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Faculty of Occupational Medicine

Record keeping: Occupational health practice in the NHS in England

A national audit

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Health and Work Development Unit

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Prepared on behalf of the Health and Work Development Unit Audit Development Group by:

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April 2012

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The audit leads, members of the audit development group and staff of the Health and Work Development Unit (HWDU) would like to thank all audit participants. We know that audit of clinical notes can be an onerous task. However, we hope that the act of participating, and the findings published here, support your clinical work and help to raise the standards of occupational health (OH) care for National Health Service (NHS) staff.

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The Faculty of Occupational Medicine aims for healthy working lives through:

- maximising people's opportunities to benefit from healthy and rewarding work while not putting themselves or others at unreasonable risk
- elimination of preventable injury and illness caused or aggravated by work
- access for everyone to advice from a competent occupational physician as part of comprehensive OH and safety services
- providing support to the Faculty's membership to raise the standard of OH practice.

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The Health and Work Development Unit (HWDU) is a partnership between the Royal College of Physicians and the Faculty of Occupational Medicine. The unit aspires to be known as a national centre of excellence for health, work and wellbeing quality improvement work. HWDU's remit is to contribute to improving the health of the workforce by

supporting the implementation of evidence-based guidance. The unit carries out national clinical and organisational audit, facilitates change management work with participants and develops evidence-based guidelines.

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NHS Plus was set up in 2001 to increase the quality and delivery of health and work services and support the broader health, work and wellbeing strategy. It funded and promoted this audit through the NHS Health at Work Network. The Network represents more than 90% of the providers of occupational health services to the NHS and is now progressing and developing the work of NHS Plus. It is dedicated to improving the health of NHS staff by influencing policy, building a robust evidence base and promoting best clinical and business practice in the innovative delivery of health and work services to NHS staff.

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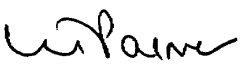
Foreword

On behalf of the Faculty of Occupational Medicine I would like to congratulate occupational health (OH) professionals, working across the NHS in England, for completing this first round of record-keeping audit.

Unlike the HWDU national back pain audit with its target of 100% participation, this audit was entirely voluntary. It is a testament to the OH community's appetite for quality improvement that nearly half of all NHS OH services participated. The findings from this audit reveal that there is good adherence to some record keeping standards and areas where practice can be improved. This is particularly important as there is evidence that good record keeping is linked to better clinical outcomes.

The Faculty of Occupational Medicine has a remit to raise the standard of OH practice. This audit complements the Faculty's newly launched service accreditation scheme (SEQOHS). Together these initiatives provide NHS OH services with the opportunity to benchmark their performance nationally, reflect on their performance and develop improvement plans.

I would like to encourage participants to review their local results in the context of the national picture, and to act on their findings.



Professor Keith Palmer
Academic Dean and Deputy President
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Executive summary

We report the findings of the first national clinical audit of compliance with record keeping standards in occupational health (OH) care in the NHS in England. Guidance and standards for clinical record keeping are published by several organisations including the Department of Health (DH), Royal College of Physicians (RCP), General Medical Council (GMC) and Nursing and Midwifery Council (NMC). Most include generic standards that apply to all health records, and some (eg the Faculty of Occupational Medicine (FOM)) include guidance specific to OH records.

OH departments were asked to audit a 10% sample of all records relating to clinical consultations with an OH doctor or nurse that took place during a two-week period in autumn 2011. The anonymised data were submitted using a web-based data collection tool and analysed by the Health and Work Development Unit (HWDU). In addition to the national results, each participating trust received its own local confidential results.

The audit questions were designed to identify whether consultation records were:

- legible
- protected from unauthorised alteration
- correctly labelled with the patient's (employee's) identity
- dated and signed by the author
- correctly identifiable by author, including professional title
- clear in recording appropriate patient consent for disclosure and access to copies of reports.

Key findings and recommendations

Participation

47% (81/172) of OH service providers participated, entering 2,343 records. 1,595 (68%) were paper based/scanned records and 748 (32%) were electronic records.

Legibility

Electronic records were more legible than paper records and contained fewer abbreviations.

Protection from unauthorised alteration

- Only 0.4% (6/1,595) of paper consultation notes could be erased.
- 34% of electronic records could be deleted or edited, however providers of OH software have confirmed that their systems generally: restrict the right to edit, record any changes, and record by whom changes have been made.
- In only 7% of paper records were all deletions or alterations signed and dated.

Correct labelling with the patient's (employee's) and OH clinician's identity

- Only 24% of paper records and 47% of electronic records included the patient's first and last name, the date and the patient's unique identifying number.
- Only 15% of paper records included the patient's first and last name, at least one unique identifying number, and the date of the consultation on each side of paper, and the legible name, signature and designation (job title) of the author at least once in the record.

Recording of patient consent for disclosure and access to copies of reports

- 20% of paper notes and 33% of electronic notes did not show whether the patient had been offered a copy of the OH clinician's report to the manager or human resources (HR) representative.
- 22% of paper and 17% of electronic records (where this was applicable) did not record the patient's signed consent (under the Access to Medical Reports Act) for requesting a medical report.

Conclusions

The audit results show that, among NHS OH departments in England, there is incomplete compliance with standards on record keeping and that electronic records are generally better quality (legibility and completeness of identification) than paper records.

Recommendations

OH departments should invest in suitable electronic record systems that:

- are secure (prevent alterations or deletions, or allow alterations only by restricted authority and with a clear audit trail to track any changes retrospectively)
- comply with NHS information governance standards.

Pending the introduction of electronic systems, OH departments with paper-based record systems should:

- investigate simple changes that will increase compliance for recording the patient's name and date of consultation on each side of paper and the author's name and designation at least once on the record.

Regardless of whether records are paper or electronic, clinicians should:

- record consent under the Access to Medical Reports Act before they request a report from another clinician
- document carefully that copies of any reports to managers have been offered to the patient.

Next steps

Occupational health providers

We recommend that OH departments consider their own results in light of the targets and in comparison with the national results detailed in this report.

Where consultations do not meet the standards set by Safe Effective Quality Occupational Health Service (SEQOHS),[1] we recommend that OH departments review their practice and develop mechanisms for service improvement. These might involve some or all of the following activities:

- education and training
- sharing good practice between staff of the department, regionally and more widely
- dialogue with OH software system providers to improve identification of multi-screen records and protect against retrospective alteration of records
- developing tools to facilitate improvement, for example action plans
- developing systems to support comprehensive documentation of consultations.

HWDU

HWDU has produced a list of the standards used in this audit. The list is available in appendix 1 of the full report. It will be circulated to all OH services providing to the NHS in England, and will be placed on the HWDU website. Services can use the list when developing their action plans for improving their standard of record keeping.

HWDU will circulate an action planning template to all participating services to support them while reviewing their data.

HWDU will repeat national data collection in 2013, so that OH services have the opportunity to:

- measure improvement since round one
- measure their baseline if they did not participate in round one
- submit participation in the audit as evidence towards SEQOHS accreditation
- submit participation in this audit as evidence of continuing professional development (CPD) for revalidation (doctors).

The participants in this audit will be key stakeholders for these activities.

Introduction

This is the first national audit of the quality and completeness of occupational health (OH) record keeping among NHS OH departments in England. The topic was chosen because high quality consultation records are deemed to be an important feature of good OH service provision.

This new audit complements two established national clinical audits of OH practice: the management of back pain; and depression detection and management of staff on long-term sickness absence. These audits have led to measurable improvements in the management of back pain and depression in the context of long-term absence in the participating NHS OH departments.

Clinical audit

The purpose of clinical audit is to measure compliance with standards and to identify areas where practice should be improved. The audit process should compare actual performance against a standard: data are collected to determine whether the standard is met. Where a standard is not met, interventions can be designed to improve practice. A further round of audit monitors the effect of the intervention activities, and identifies new priorities for change.

