Clinical Records Service Evaluation– Clarity, Accuracy and Relevance

1.0 Introduction

1.1 High-quality clinical records are essential to ensure safe, person-centred care, effective communication between professionals, and legal accountability [The Medical Defence Union (1); The Nursing and Midwifery Council (2); The Health and Care Professions Council (3)]. This is clearly outlined within St Raphael's Hospice Policy (4). This Clinical Records Service Evaluation reviewed documentation to assess whether records meet expected standards for clarity, accuracy, relevance, and legal robustness, particularly in relation to consent, decision-making, and patient involvement.

2.0 Aims

2.1 The aims of this evaluation were to assess whether clinical records:

1. Clearly document consent for information sharing
2. Accurately record decisions made and the rationale behind them
3. Demonstrate patient involvement in decision-making where possible
4. Are objective, relevant, and free from unnecessary jargon
5. Are clear, succinct, and legally appropriate

3.0 Methodology

3.1 Ten clinical records sampled from EPR (EMIS) system in line with the following criteria:

- Active within the last 2 months
- From all CPCT locality caseloads
- At least 2 records to include IPU stay
- To include multi-professional entries
- Patient to be primary subject of the record
- First assessment and most recent assessment to be reviewed.

4.0 Results

4.1 Summary of results:

4.11 Consent for sharing records

Documentation of consent was inconsistent. While several records clearly documented consent or best-interest decisions (particularly where patients had learning disabilities or cognitive impairment), consent was sometimes absent, unclear, or difficult to locate within narrative text. In one case, a clear note was made regarding preferred family contact, demonstrating good practice, but overall visibility of consent documentation varied.

4.12 Decision-making and rationale

Records consistently documented clinical decisions and the rationale behind them. Examples included clear best-interest decision-making, such as risk-feeding agreements following multidisciplinary discussions, with an explicit focus on quality-of-life considerations. This was a strong and consistent area across records.

4.13 Patient involvement

Where patients had capacity, records demonstrated patient involvement, including documenting preferences and refusals of interventions. Where patients lacked capacity, this was clearly stated. In cases involving language barriers, good practice was noted where clinicians acknowledged the importance of professional interpretation to support both patient understanding and family wellbeing.

4.14 Objectivity and relevance

Entries were consistently objective. There was no evidence of irrelevant speculation or inappropriate subjective commentary. Third-party information was relevant and appropriate, contributing meaningfully to the clinical context.

4.15 Use of jargon

Records were free from jargon, meaningless phrases, or speculative language, supporting clarity and professional standards.

4.16 Clarity and succinctness

Most records were clear; however, succinctness was variable. Some entries were unnecessarily lengthy, using full narrative sentences where brief clinical phrasing would have been sufficient. Occasional use of abbreviated clinician names (e.g. first names only) was noted, which is not appropriate for a legal document. Despite this, records demonstrated excellent documentation of emotional support and psychosocial context, adding value when directly relevant to care.

5.0 Discussion

5.1 Overall, the quality of clinical records was good, particularly in relation to decision-making, objectivity, and relevance. Documentation demonstrated strong clinical reasoning, appropriate handling of capacity issues, and thoughtful attention to patient and family experience.

The main area for improvement relates to **consistency and visibility of consent documentation** and **brevity of entries**. While detailed narrative can be helpful, excessive length may reduce clarity and increase legal risk. Additionally, consistent use of full clinician surnames is required to maintain legal standards.

Balancing succinct clinical documentation with meaningful psychosocial detail is a key strength of the service and should be preserved, while reducing unnecessary wording.

6.0 Conclusion and Action Plan

6.1 This evaluation found that clinical records are largely accurate, relevant, and legally sound, with strong evidence of ethical decision-making and patient-centred care. Improvements are needed to ensure consent documentation is consistently recorded and easily identifiable, and that entries are concise while remaining clear and informative. However, this is a very small sample and does not necessarily bear out all the issues for consideration.
The results will be shared at CHODS as well as the Clinical Quality and Governance Committee. Managers will cascade to their teams.
Staff will be reminded to use full names when referring to colleagues in the clinical record.

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References

1.https://www.themdu.com/guidance-and-advice/guides/good-record-keeping
2.NMC (2015), The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates
3. https://www.hcpc-uk.org/standards/meeting-our-standards/record-keeping/
4.St Raphael’s Policy Manual (2023); Creating and Maintaining the Clinical Record; OP31 – Records Management Policy.