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Information paper

Record Keeping Guidance

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Record Keeping Guidance

Documenting a health record

Principles of good record keeping

Physiotherapy staff have a professional and legal obligation to keep an accurate record of their interaction with patients.

A health record means any record which:

- Consists of information relating to the physical or mental health or condition of an individual
- Has been made by or on behalf of a health professional in connection with the care of that individual, in accordance with the **Data Protection Act.**

A record can be in paper or electronic format, or a mixture of both, and includes all the information relating to the health status and management of the individual patient. There are various types of records in practice: summary or full records, shared records, uni-professional records and patient-held records.

Depending on the needs of the patient and the care setting involved, the record may be maintained by an individual healthcare professional or a group of different professionals across the care pathway. The record may contain information about the current episode of care only, or may be a compilation of every episode of care for that individual in a given timeframe.

Record-keeping: content, layout and style

Whether using paper or electronic records, there are general principles that should be followed in relation to content, layout and style.

The **standards for the clinical structure and content of patient records,** compiled by the Health and Social Care Information Centre (HSCIC) in 2013, and supported by the CSP, outline generic clinical record headings and the information that should be recorded under each heading across the medical professions. Physiotherapy staff should review these standards to ensure that assessment, treatment, discharge and referral records include the information required to ensure consistent recording of patient data across all contexts.

HCPC standards, the CSP Code and the CSP Quality Assurance Standards outline profession-specific standards in record-keeping.

Physiotherapy staff work across a variety of settings and are required to maintain records in whatever system or format their employer specifies. While many physiotherapy staff use SOAP notes (Subjective/Objective/Assessment-Action/Plan) to document the patient record, other styles are in use.

Record-keeping: key considerations

A good record will enable an independent reader to understand what conversations took place with a patient, what information was exchanged, the extent of any examination performed, what treatment was provided and what clinical reasoning decisions were made.

The following points should be kept in mind when generating both paper and electronic records:

- The information must be clear to another health professional/the patient (including the use of short forms)
- Written records should be:
    - legible and written in permanent ink
    - signed at the end of the record
    - paginated, including date of consultation and time when appropriate
    - amendments should be dated, timed and signed and the original entry still clearly visible
- Electronic recording systems should be able to:
    - show who has made the record
    - show revisions or amendments
    - lock the notes

Section 6 of the CSP's Quality Assurance Standards highlights the specific standards expected of physiotherapists when keeping records.

Use of the CSP's **Record Keeping and Information Governance Audit Tool** is helpful to ensure that records fulfil key requirements.

The **NHS Professionals record-keeping guidelines** is also a useful document.

SNOMED CT and short forms/abbreviations

In clinical practice, short forms can save time and allow faster communication between professions and multi-disciplinary groups. However, with the emergence of the electronic health record (EHR), the use of SNOMED CT is now being driven by health policy. In some countries such as England its use is mandated.

SNOMED CT is the world's most comprehensive terminology for electronic health information – it underpins the EHR by allowing information to be recorded using the same language. This has multiple benefits, allowing clinicians to record and compare interventions across organisations and sectors, supporting more effective analysis of data and research, and importantly its use improves patient safety and supports clinical decision making.

You can **download the SNOMED CT subsets** here. The subsets and supporting guidance can be found in the download, as well as the links to the full SNOMED CT repository hosted by the Health and Social Care Information Centre via the Data Dictionary for Care (DD4C).

The Society has started a long term project to support physiotherapists in the use of SNOMED CT subsets. The first subsets have now been developed and published and are designed for use to underpin the EHR in any clinical setting.

The following subsets were released in April 2016:

- Deformity of spine findings
- Joint movement findings
- Mobility findings
- Musculoskeletal reflex findings
- Pain aggravating factors
- Pain easing factors
- Posture findings
- Spine movement findings
- Transfer ability findings

- Wound integrity findings

The CSP welcomes feedback on any of its SNOMED CT subsets based on review and usage so that the subsets can remain up to date and implementable. It also welcomes contact from those who might wish to participate in evaluation and review of SNOMED CT subsets in development. If you wish to participate or have any feedback then please email Sue Hayward-Giles on professionaladvicese@csp.org.uk.

The CSP will continue working with members to develop further subsets, however recognising that many clinicians are not yet using EHRs the following information outlines the CSP's position on the use of short forms.