OH record keeping

A number of authoritative guidance documents and standards articulate the need for good record-keeping in OH. These include:

- RCP Health Informatics Unit generic medical record keeping standards[2]
- Department of Health (DH) NHS Confidentiality Code of Practice[3]
- General Medical Council (GMC) Guidance on Confidentiality (2009)[4]
- Royal College of Nursing (RCN) Guidance for Occupational Health Nurses[5]
- Data Protection Act (1998)[6]
- Faculty of Occupational Medicine (FOM) 'Good Occupational Medicine Practice'[7]
- Access to Medical Reports Act (1988)[8]
- Nursing and Midwifery Council (NMC) 'Record keeping: Guidance for nurses and midwives (2010)'.[9]

Safe Effective Quality Occupational Health Services

Most of the above are generic standards that could apply to any health record. They are all referenced by Safe Effective Quality Occupational Health Services (SEQOHS),[1] a voluntary accreditation scheme for high quality OH services in the UK. Within the SEQOHS scheme, standards are grouped into key domains. Good clinical record keeping comprises one of the principal standards (B1) under Domain B (information governance).

Revalidation

Participation in this record keeping audit will not fulfil the *clinical* audit requirement for revalidation (for doctors) however it can be submitted as evidence of appropriate CPD.

Aims of the national audit

This audit examines the quality of both electronic and paper records of OH consultations. The aims are to:

- Assess variations in practice with respect to clinical record keeping in OH departments that serve NHS trusts in England and their employees.
- Enable OH departments to compare the quality of their OH clinical record keeping.
- Produce 'baseline' measures of good clinical record keeping in NHS OH care against which future progress, both locally and nationally, can be measured.
- Improve the quality and completeness of clinical consultation records in NHS OH departments.
- Develop an audit methodology that will satisfy the requirements of the SEQOHS system, thus facilitating the accreditation of NHS OH departments.

Paper versus electronic records

The audit development group considered the variation in format of clinical records. Whilst some OH departments rely heavily on paper records, many have now converted to paper-light or paper-free systems. A variety of software programmes are used by NHS OH providers. Some of these utilise scanned hand-written consultation records, while others require the clinician to type directly onto electronic proformas. To accommodate these differences, the audit was designed in two separate but related parts, applicable to paper and electronic records respectively. Where possible we tried to take account of variations in software system design.

The following chapters report the process and results of the record-keeping audit. As this is the first round we have provided an explanation of the design and data collection process as well as a detailed results section.

Methods

Notes on terminology

Sites

Trusts either have their own in-house occupational health (OH) service or commission OH from another provider. Because some trusts use more than one OH service and some OH services provide to more than one trust, we used the term 'site' for each combination of an OH provider and trust. This is the level at which we report.

Unit of audit – trusts

Because NHS OH is organised and funded at a trust level, we analysed results and produced local reports by site. Where OH services submitted more than one set of data, we combined sets to produce an OH service report. OH services will be able to infer a consistent performance across all trusts they serve if the same staff members deliver the care.

Case

A case is a member of staff from a participating trust who was seen by their OH department and whose consultation was audited.

Record

A record refers to the notes (either written or electronic) that a clinician makes to document the content and outcome of a consultation with a patient.

Audit development group

The audit tool was developed by practising clinicians supported by the Health and Work Development Unit (HWDU). The group includes specialists in OH (doctors, nurses), physiotherapists, academics, managers, experts in audit and clinical standards, and medical statisticians.

Audit tool design

Rationale

The record-keeping audit has two components:

- an audit of paper consultation records
- an audit of electronic consultation records.

The audit questions were designed to identify whether consultation records were:

- legible
- protected from unauthorised alteration
- correctly labelled with the patient's (employee's) identity
- dated and signed by the author
- correctly identifiable by author, including professional title
- clear in recording appropriate patient consent for disclosure and access to copies of reports.

Scanned records were treated the same as paper records, because they were created originally in paper format prior to scanning into an electronic system. It was assumed that electronic records were created directly into an electronic system.

National guidelines

The audit tool was derived directly from professional standards for record keeping.[2–9]

Detailed mapping of standards to specific questions in the record-keeping audit tool is shown in appendix 1.

Occupational health service recruitment

We offered the record keeping audit, along with a patient experience survey, during the same period as we were recruiting all NHS OH services in England for the second round of the national clinical audit of back pain management. While we aimed for 100% participation in the back pain audit, both the patient experience survey, and the record keeping audit reported here, were offered as a 'service' to those units that did not have their own local audit or wished to benchmark more widely. Importantly SEQOHS will accept the audit as suitable evidence for submission towards accreditation.

OH care for staff is provided by NHS trusts in England in a range of different ways. In carrying out the audit, we observed that there is a certain level of flux as service provision is re-tendered and re-organised.

At the time of this audit there were 436 trusts in England and 172 OH service providers. Trusts either have an in-house OH service or contract their service from another provider (or, for a small number, more than one provider), usually a different (local) NHS trust. Some OH providers serve multiple NHS trusts.

Recruitment for this audit was organised by OH service. However, data collection and analysis was organised at a site level. Each service provider was encouraged to submit a sample for each trust to which they provide OH care. However this was not mandatory and if the service provider had consistent record keeping practices across multiple trusts they could submit one set of records. These results can be seen as indicative of the service they provide to all of their trusts.

All OH providers to NHS trusts in England were eligible to take part. A full list of participating trusts and services can be found in appendix 2.

Data collection and entry

Participating departments were asked to calculate the total number of consultations held by each clinician in the OH service over a defined two-week period between 5 September and 23 December 2011, and to include a random 10% sample of consultation records generated by each clinician.

All data entry was through a specially designed audit website that was open between 5 September and 30 December 2011. Access to each site's data was password protected for confidentiality. For each case note audited the webtool routed the data collector through the questions, making available only the applicable answers, and responses were validated prior to completion of a case. No patient-identifiable data were requested. Help notes and definitions were provided as were free text 'comment boxes' to enable the data collector to give any clarifications.

The HWDU ran a helpdesk throughout the data collection period to answer any queries from participants. Regular reminders and updates were sent out to maximise the quantity and quality of data entered.

We specified that OH doctors and nurses should analyse records retrospectively and record the answers to the audit questions. Where feasible, data collection should have been carried out by somebody other than the clinician who wrote the record. More than one data collector could enter data for any one site – the site codes and passwords were specific to each site, rather than individuals (no clinician identifiers were used). Participants were advised that actions not explicitly documented in the record should not be recorded as having being performed, even if they were known to be normal practice for a particular OH professional or department. The audit tool and helpnotes can be found in appendix 3.

Inter-rater study

We asked sites to nominate a second OH professional to repeat the data collection for the first five cases entered into the audit. This was to enable us to assess the reliability of the questions, ie the extent to which different auditors agreed when asked to interpret the same set of notes. This is particularly important when using a set of audit questions for the first time, as in this case.

There are two factors that can reduce the reliability of data: disagreement on whether or not a particular question is applicable to the case, and disagreement on the most appropriate answer. The first of these was less relevant in this audit tool because almost all the questions applied to all the case notes and the auditor was not required to make a judgement of applicability. The second aspect was tested by calculating kappa scores for inter-rater agreement and McNemar-Bowker tests for systematic differences between the two auditors* (see appendix 4).

Pilot

The audit tool and help notes were piloted in July 2011. The audit tool was revised in light of analysis of the data and feedback from participants.

*For methods, see Altman DG (1991). *Practical Statistics for Medical Research.* Chapman and Hall, pp. 258 and 404.

Data analysis

We present descriptive statistics throughout this report without inference (p-values or confidence intervals). This means that differences between groups of cases are described but not tested for statistical significance.

The interpretation of results rests as far as possible with the audit participants, who are best placed to understand their meaning in the local context and to formulate quality improvement strategies as a result. The role of central analysis is to produce valid, reliable and high-quality local and national statistics through extensive checking and data cleaning.

Statistical analysis was carried out by the medical statistician at the Royal College of Physicians using Stata version 11. Results were interpreted by the audit development group and the project team. For clarity, figures are usually given without decimal places and graphs may be truncated to omit extreme values.

Presentation of results

The national report shows the pooled, anonymised results from all participating trusts. National results are presented as percentages.

Results and discussion

These audit results reflect the level of compliance with good practice guidelines and professional codes. General principles of good patient information management apply equally to paper / scanned and solely electronic records. The tables that follow display the audit results for paper and electronic records separately. Audit question numbers range from 4.1 to 4.26.

