and/or practice boundaries, for example, a ward of court.

5.6 Transfer within the hospital

When the responsibility for care of a patient is transferred from one clinician to another within the Hospital, including from a consultant in the emergency department, the transferring clinician should document in the patient’s progress notes:

a. date and time of the transfer
b. name of the consultant who has agreed to assume responsibility for the patient
c. reason for the transfer
d. assessment of the patient’s condition at the time of the transfer location of the patient at the time of transfer.

The clinician accepting responsibility for the patient shall document in the progress notes:

e. date and time of assuming responsibility for the patient
f. assessment of the patient’s condition at the time of acceptance of the transfer
g. plan of care.
## APPENDIX 1 – Glossary

<table>
<thead>
<tr>
<th>Term used in the document</th>
<th>main understanding of that term</th>
</tr>
</thead>
<tbody>
<tr>
<td>assessment</td>
<td>taken to include medical, psychological, risks, mobility and other investigations (whether invasive or not)</td>
</tr>
<tr>
<td>CHI number</td>
<td>Community Health Index, a unique number for each patient within NHS in Scotland, and central to transfer of patient information between any two clinical areas, within NHS Lothian and across Scotland.</td>
</tr>
<tr>
<td>Clinician</td>
<td>any and all healthcare staff who provide care to patients, e.g. doctors, dentists, nurses, midwives, allied health professionals, pharmacists, clinical or care support workers</td>
</tr>
<tr>
<td>e-Health</td>
<td>the use of information, computers and telecommunications in support of meeting the needs of patients</td>
</tr>
<tr>
<td>episode of care</td>
<td>may include one or more concurrent episode</td>
</tr>
<tr>
<td>Integrated Care Pathway [ICP]</td>
<td>A structured, chronological multidisciplinary piece of documentation</td>
</tr>
<tr>
<td>medicine</td>
<td>references to ‘medicine’ or ‘medicines’ should be interpreted in the light of the current edition of the NHS Lothian ‘Safe Handling of Medicines’ policy, from which any clarification can be sought</td>
</tr>
<tr>
<td>patient</td>
<td>taken to include instances where the individual approaching the service is not acutely ill, (e.g. pregnancy) and/or, services where terms such as ‘client’ are preferred.</td>
</tr>
<tr>
<td>patient’s family or others</td>
<td>will be taken to include relatives, carers (formal or informal as appropriate), advocates, friends etc</td>
</tr>
<tr>
<td>patient identifier</td>
<td>this implicitly includes the requirement to use the CHI number as the primary unique identifier.</td>
</tr>
<tr>
<td>plan the patient’s care</td>
<td>includes investigations, risk and/or other assessments, medicine, mobility, aids etc, required for a holistic plan of care</td>
</tr>
<tr>
<td>risk assessments</td>
<td>tools employed to assess specific patient risks e.g. MUST, Manual Handling, Waterlow</td>
</tr>
<tr>
<td>student</td>
<td>any pre-registration grade requiring supervision.</td>
</tr>
<tr>
<td>treatment</td>
<td>taken to include any therapies, (whether medical, physical, psychological, surgical or other) designed to improve the health status or well-being of the patient.</td>
</tr>
</tbody>
</table>
APPENDIX 2 – Relevant NHS Lothian policies

Safe Use of Medicines Policy and Procedures (2009)

NHS Lothian Records Management Policy


Nurse Verification of Expected Death Policy, Protocol and Procedure (draft 2009)
http://intranet.lothian.scot.nhs.uk/NHSLothian/NHSLothian/KeyDocumentsReports/NHSLothianAnnualReview/Documents/NHSLothianConsultationDocuments/Verification%20of%20Expected%20Death%20Feb%202025%202009%20Draft%202017.doc

The Immediate Discharge Document (Sign 65; 2003)
http://www.sign.ac.uk/guidelines/fulltext/65/index.html

Incident Management Operational Procedure (2008)


Policy and Operating Procedure for NHS Lothian Clinical Policies

E-Health : Casenote Maintenance

EHealth Security Policy

Recommendations on use of email to send confidential information from NHS Lothian
http://intranet.lothian.scot.nhs.uk/NHSLothian/Corporate/A-Z/ehealth/policiesandprocedures/Documents/Recommendations%20on%20use%20of%20email%20to%20send%20confidential%20information%20from%20NHS%20Lothian.pdf