Southern Health NHS
NHS Foundation Trust

Core Record Keeping Clinical Competencies

Name:	Role:
Base:	

Competency Statement:

The participant demonstrates clinical knowledge and skill in record keeping without assistance and/or direct supervision (level 3 - see level descriptors). Assessment in practice must be by a Registered Clinician who demonstrates competence at level 3 or above.

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
The Participant will be able to demonstrate accurate, timely, relevant clinical record that facilitates the delivery of safe coordinated care that involves the patient, carer and family:				
1.Standard 1: Clinical records (paper and electronic) are:				
a) documented in accordance with service specific guidance	Observation			
b) recorded in the right place, and include signposting to other documents where appropriate	Observation			
c) concise and clear, providing accurate, relevant and appropriate information	Observation			
d) recorded as soon as possible after an event has occurred (contemporaneous), providing current information on the care and condition of the patient	Observation			
e) dated and timed (24 hour clock), if the date and time differs from that of when the records are written, this must be clearly noted and explained why entered retrospectively in the record	Observation			
f) able to demonstrate a **full account** of the assessment	Observation			
g) able to demonstrate completion of a risk assessment and action plan(s) in place to address risk	Observation			
h) are able to demonstrate completion of care planning and goal setting (using care pathways where appropriate) and actions taken including information shared with other health professionals	Observation			
i) are able to demonstrate on-going evaluation and planned review of care, including the validation of electronic patient records and outcome all patient appointments within required timescales	Observation			

Performance Criteria	Assessment Method	Level achieved	Date	Assessor/self assessed
j) recorded, wherever possible, with the involvement of the patient/ client or their carer and written in language that the patient can understand	Observation			
k) Proof read and therefore do not include jargon, meaningless phrases, irrelevant speculation or offensive subjective statements, irrelevant personal opinions regarding the patient	Observation			
l) required to use only approved abbreviations	Observation			
m) able to demonstrate corrections in paper/manual records that are clear, dated and signed; for electronic records – follow the procedure in the appropriate standard operating procedure or handbook	Observation			

Date all elements of Competency Tool completed to level 3________

Name _____________________ Signature _______________ Status ___________ Date _______

I confirm that I have assessed the above named individual and can verify that he/she demonstrates competency in record keeping

Assessor _______________ Signature _______________ Status ___________ Date _______

Review Dates:	Competent Yes / No	Registered Nurse Signature	Verifier signature	Comments