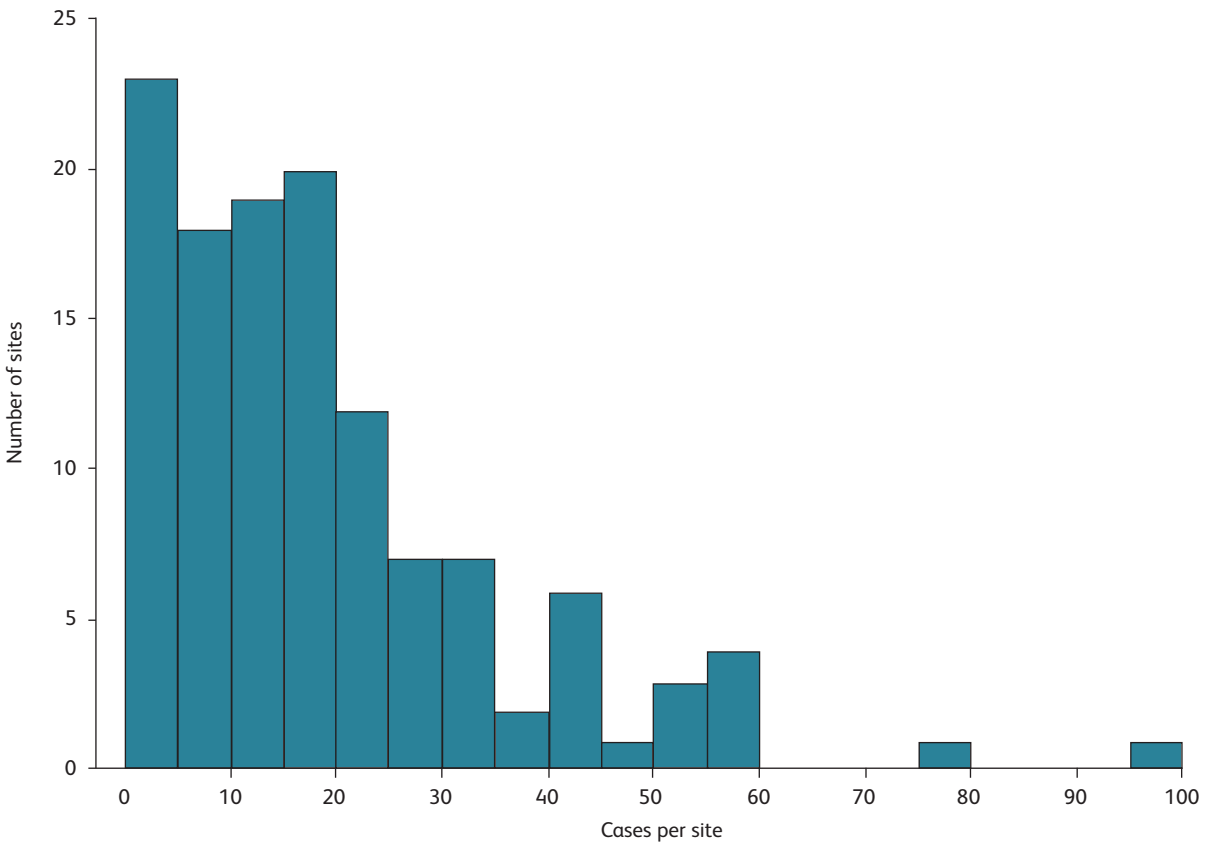
Participation

81/172 (47%) OH service providers entered data from 124 sites (covering 121 NHS trusts). Ten or more cases were entered by 83 (67%) sites and over half of the cases (1,190/2,343) came from 26 (21%) sites.

2,343 records were analysed in this audit comprising 1,595 (68%) paper/scanned records and 748(32%) electronic records.

84 sites submitted solely paper records, 16 submitted solely electronic records and 24 submitted a combination of both.

The graph below summarises the participation rates and contribution of case load to the audit.



We ask participants to note that if a small number of cases was entered for their site they should interpret their site-specific results with caution.

Legibility of case record

Legibility is the cornerstone of all clinical records whether written, scanned or in electronic format and is explicit within professional codes.

Standard

All clinically relevant words should be legible. This audit question applies a higher standard than professional codes or national guidelines as we required *every* word to be legible (not just clinically relevant words).

4.3 and 4.16: Are you able to read every word in this case note entry? (this refers to your ability to read it, not your view of whether others would be able to read it)

	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	1,345 (84%)	739 (99%)
No	250 (16%)	9 (1%)

Electronic records have a substantially higher degree of legibility than paper/ scanned records, in which approximately 1 in 6 records were not fully legible. We are not able to identify whether this is due to the clinician's handwriting or the quality of any scanned image.

Use of abbreviations and symbols

Local policies on the use of abbreviations within records vary. Some trusts allow abbreviations using specific conventions and others disallow any abbreviations.

Standard

Professional codes and national guidance suggest the use of abbreviations in clinical records is kept to a minimum.

4.4 and 4.17: Are abbreviations or symbols used?

	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	1,354 (85%)	478 (64%)
No	241 (15%)	270 (36%)

4.4.1 and 4.17.1: If yes, do they all follow common conventions?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	1,290 (95%)	461 (96%)
No	64 (5%)	17 (4%)

Fewer abbreviations were noted in electronic records versus paper / scanned records, perhaps because some software automatically inserts the full text when abbreviations are typed. Where abbreviations were used, they almost always followed recognised conventions for both paper / scanned and electronic records.

Permanence of records

Standard

It should not be possible to alter, erase or delete a clinical record without clear identification of the person making any alteration or deletion, and an audit trail showing the original record and any changes made. Good practice for paper records is to have the entry made in permanent ink, with any amendments or deletions made through crossing out with a single line and a date, signature and designation next to the changes.

4.5 and 4.16: Are ALL notes in this case note entry recorded in a way that cannot be erased (ie in permanent ink for written or scanned records) or be edited or deleted (electronic records)?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	1,522 (99.6%)	495 (66%)
No	6 (0.4%)	253 (34%)

4.13 (paper records only): Are there any deletions or alterations in the consultation record?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	310 (19%)	NA
No	1,285 (81%)	NA

4.13.2 and 4.13.3 (paper records only): If there are any deletions or alterations, have they all been countersigned and dated?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	23 (7%)	NA
No	287 (93%)	NA

A substantial proportion of sites using electronic records said that they could be amended or deleted. However, the main OH software providers have confirmed that case records can only be deleted subject to approved access and that an audit trail of changes and author of changes is retained.

When there were deletions or alterations in a paper based records, only 7% of records had all deletions or alterations countersigned and the date recorded.

Patient details

Standard

Each paper record should include the patient's full name, unique identifying number and date of consultation on each side of paper. For each paper record, sites were asked how many sides of paper related to the consultation, and then how many sides of paper had each of the following recorded: patient's full name, unique identifying number and the date of the consultation.

Electronic records

There are no formal recommendations for electronic records to include the patient's full name and unique identifying number on each page or screen of the electronic record. The audit development group (ADG) felt this was important so entries are not erroneously made in the incorrect patient's record. Both of the commonly used OH software systems allow clinicians to move to screens where the patient's full details are not in view. This could contribute to the occasional entering of data in an incorrect record.

The median number of sides of paper for a consultation was 2 (IQR 1,2) sides.*

4.7 and 4.20: Does each side of paper (or each screen of an electronic record) for this consultation have the patient's first and last name?

	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	1,033 (65%)	712 (95%)
No	562 (35%)	36 (5%)

4.8 and 4.21: Does each side of paper/screen for this consultation have the patient's unique identifying number?

	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	409 (26%)	357 (48%)
No	1,186 (74%)	391 (52%)

*Inter-quartile range (IQR) is the range within which the middle half of the results lie, one quarter being lower and one quarter higher.

4.9 and 4.22: Does each side of paper/screen for this consultation have the date recorded?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	1,187 (74%)	734 (98%)
No	408 (26%)	14 (2%)

Electronic records performed well at showing the patient's name on each screen but less well at showing a unique identifying number. In practice this is unlikely to cause problems during clinical consultations providing the identity was checked carefully when the record was first opened, although scope for errors remains.

Only 24% of paper records and 47% of electronic records met all three of these standards simultaneously (see table below).

This table combines the three tables above. 'Yes' indicates that a record had all of the following: date, patient's unique identifying number, and first and last names, on each side of paper/ screen.		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	377 (24%)	352 (47%)
No	1,218 (76%)	396 (53%)

Identification of the author of the clinical note

Standard

All clinical records should be attributed to a named person in an identified role. It is good practice for the author's name and designation to be printed at the end of each entry in the paper notes, or at least once in each entry in the electronic notes.