Developing and using short forms

The main reason healthcare professionals are keen to use short forms in clinical practice is to improve efficiency when making entries to patient records, but there is general concern about the use of short forms.

Without the use of short forms, significant extra time may be required to write entries in full. Also, in specialist units, short forms can be developed as part of a common language used to facilitate faster communication between individual professions and multi-disciplinary groups. The other reason short forms remain popular is that they help to save space used to communicate interactions with patients, thereby making the record as succinct as possible to read or view.

CSP position on the use of short forms

Physiotherapy staff need to recognise that the language they use must be understood by other health professionals. Furthermore, they need to understand that patients have the right of access to, and to an explanation of, their record under the **Data Protection Act**, thus bringing the use of short forms under further scrutiny.

The CSP acknowledges that its members face significant risks with using short forms in health records. However (alongside the HCPC and other national NHS IT programmes) it also understands that the use of short forms is common practice in the profession, and a pragmatic line needs to be taken on this issue that supports its members to mitigate the risks associated with using short forms.

The CSP has developed the following position:

- Use SNOMED terms, where they exist
- Members should only use short forms if there is an agreed list developed locally that is accessible to anyone entering information into, or viewing, health records
- If records are being transferred elsewhere, the agreed list must be transferred with the record to aid subsequent understanding of the short forms that appear in the record
- Physiotherapy staff should work with system suppliers to incorporate good practice around the use of short forms in record keeping templates to facilitate accurate, speedy entry, and to stipulate that, for sharing, review or printing of the record, the short form is fully described
- Educators within the profession need to highlight both the risks associated with, and good practice relating to, the use of short forms in pre and post registration training for physiotherapists, and in training for support workers
- The CSP will maximise any opportunity presented to lobby for a national set of agreed multidisciplinary common short forms that can be universally implemented in paper-based or electronic record keeping systems, for example NHS, HIV etc. Where electronic, this should be based on existing national terminology in electronic record keeping systems

Use of short forms: good practice

Whilst many health care professionals and their managers recognise the risks associated with using short forms, they have developed pragmatic approaches to managing the level of risk by implementing some or all of the following:

- Educating staff about the risks involved in using short forms and the potential consequences when misuse occurs
- Requiring teams to develop their own standardised list of accepted short forms with associated definitions of the clinical or management term they are describing; for example, an entry to such a list might read as follows:

    1. **Clinical term:** Active Cycle of Breathing Technique
    2. **Abbreviation:** (suggested): act cyc br tech
    3. **Initialisation:** ACBT

4. **Concept:** the use of a consistent approach to breathing through the combination of use of lower thoracic expansion exercises, the forced expiratory technique and further lower thoracic expansion exercises

- Working with electronic record keeping system suppliers to ensure they have the list of locally accepted short forms to build into their database, so that accepted short forms appear in the system when rolled out for use and, when used in the record, are spelled out in full on screen/when printed
- Requiring teams to staple standardised lists of accepted short forms to the front cover of patient records, so the meaning of short forms can readily be accessed by others viewing the relevant record
- Enforcing local policies around short forms; for example, only using short forms that are on the agreed local short forms list. If other short forms are used action should be taken and if ultimately changes to practice do not occur, disciplinary action may be necessary
- For physiotherapy staff based in the NHS, the **Knowledge and Skills Framework** could help to enforce local short forms policy, as record keeping is relevant to all the core dimensions, and is therefore reviewed in annual appraisals/performance reviews with staff

Shared Records

Shared records are increasingly common and perfectly acceptable, as long as physiotherapists keep records of their interventions. It is becoming more common for a group of different professionals involved in the delivery of patient care to input into one shared or unified record (in either paper or electronic format). This is perfectly acceptable practice.

The professional and statutory requirement to keep in mind is that the physiotherapist must keep a record of their intervention. Physiotherapists are autonomous practitioners and thus provide appropriate intervention according to the assessed needs of their patients. The physiotherapist should record the information they obtain into whatever repository their employer requires (for example, this could be within the medical ward notes if it gives the capacity to document physiotherapy treatment and decision making appropriately).

In circumstances where physiotherapy staff are asked to contribute to the main medical record (for example around the basic details of care) but there is no facility to capture decision making and intervention details, then a separate record should be maintained. However, duplication of effort around record keeping should be minimised.

