Policy on Creation of a Record	
Developed by: Director of Nursing Office, Clinical Nurse Managers	**Date Developed: Revised February 2011 Revised August 2014, August 2017, August 2020, September 2023**
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Policy in Relation to the Creation of a Record.

1.0. A wide variety of records are held across the Centre including healthcare records, financial records, HR records and general administrative records.
Traditionally, records were paper-based but in recent times an increasing number of records are being stored electronically. This document outlines the minimum retention period for records in this Centre and applies to records of all types regardless of the medium on which they are held.

2.0 Definition of Record
A record is defined under the Freedom of Information Acts 1997 and 2003 as
"any memorandum, book, plan, map, drawing, diagram, pictorial or graphic work or other document, any photograph, film or recording (whether of sound or images or both), any form in which data (within the meaning of the Data Protection Act, 1988 and 2003) are held, any other form (including machine-readable form) or device in which information is held or stored manually, mechanically or electronically and anything that is a part or a copy, in any form of any of the foregoing or is a combination of two or more of the foregoing" (Freedom of Information Act, 1997, 2003).
Records created by this Service should be both accurate and complete. They must provide evidence of the function or activity they were created to document. In order to be evidential, records must **be authentic, reliable, have integrity and be useable**.

2.1 An authentic record is one that can be proven to be what it purports to be. In order to ensure that the records created are authentic then records should be dated, timed and signed.
They should be placed into the filing system to form part of the retention schedule so that they are protected against unauthorised addition, deletion or alteration.
2.2 A reliable record is one that can be trusted to be an accurate representation of a function or action taken by the HSE location. Therefore, records should contain all relevant facts and be created at the time of the action or transaction or as soon as possible afterwards by a person authorised to carry out that function, action or transaction.
2.3 The integrity of a record refers to it being complete and unaltered. Once created, additions or annotations to the record can only be carried out by those authorised to do so and any amendment should be explicitly indicated on the record.
2.4 A useable record is one that can be located, retrieved, presented and interpreted or read whenever or wherever there is a justified need for that information. It should be traceable within a records management system. Record schedules and filing indices that capture the records are essential in ensuring records are useable. In electronic records, metadata or contextual information is required in addition to the physical transfer of records to ensure their continued usability.
2.5 Records retained should be original (or an electronic copy, transferred using the appropriate and verifiable system), unique or of continuing importance to the HSE. They should have care delivery, legal, fiscal, administrative or historical purpose.

3.1 The categories of records referred to in this document are as follows:

• Healthcare records, including acute hospitals and non acute services, including health and social care professionals such as nurses, physiotherapists, speech and language therapists and public health nurses. A healthcare record refers to all information collected, processed and held both in manual and electronic formats pertaining to the service user and their care. It includes demographics, unique identification, clinical data, images, investigations, samples, correspondence and communications relating to the service user and their care.

• Environmental Health records

• Personnel / HR records.

• Financial records.

4.0.Why good records are important

The main reason for maintaining medical records is to ensure continuity of care for the resident. They may also be required for legal purposes if, for example, the resident pursues a claim following an accident or an injury. For health professionals, good medical records are vital for defending a complaint or clinical negligence claim; they provide a window on the clinical judgment being exercised at the time.

In general, records that are adequate for continuity of care are also sufficiently comprehensive for legal use.

In this Service A medical Record is created when a resident is admitted to Extended Care or Short Stay Care

5.0. Colour Code.

Extended Care: Red Cover

4.0. Good medical records summarise the key details of every patient contact. On the first occasion a resident is seen, records should include:

- Relevant details of the history, including important negatives
- Examination findings, both positive and negative
- Differential diagnosis
- Details of any investigations requested and any treatment provided

- Follow-up arrangements
- What you have told/discussed with the patient.
- Pre admission assessments, medical assessments and allied health professional assessments

On subsequent occasions, you should also note the residents progress, findings on examination, monitoring and follow-up arrangements, details of telephone consultations, details about chaperones present, and any instances in which the patient has provided or refused consent to be examined or treated. It is also important to record your opinion at the time regarding, for example, diagnosis.

5.0. Medical records must be:

- Objective recordings of what you have been told or discovered through investigation or examination
- Clear and legible
- Made contemporaneously, signed and dated
- Kept securely.

NB Although abbreviations are undoubtedly a great time-saver, you should take care to use them only where their meaning is unambiguous and would be easily understood by your colleagues. Never use abbreviations for making derogatory comments about the patient. There is a list of approved abbreviations on your Unit as issued by HSE (2010)

Medical records should contain all the pertinent information about a resident's care and can cover a wide range of material including:

- Handwritten notes
- Computerised records
- Correspondence between health professionals
- Laboratory reports
- Imaging records, including x-rays
- Photographs
- Video and other recordings

- Printouts from monitoring equipment.

6.0. Ethical expectations

The Medical Council states in its publication, Guide to Ethical Conduct and Behaviour (2004, 6th edition, paragraphs 4.10 and 16.4) that "It is in the interest of both doctors and patients that accurate records are always kept [indefinitely]. These should be retained for an adequate period… eventual disposal may be subject to advice from legal and insurance bodies… Doctors should take all reasonable measures to ensure that other health professionals and ancillary staff maintain confidentiality."

Patients have a right to access their own medical records under current Irish Data Protection and Freedom of Information legislation, on the condition that doing so will not compromise their health or the health of others. Inadequate records that fail to address the key issues will create a poor impression, particularly if they include inappropriate subjective comments about the patient.

7.0. Additions or alterations

If you need to delete something from a resident's record, you should put a thin line through the incorrect entry in pen. Insert the date and your initials, and make a note of the reason for the alteration. The original note must not be overwritten and should still be legible, so no one can accuse you of trying to pass off the amended entry as contemporaneous.

Resident's have the right, under the Data Protection (Amendment) Act (2003), to ask for factual inaccuracies in the record to be rectified or deleted. The Act does not, however, give them the right to ask for entries expressing professional opinions to be changed. You should only comply with a request if you are satisfied that it is valid – i.e., the entry is indeed factually inaccurate – but if you decide that a correction is not warranted, you should still annotate the disputed entry with the patient's view.

If you decide that the request is valid, add a signed and dated supplementary note to correct the inaccuracy and make it clear that the correction is being made at the resident's request. Avoid deleting the original entry, though. If the resident demands nothing less than deletion, refer him/her to the Information Commissioner, who will then assess the validity of the request and, if necessary,

order the deletion.

Doctors and Nurses and all staff have a duty to keep proper medical records. Medical records relating to care must also be kept confidential by GPs and hospital staff. However, a resident is entitled to get access to the records and can do so in several ways.

9.0. Further information

- Data Protection (Amendment) Act 2003 – www.irishstatutebook.ie
- Medical Council, newsletter September 2006 – www.medicalcouncil.ie
- Medical Council, Guide to Ethical Conduct and Behaviour 2009, 7th edition
- Office of the Information Commissioner Ireland – www.oic.gov.ie.