4.10 (paper records only): Does the consultation record have a signature of the author at the end of the record?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	1,499 (94%)	NA
No	96 (6%)	NA

4.11 and 4.23: Does the consultation record have the name of the author legibly printed at the end of the record (paper records) or recorded somewhere in the record (electronic records)?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	1,031 (65%)	722 (97%)
No	564 (35%)	26 (3%)

4.12 and 4.24: Does the consultation record have the author's job title legibly printed or recorded electronically in the record?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	918 (58%)	372 (50%)
No	677 (42%)	376 (50%)

Entries made in paper records are much less likely to contain the legibly printed name of the author than electronic records but are more likely to contain the author's designation.

Paper records did not consistently contain the employee's name, unique identifying number and consultation date on each side of paper, and the clinician's name, designation and signature at least once for each consultation. Only 15% of paper records met all of these standards (data table not shown).

Offering the report to the patient

Standard

A formal requirement to copy letters to patients following clinical assessments was initially contained in the DH 2003 publication 'Copying Letters to Patients'[10] and subsequently within the GMC 2009 guidance on confidentiality.[4]

4.14 and 4.25: Does the record show that the clinician has offered a copy of the manager's (or Human Resources representative's) report to the patient?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	808 (51%)	190 (25%)
No	207 (13%)	94 (13%)
NA	580 (36%)	464 (62%)

Excluding all non-applicable cases, an offer to copy the report to the patient was more likely to have been recorded on paper (80% (808/1015)), than if the record had been created electronically (67% (190/284)).

Record of consent under Access to Medical Reports Act 1988

The Act is the principle legislation that protects the rights of patients where their treating practitioner is asked to prepare a report for employment or insurance purposes.

Standard

Requests for medical reports must contain a formal written and signed request and consent from the patient.

4.15 and 4.26: If a report has been requested from another practitioner, is the patient's informed consent under the Access to Medical Reports Act clearly recorded?		
	National data	
	Paper / scanned records Number (%)	Electronic records Number (%)
Yes	82 (78%)	20 (83%)
No	23 (22%)	4 (17%)

The results show that medical reports are rarely requested but when they are, consent is usually documented in either the paper records (78% of the time) or electronic records (83% of the time).

Conclusions

Good documentation of an occupational health (OH) consultation is essential to provide evidence of good clinical care, provide continuity of care (particularly where more than one clinician is involved in a case), allow a patient to understand their clinical record, and to act as a defence in the event of litigation.

This audit has provided valuable data for individual OH departments to benchmark against the national results, and to identify where local performance can be improved.

The audit did not intend to make inferences about the quality of patient care or analyse the clinical content of the consultation notes, and instead focussed upon the processes around record keeping. The audit was not intended to provide evidence of the efficacy of paper / scanned notes versus electronic notes and indeed, both methods of record keeping had advantages over the other for several audit measures.

The variation in results both between and within paper and electronic records suggests that OH record keeping needs to improve, and that there are solutions to support better record keeping.

Legibility

Electronic records were consistently more legible than paper records and used fewer abbreviations and/or symbols. Where abbreviations/symbols were used they almost always followed common conventions irrespective of record type.

Correct labelling with the patient's and OH clinician's identity

Electronic records were more likely to record the relevant details of both the patient and OH clinician, with the exception of the clinician's designation (67% of electronic records versus 80% of paper records). Paper records did not consistently contain the employee's name, unique identifying number and consultation date on each side of paper, and the clinician's name, designation and signature at least once for each consultation. Only 15% of paper records met all of these standards.

Although this is disappointing, it gives rise to an area for clinicians to drive improvement using simple methods eg a stamp with the clinician's name and designation and patient identification stickers.

Reports

It is interesting to note that very few medical reports are requested following consultation with an OH doctor or nurse. Where they are requested, the majority of notes (78% paper and 83% electronic) show that appropriate consent has been obtained.

Electronic records performed less well on recording that the clinician had offered a copy of any manager's or HR representative's report to the patient (67% of electronic records versus 80% of paper records).

There is potential for improving formal documentation of discussions with patients about reports; both reports sent to managers and reports requested from other clinicians.

Recommendations

OH departments should invest in suitable electronic record systems that:

- are secure (prevent alterations or deletions, or allow alterations only by restricted authority and with a clear audit trail to track any changes retrospectively)
- comply with NHS information governance standards.

Pending the introduction of electronic systems, OH departments with paper-based record systems should:

- investigate simple changes that will increase compliance for recording the patient's name and date of consultation on each side of paper and the author's name and designation at least once on the record.

Regardless of whether records are paper or electronic, clinicians should:

- record consent under the Access to Medical Reports Act before they request a report from another clinician
- document carefully that copies of any reports to managers have been offered to the patient.

Next steps

Occupational health providers

We recommend that occupational health (OH) departments consider their own results in light of the targets and in comparison with the national results detailed in this report.

Where consultations do not meet the standards set by SEQOHS,[1] we recommend that OH departments review their practice and develop mechanisms for service improvement. These might involve some or all of the following activities:

- education and training
- sharing good practice between staff of the department, regionally and more widely
- dialogue with OH software systems providers to improve identification of multi-screen records and protect against retrospective alteration of records
- developing tools to facilitate improvement, for example action plans
- developing systems to support comprehensive documentation of consultations.

HWDU

HWDU has produced a list of the standards used in this audit. The list is available in appendix 1 of this report. It will be circulated to all OH services providing to the NHS in England, and will be placed on the HWDU website. Services can use the list when developing their action plans for improving their standard of record keeping.

HWDU will circulate an action planning template to all participating services to support them while reviewing their data.

HWDU will repeat national data collection in 2013, so that OH services have the opportunity to:

- measure improvement since round one
- measure their baseline if they did not participate in round one
- submit participation in the audit as evidence towards SEQOHS accreditation
- submit participation in this audit as evidence of CPD for revalidation (doctors).

The participants in this audit will be key stakeholders for these activities.

References

1. Safe Effective Quality Occupational Health Service. *Occupational Health Service Standards for Accreditation.* SEQOHS, 2010.
2. Royal College of Physicians – Health Informatics Unit. *Generic medical record keeping standards.* [Online] 2007. [Cited: 25 February 2012.] www.rcplondon.ac.uk/.
3. Department of Health. *Confidentiality. NHS Code of Practice.* London: Crown Copyright, 2003.
4. General Medical Council. *Confidentiality.* General Medical Council, 2009.
5. Royal College of Nursing. *Confidentiality: RCN guidance for occupational health nurses.* London: Royal College of Nursing, 2005.
6. Crown Copyright. *Data protection act.* Crown, 1998.
7. Faculty of Occupational Medicine. *Good occupational medicine practice.* FOM, 2010.
8. Crown Copyright. *Access to Medical Reports Act.* Crown, 1988.
9. Nursing and Midwifery Council. *Record Keeping: Guidance for Nurses and Midwives.* Nursing and Midwifery Council, 2009.
10. Department of Health. *Copying Letters to Patients: Good Practice Guidelines.* Department of Health, 2003.

Appendix 1: Detailed mapping of standards to specific questions in the record-keeping audit tool

HWDU audit question number	HWDU question wording	Complies with standard	Derived from
4.3 and 4.17	Are you able to read every word in this case note entry? (this refers to your ability to read it, not your view of whether others would be able to read it)	SEQOHS B1.1 FOM Ethics 2006	SEQOHS evidence required for standard B1.1
4.5 and 4.19	Are ALL notes in this case note entry recorded in a way that cannot be erased? ie in permanent ink	SEQOHS B1.1	SEQOHS evidence required for standard B1.1 RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q1
4.6	How many sides of paper relate to this consultation record?	SEQOHS B1.1	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q1
4.7 and 4.20	How many sides of paper for this consultation record have both the patient's first and last name?	SEQOHS B1.1	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q2
4.8 and 4.21	How many sides of paper for this consultation record have the patient's unique identifying number?	SEQOHS B1.1	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q3a and 3b
4.9 and 4.22	How many sides of paper for this consultation record have the date recorded?	SEQOHS B1.1 FOM Ethics 2006 NMC code 2008	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q15
4.10	Does the consultation record have a signature of the author at the end of the record?	SEQOHS B1.1 FOM Ethics 2006 NMC code 2008	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q17
4.11 and 4.23	Does the consultation record have the name of the author printed legibly at the end of the record?	SEQOHS B1.1 NHS Conf COP RCN conf 2003	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q18a
4.12 and 4.24	Does the consultation record have the author's job title printed legibly somewhere in the record?	SEQOHS B1.1	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q18b
4.13.1	How many deletions or alterations are there in the consultation record?	SEQOHS B1.1 NHS Conf COP	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q19

continued

HWDU audit question number	HWDU question wording	Complies with standard	Derived from
4.13.2	How many deletions or alterations are countersigned in the consultation record?	SEQOHS B1.1 NHS Conf COP FOM Ethics 2006	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q20
4.13.3	How many deletions or alterations in the consultation record was the date recorded?	SEQOHS B1.1 NHS Conf COP FOM Ethics 2006	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q21
4.14 and 4.25	Does the record show that the clinician has offered a copy of the manager's (or Human Resources representative's) report to the patient?	SEQOHS B1.1 GMC Conf 2009	New question HWDU
4.1 and 4.18	Are abbreviations or symbols used?	SEQOHS B1.1 NHS Conf COP	New question HWDU
4.4.1 and 4.18.1	If yes, do they all follow common conventions?	SEQOHS B1.1 NHS Conf COP	New question HWDU
5.15 and 4.26	If a report has been requested from another practitioner, is the patient's informed consent under the Access to Medical Reports Act clearly recorded?	AMR 1998	New question HWDU

