From:	COMMUNICATIONS, Clch (CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST)
To:	COMMUNICATIONS, Clch (CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST)
Subject:	CQC 7-minute learning: allergy recording
Date:	26 February 2020 13:26:08
Attachments:	image001.png

Following the recent CQC inspection, today's 7-minute learning bulletin is about recording allergy information.

Read about it now via the Hub (PDF).

Find out more about our 7-minute learning resources via the quality team page on the Hub.

If you have any queries, email the patient safety team mailbox on clcht.rca@nhs.net.

Learning relating to Recording Allergy Information

NHS
Central London Community Healthcare
NHS Trust

1 Background

During a CQC inspection, it was highlighted that a number of records had no allergy recorded.

Good record keeping is an integral part of professional practice and is essential to the provision of safe and effective care.
Accurate and comprehensive clinical records are essential for high quality patient care and enable effective communication with other professionals involved in patients' care while demonstrating individual professional accountability and responsibility.
It is therefore important that clinical health records are accurate, up to date and easily accessible.

2 Context

Good record keeping supports a range of clinical, administrative and educational uses which include:

Identifying risks to enable the early detection of complications

Promoting better communication and sharing of information between members of the multi-professional healthcare team

Improving patient care and accountability

3 Current Systems in Place:

NMC CODE

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

CLCH Policy Section 5.2 Essential Requirements:

Clinical records must contain:

Evidence that patients have been asked about allergies and sensitivities

4 Information for staff

SOP for S1 available on the Hub:
http://thehub/esystems/systmone/PublishedDocuments/CLCH%20SystmOne%20Children's%20Services%20Standard%20Operating%20Procedure%20v1.5.pdf

5 QUICK REFERENCE GUIDE

Crib sheets showing how to complete this on SystmOne are available on the Hub. RIO SOPS are available within Merton teams. (EMIS guides are in development)

S1 web link:
http://thehub/esystems/systmone/PublishedDocuments/AS020%20Allergies%20and%20Sensitivities%20QRG%20v0.1.pdf

6 Annual Audit

Record Keeping Question Recording of Allergy Details:
This includes records that may be in patients' drug charts or home visits care plans/notes. Allergy and/or sensitivity status must be recorded (including where the patient has "No known allergies").

Latest annual audit results showed that across the Trust the achievement of this requirement was 71%.

7 Key Point

Local ownership and professional accountability in line with regulatory standards is essential to ensure that quality of care is not jeopardized by inadequate record keeping

Next Steps

7 minute briefing to be discussed in every team meeting in March 2020

Spot checks to be carried out during 1:1s in April 2020