SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST

CONTENT OF HEALTH RECORDS

In accordance with the King's Fund National Standards, Southampton University Hospitals NHS Trust advises all clinicians writing in the notes to comply with the following guidelines:

1. General principles

1.1 All entries in the notes are signed (name and designation) and dated.

1.2 All entries are legible, written in permanent ink that will photocopy.

1.3 Abbreviations are kept to a minimum.

1.4 Notes are kept in chronological order.

1.5 All clinical decisions are clearly justified.

1.6 The full patient name must appear on every page.

1.7 Notes will be divided in chronological order into the following sections:

- Medical history sheets
- Investigations
- Nursing notes
- Correspondence

2. Patient admission

2.1 A clinical history and examination must be taken and recorded by a clinician* either at a pre-admission clinic, or as soon as possible after admission. It must include pertinent:

- Social considerations
- Present and past medical history
- Relevant medications
- Family history

2.2 There must be a written report of the initial physical examination performed by a clinician*.

2.3 Any pre-admission history and examination must be verified and updated on admission.

2.4 A written admission provisional diagnosis must be recorded by a doctor with the date and time of the initial consultation.

3. Patient progress

3.1 Progress notes, observations and consultations are written, signed and dated to ensure all significant events, eg. alterations in patients' condition/response to treatment are recorded.

3.2 Therapeutic orders and orders for special diagnostic tests are noted.

3.3 There is a written record of information given to patients/carers.

* Clinician refers to any suitably trained medical practitioner or nurse.