Appendix 2: List of participating trusts and occupational health services

Trusts for which data were entered

2gether NHS Foundation Trust
Ashford & St Peter's Hospital NHS Trust
Barnet & Chase Farm Hospitals NHS Trust
Barnet, Enfield and Haringey Mental Health NHS Trust
Bedford Hospital NHS Trust
Blackpool Teaching Hospitals NHS Foundation Trust
Bolton NHS Foundation Trust
Calderdale & Huddersfield NHS Foundation Trust
Cambridgeshire Community Health Services NHS Trust
Camden and Islington NHS Foundation Trust
Central and North West London NHS Foundation Trust
Central and North West London NHS Foundation Trust (Camden Provider Services)
Central London Community Healthcare NHS Trust
City Health Care Partnership
City Hospitals Sunderland NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
Coventry & Warwickshire Partnership NHS Trust
Croydon Health Services NHS Trust
Derby Hospitals NHS Foundation Trust
Dorset HealthCare University NHS Foundation Trust
Ealing Hospital NHS Trust
East and North Hertfordshire NHS Trust
George Eliot Hospital NHS Trust
Great Western Hospitals NHS Foundation Trust
Halton and St Helens Community Health Services
Heart of England NHS Foundation Trust
Hinchingbrooke Health Care NHS Trust
Homerton University Hospital NHS Foundation Trust
Humber NHS Foundation Trust
Ipswich Hospital NHS Trust
Isle of Wight NHS Primary Care Trust
James Paget University Hospitals NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Leicestershire Partnership NHS Trust
Liverpool Women's NHS Foundation Trust
Luton and Dunstable Hospital NHS Foundation Trust
Manchester Mental Health & Social Care Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Staffordshire NHS Foundation Trust
NHS Barking and Dagenham
NHS Barnet
NHS Bedfordshire
NHS Brent
NHS Brent - Community Services
NHS Camden
NHS Cumbria
NHS Ealing
NHS East Riding of Yorkshire
NHS Harrow
NHS Hull
NHS Islington
NHS Kensington and Chelsea
NHS Leeds
NHS Leeds - Community Healthcare
NHS Oldham
NHS South East Essex - Community Healthcare
NHS South of Tyne - Gateshead Primary Care Trust
NHS Suffolk
NHS West Essex
NHS Westminster
Norfolk and Norwich University Hospitals NHS Foundation Trust
North Bristol NHS Trust
North East Ambulance Service NHS Trust
North East London NHS Foundation Trust
North Tees & Hartlepool NHS Foundation Trust
Northern Devon Healthcare NHS Trust
Northumberland, Tyne and Wear NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust
Oxford Radcliffe Hospitals NHS Trust
Papworth Hospital NHS Foundation Trust
Pennine Care NHS Foundation Trust
Poole Hospital NHS Foundation Trust
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust
Royal Devon & Exeter NHS Foundation Trust
Royal Free Hampstead NHS Trust
Royal National Orthopaedic Hospital NHS Trust
Salford Royal NHS Foundation Trust
Scarborough and North East Yorkshire Healthcare NHS Trust

Sheffield Children's NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Central Ambulance Service NHS Trust
South Essex Partnership University NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
Southend University Hospital NHS Foundation Trust
St George's Healthcare NHS Trust
Stockport NHS Foundation Trust
Sussex Community NHS Trust
Tameside Hospital NHS Foundation Trust
The Leeds Teaching Hospitals NHS Trust
The Mid Yorkshire Hospitals NHS Trust
The North West London Hospitals NHS Trust
The Pennine Acute Hospitals NHS Trust
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
The Queen Victoria Hospital NHS Foundation Trust
The Rotherham NHS Foundation Trust
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
The Shrewsbury and Telford Hospital NHS Trust
Trafford Healthcare NHS Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry & Warwickshire NHS Trust
University Hospitals of Leicester NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
Walsall Healthcare NHS Trust
West Hertfordshire Hospitals NHS Trust
West London Mental Health NHS Trust
West Middlesex University Hospital NHS Trust
Weston Area Health NHS Trust
Whittington Health
Winchester & Eastleigh Healthcare NHS Trust
Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust
Wrightington, Wigan & Leigh NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

Participating services

2gether NHS Foundation Trust
Ashford & St Peter's Hospital NHS Trust
Barnet & Chase Farm Hospitals NHS Trust
Bedford Hospital NHS Trust
Blackpool Teaching Hospitals NHS Foundation Trust
Bolton NHS Foundation Trust
Calderdale & Huddersfield NHS Foundation Trust
Central and North West London NHS Foundation Trust (Camden Provider Services)
Central London Community Healthcare NHS Trust
City Hospitals Sunderland NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
Coventry & Warwickshire Partnership NHS Trust
Croydon Health Services NHS Trust
Derby Hospitals NHS Foundation Trust
Dorset HealthCare University NHS Foundation Trust
Ealing Hospital NHS Trust
East and North Hertfordshire NHS Trust
Great Western Hospitals NHS Foundation Trust
Heart of England NHS Foundation Trust
Hinchingbrooke Health Care NHS Trust
Homerton University Hospital NHS Foundation Trust
Humber NHS Foundation Trust
Ipswich Hospital NHS Trust
Isle of Wight NHS Primary Care Trust
James Paget University Hospitals NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Luton and Dunstable Hospital NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Staffordshire NHS Foundation Trust
NHS South of Tyne - Gateshead Primary Care Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
North East Ambulance Service NHS Trust
North Tees & Hartlepool NHS Foundation Trust
Northern Devon Healthcare NHS Trust
Northumbria Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust
Oxford Radcliffe Hospitals NHS Trust
Papworth Hospital NHS Foundation Trust
Poole Hospital NHS Foundation Trust
Royal Devon & Exeter NHS Foundation Trust
Royal Free Hampstead NHS Trust
Royal National Orthopaedic Hospital NHS Trust
Salford Royal NHS Foundation Trust
Scarborough and North East Yorkshire Healthcare NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
Southend University Hospital NHS Foundation Trust

St George's Healthcare NHS Trust
Stockport NHS Foundation Trust
Sussex Community NHS Trust
Tameside Hospital NHS Foundation Trust
Team Prevent
The Leeds Teaching Hospitals NHS Trust
The Mid Yorkshire Hospitals NHS Trust
The North West London Hospitals NHS Trust
The Pennine Acute Hospitals NHS Trust
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
The Rotherham NHS Foundation Trust
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
Trafford Healthcare NHS Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry & Warwickshire NHS Trust
University Hospitals of Leicester NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
Walsall Healthcare NHS Trust
West Hertfordshire Hospitals NHS Trust
West London Mental Health NHS Trust
West Middlesex University Hospital NHS Trust
Whittington Health
Winchester & Eastleigh Healthcare NHS Trust
Worcestershire Acute Hospitals NHS Trust
Wrightington, Wigan & Leigh NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

Appendix 3: Audit tool and help notes

Health and Work Development Unit
National Audit of Record Keeping by Occupational Health Services 2011

Case note review _____

Your Site Code _____

Instructions for completion:

Please use a ball-point pen for all sections.

Please cross the boxes as appropriate (☒ or ⊗).