The CSP contributed to a research project, conducted by the Royal College of GPs, looking at issues relating to the shared record in primary and community care. This sets out 16 principles and guidance as a means of increasing public and professional confidence in shared record keeping. This is a key document for physiotherapy staff working in these sectors.

The Welsh Government has also published guidance on the **sharing and exchange of personal information** between different partners in the health and social care environment.

The current direction of travel in UK health policy is to give patients better access to their health records, in order to empower them to make informed decisions about their care. Further work on making records understandable and accessible will be required to fully deliver on this in a meaningful way for patients.

Electronic records

Across healthcare there is a need for an efficient and transparent means of recording, transmitting and accessing reliable clinical information in order to deliver high-quality care to patients.

Published in February 2013, **The Francis Report** emphasised the need for better information and highlighted the risks that increasing service pressures bring to patients. It is increasingly accepted that these challenges can only be met by the development and use of electronic health records in which data are recorded consistently across all contexts.

The **Personalised Health and Care 2020** Framework for action along with the DH's Independent report on **Making IT Work** highlight the current thinking and steps being taken to digitise the NHS.

An electronic record should enable the same information as a paper record to be conveyed. It should capture the conversations that were had with a patient, the subjective and objective examinations and the clinical reasoning and decision-making as well as what treatment was provided.

Initiatives such as **Common User Interface (CUI) programme**, developed through NHS Digital, are working to standardise components within the electronic health record to ensure increased familiarity with screen layouts. This should lead to improved patient safety, increase clinician effectiveness and efficiency, and reduce training and support costs as staff move between employers using the common interface within their systems.

SNOMED CT is the world's most comprehensive terminology for electronic health information – it underpins the electronic health record by allowing information to be recorded using the same language (see p6 for more information).

However, those physiotherapy staff working in organisations that have not invested in such initiatives, may be called upon to do the thinking about what to include in a record keeping template, and how to ensure a professional approach is adhered to within organisation-wide record keeping practice.

For more information on IT security specifically for small and medium businesses visit the **Information Commissioners Office** (ICO).

NHS Scotland's **eHealth Strategy** outlines the vision and key aims for eHealth in Scotland.

Electronic record-keeping and the Cloud

A number of professionals, particularly those in private practice, are looking to the Cloud to help in their move toward electronic record keeping. The ICO has produced guidance on the use of the Cloud for **members of the public** and more general information **for organisations**.

Key considerations should be made when considering using the Cloud for electronic record keeping, these include:

- Whether the specific technical capabilities of the system enable the required regulatory, professional and legal standards of clinical record keeping to be met
- The need to be able to distinguish the entries in the record made by the different members of staff involved in delivering care to the patient
- Ensuring confidentiality is protected
- The system needs to be secure and adequately backed up in case of theft or damage
- Data storage limits should be sufficient to ensure the necessary storage and retention of records is achievable now and in the future

Countersigning entries and delegation

Registered health professionals are accountable for the care of their patients; they remain professionally accountable for the appropriateness of any delegated duties and acts or omissions of care undertaken by students or support workers who they are supervising. They also remain professionally accountable for the quality of record keeping entries undertaken by students and support workers, in respect of delegated duties relating to their patients.

There is no explicit direction from the HCPC regarding when or if the physiotherapist who has delegated tasks to a support worker or undergraduate student should countersign their respective entries to the health record.

The **HCPC standards of conduct, performance and ethics** state:

- You are responsible for the appropriateness of your decision to delegate a task
- Whenever you give tasks to another person to carry out on your behalf, you must be sure that they have the knowledge, skills and experience to carry out the tasks safely and effectively. You must not ask them to do work which is outside their scope of practice

For many physiotherapists, the decision to delegate tasks will be governed by a combination of national and local policy on the delivery of care across a patient pathway utilising skill mix. Physiotherapists will also be governed by local employer policy on delegation and supervision of students and support workers.

Health record entries: support workers

The qualified physiotherapist remains accountable for the management of a patient's physiotherapy needs at all times, although the management of some patients may be delegated to appropriately trained support workers, either by the physiotherapist themselves, or by the existence of an organisational policy that defines which groups of patients may have part of their care delivered solely by support workers.

