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# Quality Assurance Standards

# Audit tool

# Section 6: Record keeping and information governance

**Section 6 Record keeping and information governance: Quality Assurance audit tool**

| **Section 6 - Part 1 A - Data collection tool from service user records** | **Yes** | **No** | **N/A** | **Comments** |
|---|---|---|---|---|
| **Records include the following components:** | | | | |
| Started at the time of the initial contact | | | | |
| Written immediately after the contact with the service user or before the end of that working day | | | | |
| Include a reference in each entry to the date and time of treatment or advice | | | | |
| Include a reference to the date and time that the entry into the record was made | | | | |
| Are legible, factual, consistent and accurate such that service users and other health professionals can understand the content | | | | |
| Are attributable to the individual completing them | | | | |
| Provide evidence of the care planned, the decisions made, the care delivered and the information shared | | | | |
| Identify problems that have arisen and the action taken to rectify them | | | | |
| Provide evidence of actions agreed with the service user including consent to treatment and/or consent to disclose information) | | | | |
| Are written, wherever appropriate, with the involvement of the service user | | | | |
| Use standard coding techniques and protocols for electronic records where appropriate | | | | |
| Short forms used are included in a glossary describing the | | | | |

| | | | | |
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| allowable abbreviations and their meaning | | | | |

| **Section 6 - Part 1 B - Data collection tool from organisational policies and procedures** | **Yes** | **No** | **N/A** | **Comments** |
|---|---|---|---|---|
| **There are organisational policies for records which include;** | | | | |
| Records including the following components;<br>• Are started at the time of the initial contact<br>• Are written immediately after the contact with the service user or before the end of that working day<br>• Include a reference in each entry to the date and time of treatment or advice<br>• Include a reference to the date and time that the entry into the record was made<br>• Are legible, factual, consistent and accurate such that service users and other health professionals can understand the content<br>• Are attributable to the individual completing them<br>• Provide evidence of the care planned, the decisions made, the care delivered and the information shared<br>• Identify problems that have arisen and the action taken to rectify them<br>• Provide evidence of actions agreed with the service user (including consent to treatment and/or consent to disclose information)<br>• Are written, wherever appropriate, with the involvement of the service user<br>• Use standard coding techniques and protocols for electronic records where appropriate | | | | |

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| • a locally agreed short forms glossary<br>• disclosure of information<br>• service user access to records, including charges for viewing or receiving a copy of a health record | | | | |
| **There are policies for:** | | | | |
| the retention of records | | | | |
| the secure storage of records while current so that they can be easily retrieved | | | | |
| the secure storage of records once they are no longer current | | | | |
| the disposal of records in accordance with statutory requirements | | | | |
| identification of who has storage and access rights over the record | | | | |
| access to records by service users and others | | | | |
| Records are kept in accordance with relevant legal and regulatory requirements | | | | |
| A policy for IT (Information Technology) and data security which is updated annually. | | | | |
| **There is:** | | | | |
| a signature book to ensure physiotherapy team members can be recognised and traced by their signature, job title and work area or other identifiable information | | | | |
| information available to ensure that the service user is aware of their right to access their records | | | | |
| a glossary of short forms describing the allowable abbreviations and their meaning | | | | |
| a process for destroying service user records in a secure manner after the (lapse of the) required time | | | | |

| **There is a procedure to ensure;** | | | | |
|---|---|---|---|---|
| Members are aware of their responsibilities under the Data Protection Act (1998). | | | | |
| Members comply with local health informatics/ IT security policies | | | | |
| Members are clear of the standards in place for governing their record keeping practice | | | | |
| Audit of record keeping planned and undertaken annually to monitor compliance with relevant legislation and ensure best practice guidance is being upheld | | | | |
| The results of audit are disseminated and recommendations made for action | | | | |
| Systems are configured to meet information governance standards around maintaining the security and confidentiality of service user identifiable data, including encryption of emails and use of mobile/portable device. | | | | |
| There is evidence that action is taken as a result of the outcomes of audit | | | | |

| **Section 6 - Part 2 - Service user feedback** | **Yes** | **No** | **N/A** | **Comments** |
|---|---|---|---|---|
| **I was given information on** | | | | |
| How to access my physiotherapy records | | | | |