Data should be submitted to HWDU via our webtool at https://audits.rcplondon.ac.uk between 5 September and 9 December 2011. Please note we are unable to accept forms submitted on paper for this audit.

You are required to audit 10% of records seen by each clinician within your department/ service during a 2 week period between 5 September and 9 December 2011. To do this you will need to: count the total number of consultations (irrespective of type) held by each clinician and calculate how many are needed to meet the 10% sample size. The sample should be constructed of consecutive cases, ordered by the date of the first consultation in OH. If this number of cases seems unreasonable please use your best judgment for an appropriate sample size and contact the HWDU helpdesk to discuss your situation.

Data should be extracted by a member of the OH unit staff with clinical knowledge. Ideally a single individual should audit all cases. Individuals must not audit their own case notes. A second auditor should be identified to submit data for 5 inter-rater cases.

An inter-rater study is conducted for each sample to assess the reliability of the audit tool. A second, independent auditor must audit the first five cases of each sample for a second time, and these cases should be entered onto the webtool as pairs. The first auditor must make a note of the record ID assigned by the system when entering the case onto the webtool. The second auditor should then enter the case as a new case, and link the two entries using the case number assigned at the first entry by entering the record ID on question 4.2.1 (or 4.16.1 if it is an electronic record).

Please refer to the accompanying helpnotes booklet for full instructions.

The help desk can be contacted on 0203 075 1585 or hwdu@rcplondon.ac.uk.

4.1 The consultation record being audited is a(n):

◯ PAPER BASED / SCANNED RECORD (COMPLETE questions 4.2 to 4.15 ONLY)

◯ ELECTRONIC RECORD (COMPLETE questions 4.16 to 4.26 ONLY)

Section A: PAPER BASED / SCANNED RECORDS ONLY

4.2 Is this a reliability case? ◯ Yes ◯ No

4.2.1 If yes, please enter the record ID of the case you are entering for a second time? ☐

4.3 Are you able to read every word in this case note entry? (this refers to your ability to read it, not your view of whether others would be able to read it) ◯ Yes ◯ No

4.4 Are abbreviations or symbols used? ◯ Yes ◯ No

4.4.1 If yes, do they all follow common conventions? ◯ Yes ◯ No

4.5	Are ALL notes in this case note entry recorded in a way that cannot be erased? i.e. in permanent ink	◯ Yes ◯ No ◯ N/A (scanned record)
4.6	How many sides of paper relate to this consultation record?	
4.7	How many sides of paper for this consultation record have both the patient's first and last name?	
4.8	How many sides of paper for this consultation record have the patient's unique identifying number?	
4.9	How many sides of paper for this consultation record have the date recorded?	
4.10	Does the consultation record have a signature of the author at the end of the record?	◯ Yes ◯ No
4.11	Does the consultation record have the name of the author printed legibly at the end of the record?	◯ Yes ◯ No
4.12	Does the consultation record have the author's job title printed legibly somewhere in the record?	◯ Yes ◯ No
4.13	Are there any deletions or alterations in the consultation record?	◯ Yes ◯ No
4.13.1	If yes, how many deletions or alterations are there in the consultation record?	
4.13.2	If yes, how many deletions or alterations are countersigned in the consultation record?	
4.13.3	If yes, for how many deletions or alterations in the consultation record was the date recorded?	
4.14	Does the record show that the clinician has offered a copy of the manager's (or Human Resources representative's) report to the patient?	◯ Yes ◯ No ◯ N/A
4.15	If a report has been requested from another practitioner, is the patient's informed consent under the Access to Medical Reports Act clearly recorded?	◯ Yes ◯ No ◯ N/A (report not requested)

Section B: ELECTRONIC RECORDS ONLY

4.16	Is this a reliability case?	◯ Yes ◯ No
4.16.1	If yes, please enter the record ID of the case you are entering for a second time?	
4.17	Are you able to read every word in this case note entry? (this refers to your ability to read it, not your view of whether others would be able to read it)	◯ Yes ◯ No
4.18	Are abbreviations or symbols used?	◯ Yes ◯ No
4.18.1	If yes, do they all follow common conventions?	◯ Yes ◯ No
4.19	Are ALL notes in this case note entry recorded in a way that they cannot be edited or deleted?	◯ Yes ◯ No
4.20	Does each screen for this consultation record have the patient's first and last name?	◯ Yes ◯ No

4.21	Does each screen for this consultation record have the patient's unique identifying number?	◯ Yes ◯ No
4.22	Does the consultation record have the date recorded?	◯ Yes ◯ No
4.23	Does the consultation record have a legible electronic name of the author?	◯ Yes ◯ No
4.24	Does the consultation record have the author's legible electronic job title?	◯ Yes ◯ No
4.25	Does the record show that the clinician has offered a copy of the manager's (or Human Resources representative's) report to the patient?	◯ Yes ◯ No ◯ N/A
4.26	If a report has been requested from another practitioner, is the patient's informed consent under the Access to Medical Reports Act clearly recorded?	◯ Yes ◯ No ◯ N/A (report not requested)

National Audit of Record Keeping Standards by Occupational Health Services 2011: Helpnotes

Version: August 2011

1 Acknowledgements

The Health and Work Development Unit (HWDU) audit development group thanks all those who have been involved in developing and piloting the audit tool, and colleagues for their help and advice.

The audit has been part funded by NHS Plus and the Academy of Medical Royal Colleges.

2 Help and support for data collection

These helpnotes contain all the information needed to participate in the audit. Please read them carefully before commencing data collection and entry onto the webtool. If you have any queries, or find that your occupational health (OH) provision does not fall into the structures described, the audit helpdesk should be contacted for advice, either by email to hwdu@rcplondon.ac.uk or by phone on 020 3075 1585 (Monday – Friday, 10:00am–4:00pm).

3 The Health and Work Development Unit

The HWDU is a partnership between the Royal College of Physicians (RCP) Clinical Standards department and the Faculty of Occupational Medicine (FOM). HWDU aims to improve the health of the workforce through the delivery of national quality improvement projects. HWDU measures and raises standards, and reduces variability, of OH care through the development of evidence-based guidelines and by conducting national clinical and organisational audits. HWDU also works to improve the implementation of NICE public health guidance for the workplace.

4 Introduction

This national comparative audit aims to measure NHS OH services' compliance with guidance on record keeping standards and benchmark against NHS OH services nationally.

Participation in this national audit is optional and will provide participating services with evidence of compliance with Safe Effective Quality Occupational Health Service (SEQOHS) accreditation standard B1.1.

5 Methodology

Eligibility

All NHS trusts in England are eligible and encouraged to participate, irrespective of OH provider. The unit of audit is the OH service.

OH services that provide to more than one trust do not need to enter data for every trust they provide to, assuming the record keeping is the same. However as a service provider we encourage you to confer with your contract manager regarding their expectations.

Site codes

Trusts either have their own in-house OH service or commission it from another provider. Because some trusts use more than one OH service and some OH services provide to more than one trust, we are registering participants

by OH service. However, results will be fed back by site – we use the term 'site' for each combination of an OH provider and trust. A unique site code, which will double as a username for the online data collection tool, will be provided for each site to submit data.

How has this audit been designed?

The national audit of record keeping standards is a case note review of documentation. The audit criteria are based on guidance on medical record keeping standards from the Health Informatics Unit at the RCP,* the Department for Health (DH) NHS Confidentiality Code of Practice,** General Medical Council (GMC) Guidance on Confidentiality (2009),† Royal College of Nursing (RCN) Guidance for Occupational Health Nurses,‡ the Data Protection Act (1998),§ FOM 'Good Occupational Medicine' guidance,§§ Access to Medical Reports Act (1988)†† and Nursing and Midwifery Council (NMC) 'Record keeping: Guidance for nurses and midwives' (2010).‡‡

An inter-rater study will be conducted for each sample of data to assess the reliability of the audit tool.

Audit tool development has been overseen by a multidisciplinary development group. The tool was piloted in 21 NHS OH services, and amended in response to feedback from participants and statistical analysis of the pilot data.

How do I select cases for this audit?

You are required to audit 10% of records relating to any consultation by each clinician within your department/ service during a 2 week period between 5 September and 9 December 2011.

To do this, you should count the total number of consultations (irrespective of type) held by each clinician and calculate how many are needed to meet the 10% sample size. When working out your 10% sample it is advised that you take records from a variety of clinic types.