National or local policy may dictate the approach physiotherapists must take in relation to delegation of tasks to support workers. In the absence of such a policy, the CSP advises that:

- If the physiotherapist is delegating tasks to support workers, the decision to delegate should be recorded in the records. Thereafter, the records made by the support worker to document their intervention do not need to be countersigned. The physiotherapist should only countersign where an event occurs which changes the

overall patient management plan such that the support worker needs further direction from the physiotherapist

- If the organisation delegates aspects of the care pathway for groups of patients solely to the support worker no countersignature is needed, provided that the activities are performed within the context of a formal written policy and care pathway that clearly states that individual patients may be managed solely by a support worker if the patient fits the overall care pathway that is managed by the support worker

Health record entries: undergraduate students

The **HCPC standards of conduct, performance and ethics** state:

- You have a duty to make sure, as far as possible, that records completed by students under your supervision are clearly written, accurate and appropriate

The practice educator, physiotherapist or qualified member of the multidisciplinary team is responsible for the patient and professionally accountable for the actions of the student, who is performing delegated tasks.

The person who is responsible for the care of the patient must provide the countersignature.

Students will often make notes in a notebook to support their learning. It is important to ensure that these notebooks do not contain any patient identifiable information.

Students should discuss any support requirements in relation to record keeping with the practice educator and university so that reasonable adjustments are made to ensure the notes reach the required standard.

Delegation and supervision policy for students

If no delegation/supervision policy or record keeping policy exists that is specific about countersignatures relating to student entries to the health record, it is good practice to establish one (bearing in mind HCPC guidance on this) which should address the following issues:

- How the practice educator will ensure the student is competent to carry out the delegated tasks safely and effectively (for example, by documenting the training given and how their competency has been tested)
- What level of supervision the practice educator deems appropriate for the setting in which the student is working and for the tasks they are undertaking (for example, direct observation, out of sight but with follow-up discussion, etc)

- How students and their supervisors review entries to health records to ensure the entries are accurate and reflect the interaction with the patient
- What the countersignature signifies; for example, does it convey that the supervisor has observed the student undertaking the delegated task with the patient (this is not a mandatory approach), or does it signify that the student's work regarding the delegated task has subsequently been reviewed and discussed between the student and supervisor, and the supervisor is approving of the student's actions? The latter is acceptable, if there is a robust system in place for checking competence regularly (including, if appropriate, knowledge of child/vulnerable adult procedures)
- The student must understand that he/she should ask for help immediately if it is needed (this does not just cover clinical support). For example, if the patient starts to indicate unrealistic expectations or behaves in such a way as to call into question mental capacity etc, then the delegator must be open to requests for assistance in reality rather than in theory

Access to and use of record keeping systems by students

So that students on clinical placement are able to access and input to record keeping systems from the start of their placement, the university's practice education coordinator and the practice educator should plan ahead. They should consider and address the following issues:

- Does the placement provider require the student to have an 'honorary contract' in place before they can work with patients and input to relevant health records?
- Does the placement provider use an electronic system to manage health records, and if so, does the student need to be supplied with a password, smartcard, or other access/authentication device to enable them to make entries in health records?
- Does the placement provider need to be supplied with a photograph of the student for a smartcard, or carry out an identification check before issuing login details for the record keeping system, and how long does this take to organise?
- What training must be provided for the student on how to use the provider's electronic or paper record keeping system, and how will this be organised and delivered?
- Will the student need to return any smartcard or other access device at the end of placement, or to keep it if they will be returning to the placement provider?

In the electronic record keeping environment, **procedures are being put in place** to give appropriate access to health records and to ensure that student contributions are clearly labelled within the health record.

However some systems are not yet configured to allow student access and input of data. In such circumstances, common practice is for the responsible staff member to input into the record on behalf of the student, noting that the work was actually delegated to the named student so that this is clearly flagged in the record.

Health record entries: physiotherapists undertaking post graduate training and/or returning to work

HCPC registered physiotherapists (whether undertaking postgraduate studies or returning to practice after a career break) do not need to have their entries into the health record countersigned.

Physiotherapists undergoing a formal return-to-work programme who are not yet HCPC registered must have his or her records countersigned, as they have not yet fulfilled the requirements of autonomous practice associated with HCPC registration.

Competence in record keeping

It is your responsibility to develop and maintain competence in record keeping.

The publication 'Learning to manage health information' provides a framework that consolidates learning outcomes in health informatics, which should be embedded into all health professional education programmes.

The framework covers the following aspects:

- Protection of Individuals & Organisations
- Data, Information & Knowledge
- Communication & Information Transfer
- Health & Care Records
- The Language of Health: Clinical Coding & Terminology
- Clinical Systems & Applications
- eHealth: the Future Direction of Clinical Care
- Essential information technology skills needed to support the other themes.

Maintaining competence in record keeping

As poor record keeping poses a significant clinical safety risk, it is paramount that staff are supported to maintain their competence in this area.

Individual training needs in relation to record keeping should be discussed and prioritised through line management support and the appraisal process. Such training may encompass improved understanding around the legal and regulatory framework within which physiotherapy staff work, through to how to input data into an electronic clinical information system, a mobile networked tablet device, or a personal digital assistant (PDA).

National IT programmes in the four UK countries offer support around information governance training. There are also courses or online training modules that cover topics such as access to health records, confidentiality etc. Employers may also offer information governance training tailored to increase understanding of local procedures.

Accessing a health record

Confidentiality and disclosure

The duty to share information can be as important as the duty to protect patient confidentiality. Maintaining the confidentiality of health records is the duty of all staff involved in the delivery of health care. Accurate and secure personal health information is an essential part of patient health care.

Information that can identify individual patients must not be used or disclosed for purposes other than healthcare without the individual's explicit consent, some other legal basis, or where there is a robust public interest or legal justification to do so. In contrast, anonymised information is not confidential and may be used with relatively few constraints as stated in the **NHS Confidentiality Code of Practice**.

The 2013 **Caldicott Review in England** introduced an additional principle: 'The duty to share information can be as important as the duty to protect patient confidentiality.' The review found a strong consensus of support among professionals and the public that safe and appropriate sharing in the interests of the individual's direct care should be the rule, not the exception.

Your local Data Protection Officer or Caldicott Guardian within your organisation, if you are employed, should be a source of further guidance on confidentiality queries.

Confidentiality: Education for patients

Physiotherapists must educate patients about necessary disclosures; for example, explaining that information will be shared between different members of the team providing their care, and possibly with other agencies or organisations who will continue supporting them at different stages in the care pathway.

Patients have the right to object to the use and disclosure of confidential information that identifies them, and they should be informed of this right. If the patient exercises their right to prevent disclosure, it is the responsibility of the health professional involved to explain to the patient that their decision may impact on the ability of the organisation to provide certain care or treatment.

Confidentiality: Useful documents and websites

The following documents provide further information on confidentiality, seeking consent to disclose and the use of personal and sensitive data:

- **Confidentiality: NHS Code of Practice**
- **The Caldicott Review**
- **Health and Care Professionals Council. Confidentiality – guidance for registrants**
- **Information Commissioners Office Health webpage**
- **Department of Health Social Services and Public Safety. Code of Practice on Protecting the Confidentiality of Service User Information**
- **NHS Scotland Code of Practice: Protecting Patient Confidentiality**
- **Welsh Assembly Government. Confidentiality: code of practice for health and social care in Wales**
- **DoH Confidentiality: NHS Code of Practice – supplementary guidance: public interest disclosures**
- **CSP: Consent and physiotherapy practice**
- **Lowth, M. Confidentiality in the modern NHS (parts 1 and 2)**

Access to records

Providing access to electronic health records presents new challenges and opportunities for health professionals. The following links outline some of the plans:

- The **Personalised Health and Care 2020** framework for action and the independent report on **Making IT Work** highlight the current thinking and steps being taken to digitise the NHS.
- The Scottish Government's **eHealth strategy** outlines similar plans to give patients access to their own health records.

Application for access to records

An application for access to records is made to whoever holds the records at the time the request is made. An application should be made under the terms of the **Data Protection Act**. You can learn more about the legal requirements governing how a patient may request access to their records in the 'Legal, Regulatory and Employer responsibilities' section.

If an individual physiotherapist receives a direct approach for records that were made in the course of a previous employment and/or contract, then the physiotherapist must redirect the request to the previous employer and not deal with it personally.