The sample should be constructed of consecutive cases, ordered by the date of the first consultation in OH. If the 10% sample total seems unreasonable please use your best judgment for an appropriate sample size and contact the HWDU helpdesk to discuss your situation.

6 Data collection

How does the audit ensure the quality of the data collected?

Each trust will have a designated lead clinician who will take overall responsibility for the data submitted to the audit.

The data should be extracted by a member of OH unit staff with clinical knowledge. A single individual should audit all cases and individuals should not audit their own records. A second auditor should be identified to submit data for 5 inter-rater cases.

When is data collection running?

The data collection period is 5 September to 9 December. The helpdesk can be contacted by email to hwdu@rcplondon.ac.uk or phone to 020 3075 1585 throughout this period.

*http://www.rcplondon.ac.uk/sites/default/files/generic-medical-record-keeping-standards-2009.pdf
**Confidentiality. NHS Code of Practice. 2003. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253
†Confidentiality, General Medical Council. 2009. http://www.gmc-uk.org/guidance/news_consultation/confidentiality_guidance.asp
‡http://www.rcn.org.uk/__data/assets/pdf_file/0003/78582/002043.pdf
§Data Protection Act 1998. http://www.legislation.gov.uk/ukpga/1998/29/contents
§§http://www.facoccmed.ac.uk/library/docs/p_gomp2010.pdf
††http://www.legislation.gov.uk/ukpga/1988/28/contents
‡‡http://www.nmc-uk.org/Documents/Guidance/nmcGuidanceRecordKeepingGuidanceforNursesandMidwives.pdf

What should I do to prepare for data collection?

Those responsible for collecting data and feeding back results (the audit clinical lead and/or coordinator) should set aside time ahead of data collection to plan the service's participation in the audit.

Auditors should review the tool and identify the sample of case notes as described above.

An individual with clinical knowledge should be identified to enter cases into the audit (first auditor). A second individual should also be identified to enter data from the records that have resulted from consultations conducted by the first auditor. This is because individuals should not audit their own records. The second auditor should also enter data from 5 inter-rater cases (see below for more details).

You should keep a secure, local record of the webtool record ID number that has been assigned to each clinical case in your sample. This is in case we need to contact you for any further information whilst we are cleaning and analysing your data. It is also used to match inter-rater cases entered by the second auditor with those initially entered by the first auditor.

How can I access the webtool and how do I use it?

The webtool is accessed at https://audits.rcplondon.ac.uk and full details of how to enter data online are available in the support document 'Guide to using the webtool'. This can be downloaded once you have logged into the website. If you have any difficulty getting started please contact the helpdesk and we will talk you through the process.

Online help is available at the right hand side of the screen as you respond to each question.

The webtool has been designed for data to be entered at the time of extraction from the case notes. A printable version of the audit tool is available should you prefer to collect data on paper before transferring it onto the webtool.

HWDU is also conducting the national audit of back pain management – when you go to add a new record you will be asked which audit you are entering data for; please select the 'record keeping audit' to enter data for this audit. The webtool will only allow you to answer questions on section 4 on the data entry screen.

Your raw data can be exported into spreadsheet format as a local record, or for additional, local analysis.

Please note that the HWDU does not have capacity to accept audit data on paper proformas; all data should be submitted via the webtool.

You can leave additional comments via the webtool. In the interests of patient confidentiality, no name, number or other information that could potentially identify an individual should be entered onto the webtool, including into the comment facility.

You must 'commit' your audit cases when finalised. This indicates to HWDU that your data are ready for analysis.

How do I complete the audit proforma?

The data submitted must reflect what is in the records being audited.

The audit tool should contain data only from the consultation being audited.

The data must not represent what the auditor knows or assumes about the clinical state of the individual case.

Data may be collected by any member of the clinical team but ideally only two auditors should audit the records, with one individual auditing the majority of the cases and a second individual auditing the first auditor's records and the five inter-rater cases.

Why does my colleague need to re-audit my first 5 cases?

An inter-rater study is conducted for each sample to assess the reliability of the audit tool. A second, independent auditor must audit the first five cases of each sample for a second time, and these cases should be entered onto the

webtool as pairs. The first auditor must make a note of the record ID assigned by the system when entering each case onto the webtool. The second auditor should then enter the data as a new case, and link the two entries using the case number assigned at the first entry by entering the record ID on question 4.2.1 (or 4.16.1 if it is an electronic record).

7 Results and publication

How will the results be disseminated?

A generic national report will be publicly available describing the national average picture, and each site will be provided with a confidential report detailing average results in comparison to the national average results. These reports will be ready by March 2012.

Individual trust's data will not be put into the public domain. A participation list will be published in the final national report. Trusts and/ or services will not be ranked and performance indicators will not be used.

8 Ethics, confidentiality and data protection

Do I need to submit this audit to my local ethics committee?

It is the understanding of the HWDU that you will not need to submit this audit to your local ethics committee. No patient- or clinician-identifiable data will be collected, and reports will provide the average data for occupational health record keeping of a given trust in comparison to the national average data. If local arrangements require you to submit the audit to the local ethics committee and you need help with a proposal for ethics committee review please let us know and we will do our best to support you.

How can I ensure confidentiality/ anonymity of clients? Should I inform our clients the audit is taking place?

Each OH unit is responsible for ensuring that clients are aware that clinical audits are carried out by the service, and that their records may be included in an audit so that they have the opportunity to opt out (for example by placing notices in staff/waiting areas). Due to the sensitivity of auditing the case notes of employees we advise that a member of the OH unit's clinical team extracts the data.

How are data confidentiality and security ensured?

Data will be submitted via the webtool which is hosted on a secure server. OH services will be provided with a site code and password relating to each trust for which they are submitting data, as described under 'How do I select cases/ patients for the survey'. These site codes and passwords are confidential to the OH service and employing trust. Under no circumstances should site codes or passwords be passed on to others outside the organisation. If a user believes that their password has been compromised they should inform the HWDU immediately. Users will only be able to see data in records from their own service. If a user detects what he or she believes is a breach of security or confidentiality then it is their responsibility not to disseminate the information obtained and to report the event to the HWDU immediately. In the interests of patient confidentiality, no name, number or other information that could potentially identify an individual should be used on the audit documentation or entered onto the webtool, including into the comment facility.

Data protection and information governance

The HWDU processes the contact details held for the purpose of managing the audits in line with the data protection act. The HWDU operates under the Royal College of Physicians' Clinical Standards Department information governance policy, if you would like a copy of this document, please email HWDU (hwdu@rcplondon.ac.uk).

National Audit of Record Keeping: helpnotes and rationale for the case note review

Question Number	Question Text	Standard	Source	Helpnotes
Part Four: Record Keeping Please tick to indicate whether the OH record for this consultation complies with the following standards?				
4.1	The consultation record being audited is a(n):			◯ PAPER BASED/ SCANNED RECORDS (COMPLETE questions 4.1 to 4.15 ONLY) ◯ ELECTRONIC RECORDS ONLY (COMPLETE questions 4.17 to 4.26 ONLY)
Section A: PAPER BASED/ SCANNED RECORDS ONLY				
4.2	Is this a reliability case?			An inter-rater study is conducted for each sample to assess the reliability of the audit tool. A second, independent auditor must audit the first five cases of each sample for a second time. If this is the second time a case has been entered into the tool then choose 'yes'.
4.2.1	If yes, please enter the record ID of the case you are entering for the second time			The first auditor must make a note of the record ID assigned by the system when entering each case onto the webtool. The second auditor should then enter the case for a second time as a new case, and link the two entries using the case number assigned at the first entry by entering the record ID here.
4.3	Are you able to read every word in this case note entry? (this refers to your ability to read it, not your view of whether others would be able to read it)	SEQOHS B1.1 FOM Ethics 2006	SEQOHS evidence required for standard B1.1	To answer yes for handwritten notes, all words must be legible. The reader should not have to guess or make assumptions about words based on the sentence or adjacent words.
4.4	Are abbreviations or symbols used?	SEQOHS B1.1	New question HWDU	
4.4.1	If yes, do they all follow common conventions?	SEQOHS B1.1	New question HWDU SEQOHS evidence required for standard B1.1	To answer 'yes', you should understand every abbreviation and / or symbol used. (The reader should not have to guess or make assumptions about abbreviation and/ or symbol based on the sentence or adjacent words. Which abbreviations are acceptable is a matter of judgment for the auditor and / or policy of the trust).