In the case of a child, the parent, person with parental responsibility, or guardian may apply; and in the case of an adult that lacks capacity, any individual appointed to manage the patient's affairs by the Court may make an application.

Deceased individuals

In the case of a deceased person, his or her health records form part of his or her estate, and records may only be released to the person with the authority to access the records, such as the Legal Executor or Administrator of the Estate, or a potential beneficiary with a claim to the Estate. Applications to access the records must be made under the **Access to Health Records Act** and the **Access to Health Records (Northern Ireland) Order 1993**. Occasionally, family members may ask to see records, but records should not be released until the organisation/individual is satisfied that an application has been made by a person with a legitimate claim to see the records.

Charges for viewing or receiving a copies of records

Maximum charges are laid down in relation to providing access to a copy of, or allowing someone to view, a health record under the **Data Protection (Subject Access) (Fees and Miscellaneous Provisions) Regulations 2000**. These are summarised in the **Subject access code of practice produced by the ICO.**

Exceptions around access

There are some circumstances when information can be released without the data subject's permission.

- Personal data such as name and address of patients can be released to a statutory regulator if requested as an outcome of concluded regulatory proceedings. For example, the HCPC can require a physiotherapist who is under a 'Conditions of Practice Order' to release the names of the patients being treated to the HCPC. In this example, the HCPC is exercising its legal right to 'protect members of the public against dishonesty, malpractice, unfitness or incompetence of a person authorised to carry on any profession …'
- In connection with formal legal proceedings, solicitors may request information. The CSP recommends that members should seek individual advice first if they are asked to disclose under this circumstance.

Physiotherapists should **always seek personal advice** before disclosing health records without permission, unless such direction comes directly in the form of a Court Order.

Access to records: Useful documents and websites

The following documents provide further information on accessing health records:

- **DoH Guidance for access to health records requests**
- **Department of Health Social Services and Public Safety: Code of Practice on Protecting the Confidentiality of Service User Information**
- **The Scottish Government: Records Management NHS Code of Practice (Scotland)**
- **Welsh Assembly Government Confidentiality: Code of practice for health and social care in Wales**

Control of records

Control of records can vary according to employer and employment type.

Physiotherapists in employment

When a physiotherapist is employed, the records he or she creates or contributes to belong to the employer. Requests for access to see records will be made to the employer, who will follow the local policy, and process the request in accordance with the **Data Protection Act 1998** or the **Access to Health Records Act** for deceased patients. As the record is owned by the organisation, it controls access and release, not the individual who created the record, so it does not matter if the individual has moved on or not.

NHS

In the NHS, records are owned by the Secretary of State, and are managed locally by the associated health organisation or GP practice. In cases in the NHS where there has been a decision to allow a patient to hold their own health record, the record is still owned by the NHS body providing care to the patient. The record is stored with the patient until such time as that care has ended, at which point the record is returned to the NHS body.

Sole practitioners

Where a person is self-employed and a 'sole practitioner' i.e. not contracted to provide services on behalf of another (for example a private practice, a private hospital or even a NHS hospital), it is the self-employed physiotherapist who owns the notes. In this case, the self-employed physiotherapist also has legal responsibility to register with the Information Commissioner and take on the burden of all Data Protection issues including storage, retention, security, processing and destruction of records. Failure to comply with such requirements can result in legal penalty.

Self-employed physios contracted to provide services for/on behalf of a third party

Where a person is self-employed but is contracted to provide services for/on behalf of a third party, for example to a private practice or clinic, private hospital or NHS establishment, private company or industry, the self-employed physiotherapist is in effect working on a consultancy basis. In this situation the Practice contracting with the self-employed physiotherapist is normally considered to 'own' the records, for the following practical reasons:

- In most circumstances the records are generated as a by-product of the 'contract' and in the first instance it would be the company that would be sued if something untoward happened, therefore it should be the company that retains the records. In these circumstances, the self-employed physiotherapist is also exposed to liability, so he/she must be able to access the records to defend him or herself. Having access to the records does not mean that they have to own the records.
- If the self-employed physiotherapist is absent from the Practice for some time, the patient is likely to wish to be treated by someone else within the Practice, and in these cases the other physiotherapist must have access to the notes, again making it essential that the Practice own the notes.

The Practice has the legal responsibility for correct registration for all data protection issues.