continued

Question Number	Question Text	Standard	Source	Helpnotes
4.5	Are ALL notes in this case note entry recorded in a way that cannot be erased? ie in permanent ink	SEQOHS B1.1	SEQOHS evidence required for standard B1.1 RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q1	
4.6	How many sides of paper relate to this consultation record?	SEQOHS B1.1	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q2	Count all sides of paper that include an entry for this consultation, even if the majority of the page relates to a previous or subsequent consultation.
4.7	How many sides of paper for consultation record have both the patient's first and last name?	SEQOHS B1.1	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q3a and 3b	To answer 'yes' the first and last name of the patient must be legible.
4.8	How many sides of paper for this consultation record have the patient's unique identifying number?	SEQOHS B1.1	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q15	This is a group of numbers, letters or both that is assigned to the patient's record in occupational health e.g. one that is generated by the OH service, NHS number or NI number. Date of birth is not a unique identifier by itself. Name, date of birth and address together are acceptable as a unique identifier – but all three items must be present.
4.9	How many sides of paper for this consultation record have the date recorded?	SEQOHS B1.1 FOM Ethics 2006 NMC code 2008	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q15	
4.10	Does the consultation record have a signature of the author at the end of the record?	SEQOHS B1.1 FOM Ethics 2006 NMC code 2008	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q17	The signature does not need to be on every page of the record but should appear on the last page of the record. Initials alone are not acceptable unless they are recognisable distinctly as the OH clinician's unique signature.

continued

Question Number	Question Text	Standard	Source	Helpnotes
4.11	Does the consultation record have the name of the author printed legibly at the end of the record?	SEQOHS B1.1 NHS Conf COP RCN conf 2003	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q18a	If a signature is legible enough to identify the practitioner to an unfamiliar reader, the signature may be counted for a 'yes' answer. If the signature is not legible, the practitioners name must otherwise be written or printed in a legible form to answer 'yes'.
4.12	Does the consultation record have the author's job title printed legibly somewhere in the record?	SEQOHS B1.1	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q18b	This is the job title of the OH professional who conducted the consultation.
4.13	Are there any deletions or alterations in the consultation record?			Deletions or alteration include any change or strike through to any note or word or date.
4.13.1	If 'yes', how many deletions or alterations are there in the consultation record?	SEQOHS B1.1 NHS Conf COP	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q19	
4.13.2	If 'yes', how many deletions or alterations are countersigned in the consultation record?	SEQOHS B1.1 NHS Conf COP FOM Ethics 2006	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q20	
4.13.3	If 'yes', for how many deletions or alterations in the consultation record was the date recorded?	SEQOHS B1.1 NHS Conf COP FOM Ethics 2006	RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q21	

continued

Question Number	Question Text	Standard	Source	Helpnotes
4.14	Does the record show that the clinician has offered a copy of the manager's (or Human Resources representative's) report to the patient?	SEQOHS B1.1 GMC Conf 2009	New question HWDU	To answer 'yes', the record must clearly show that the patient has received an explanation of their right to a copy of the report either at the same time as the manager or before it is released. This may be as part of the consultation notes or part of a consent form relating to that consultation. Answer' N/A' if a report has not been produced as a result of the consultation (for example, self referrals where the patient has asked that a report not be produced).
4.15	If a report has been requested from another practitioner, is the patient's informed consent under the Access to Medical Records Act clearly recorded?	AMR 1998	New question HWDU	This may be recorded as a letter or form signed by the patient.
Section B: ELECTRONIC RECORDS ONLY				
4.16	Is this a reliability case?			An inter-rater study is conducted for each sample to assess the reliability of the audit tool. A second, independent auditor must audit the first five cases of each sample for a second time. If this is the second time a case has been entered into the tool then choose 'yes'.
4.16.1	If yes, please enter the record ID of the case you are entering for the second time			The first auditor must make a note of the record ID assigned by the system when entering each case onto the webtool. The second auditor should then enter the case for a second time as a new case, and link the two entries using the case number assigned at the first entry by entering the record ID here.
4.17	Are you able to read every word in this case note entry? (this refers to your ability to read it, not your view of whether others would be able to read it)	SEQOHS B1.1 FOM Ethics 2006	SEQOHS evidence required for standard B1.1	To answer yes for electronic notes, all words must be legible. The reader should not have to guess or make assumptions about words based on the sentence or adjacent words.
4.18	Are abbreviations or symbols used?	SEQOHS B1.1 NHS Conf COP	New question HWDU	

continued

Question Number	Question Text	Standard	Source	Helpnotes
4.18.1	If yes, do they all follow common conventions?	SEQOHS B1.1 NHS Conf COP	New question HWDU	To answer yes, you must be able to understand every abbreviation and / or symbol used. (The reader should not have to guess or make assumptions about abbreviation and/ or symbol based on the sentence or adjacent words. Which abbreviations are acceptable is a matter of judgment for the auditor and / or policy of the trust).
4.19	Are ALL notes in this case note entry recorded in a way that cannot be edited or deleted?	SEQOHS B1.1	SEQOHS evidence required for standard B1.1 RCP HIU Audit tool for the generic health records keeping standards for inpatient records. Q1	The accepted quality standard for electronic records is that it must not be possible for users to delete or alter clinical data without the permission of the system manager (usually a lead nurse or physician).
4.20	Does each screen for this consultation record have the patient's first and last name?	SEQOHS B1.1	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q3a and 3b	
4.21	Does each screen for this consultation record have the patient's unique identifying number?	SEQOHS B1.1	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q15	This is a group of numbers, letters or both that is assigned to the patient's record in occupational health eg generated by the OH service or the IT system, NHS number or NI number. Date of birth is not a unique identifier on its own. Name, date of birth and address together are acceptable as a unique identifier – but all three items must be present.
4.22	Does the consultation record have the date recorded?	SEQOHS B1.1 FOM Ethics 2006 NMC code 2008	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q15	

continued

Question Number	Question Text	Standard	Source	Helpnotes
4.23	Does the consultation record have a legible electronic name of the author?	SEQOHS B1.1 NHS Conf COP RCN conf 2003	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q18a	
4.24	Does the consultation record have a legible electronic job title of the author?	SEQOHS B1.1	RCP HIU audit tool for the generic health record keeping standards for inpatient records. Q18b	
4.25	Does the record show that the clinician has offered a copy of the manager's (or Human Resources representative's) report to the patient?	SEQOHS B1.1 GMC Conf 2009	New question HWDU	To answer 'yes', the record must clearly show that the patient has received an explanation of their right to a copy of the report either at the same time as the manager or before it is released. This may be as part of the consultation notes or part of a consent form relating to that consultation. Answer' N/A' if a report has not been produced as a result of the consultation (for example, self referrals where the patient has asked that a report not be produced).
4.26	If a report has been requested from another practitioner, is the patient's informed consent under the Access to Medical Reports Act clearly recorded?	AMR 1998	New question HWDU	This may be recorded as a letter or form signed by the patient. It could be scanned into the electronic record or flagged on the record but kept in a separate paper file.

Appendix 4: Inter-rater reliability

Reliability (agreement between auditors) is not the same as validity (accuracy of measure). However establishing good agreement between auditors is an important part of the process of validation as valid data by definition will have to be reliable.

We compared the data entered on duplicate cases by first and second auditors (see Methods).

For categorical questions (mostly yes / no / not documented), we applied the kappa statistic. This quantifies the degree to which the assessors agree over and above what could be expected by chance (kappa score). Kappa ranges from 1 (perfect agreement) to 0 (no more than chance agreement) to –1 (complete disagreement). Additionally, we used the McNemar's test to see whether one of the assessors was inclined to disagree in one direction more often than another.

Question	Kappa
4.3	0.63
4.4	0.59
4.4.1	0.37
4.1	0.60
4.11	0.80
4.12	0.80
4.13	0.79
4.14	0.79
4.18	0.64
4.18.1	1.00
4.19	0.96
4.2	0.56
4.21	0.96
4.22	1.00
4.23	0.27
4.24	0.91
4.25	0.89
Average	0.74

Some questions either had too few valid responses. These are not included in the kappa results. Only two questions, both from the electronic records audit, showed a significant result using McNemar's test. In question 4.18 the second assessor was more likely to answer 'yes' when disagreeing with the first assessor, whilst for question 4.23 they were more likely to answer 'no' when disagreeing.

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