Transferring records

The means of transferring patient information securely between departments, practices or different health care providers must ensure that confidentiality is maintained throughout the process.

The use of fax machines to transfer personal health information is not recommended but some guidance has been issued by **NHS Scotland**.

In the case of emailing personal health information, there is much guidance available about using secure email systems. The use of NHS Mail was mandated by NHS Scotland from October 2006 to ensure that all email communications concerning patient and sensitive data are made using NHS Mail (the only secure email system offering a high level of encryption available in NHS England and NHS Scotland). The use of NHS Mail in both NHS England and NHS Scotland is endorsed by the CSP for the secure transfer of clinical information between NHS Mail users.

Encryption and personal data: Useful documents and websites

- NHS England: **NHS England Confidentiality Policy June 2014**
- Guidance on **the implementation of encryption within NHS organisations**
- NHS Wales: encryption code of practice setting out guidance for staff in this area (Lowth M. Confidentiality in the modern NHS: Part 2. *Practice Nurse*. 2013; 43 (10): 49-52)
- NHS Scotland has **minimum standards** on the protection of personal data carried on mobile devices

Storing a health record

Retaining records, disposal and security.

Records form a legal record of treatment and therefore must be retained safely and securely in accordance with the **Data Protection Act 1998**. The legal requirement to retain records for a certain period relates to the legal period for bringing civil claims under either Personal Injury law or Contract law as defined by the **Limitation Act 1980** and **The Limitation (Northern Ireland) Order 1989**.

An individual has three years to bring a personal injury claim (with some exceptions) and six years if they wish to bring a claim under contract law. Therefore, records must be retained at least until the limitation period has expired.

Each UK country sets out minimum retention periods for NHS health records. Local NHS organisations may decide to retain records for longer, so physiotherapy staff must consult their employer's guidance before disposing of any records. However, it's important to consider that the fifth principle of the Data Protection Act 1998 prohibits the retention of personal data for longer than is necessary.

The minimum retention periods apply to all formats/mediums which contain components of information relating to the health record. Although the retention periods quoted apply to the health departments in the devolved nations, private practitioners would be advised to apply the same retention periods.

Retention schedules for England, Northern Ireland and Wales:

It is important to refer to the comprehensive guidance given in the links below for specific records but the following tables summarise guidance for England, Northern Ireland, Wales and Scotland.

Recommended summarised minimum lengths of retention of hospital and GP records in England, Northern Ireland and Wales:

Hospital Records	
Children and Young People	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death.
Mentally disordered persons within the meaning of the Mental Health Act	20 years after the date of last contact between the patient/client/service user and any health/care professional employed by the mental health provider, or 8 years after the death of the patient/client/service user if sooner
Maternity records (including all obstetric and midwifery records, including those of episodes of maternity care that end in stillbirth or where the child later dies)	25 years after the birth of the last child
All other hospital records (other than non-specified secondary care records)	8 years after the conclusion of treatment or death
GP Records	
Maternity records	25 years after last live birth
Records relating to persons receiving treatment for a mental disorder within the meaning of the mental health legislation	20 years after the date of the last contact; or 10 years after patient's death if sooner
Records relating to those serving a prison sentence	Not to be destroyed.
Records relating to those serving in HM Armed Forces	Not to be destroyed.
GP records	GP Records, wherever they are held, other than the records listed below retain for 10 years after death or after the patient has permanently left the country unless the patient remains in the European Union. In the case of a child if the illness or death could have potential relevance to adult conditions or have genetic implications for the family of the deceased, the advice of clinicians should be sought as to whether to retain the records for a longer period.

England: Records Management Code of Practice for Health and Social Care 2016

Wales: NHS Wales Governance e-manual

Northern Ireland: Department of Health, Social Services and Public Safety (Northern Ireland) Good management Good Records

Retention Schedules for Scotland:

Summary of minimum retention periods for personal health records (electronic or paper-based, and concerning all specialties, including GP medical records)

GP records	Retain for the lifetime of the patient and for 3 years after their death.
Records relating to children and young people (16 years on admission)	Retain until the patient's 25 th birthday or 26 th if young person was 17 at conclusion of treatment, or 3 years after death.
Adult	6 years after date of last entry or 3 years after death if earlier
Mentally disordered person (within the meaning of any Mental Health Act)	20 years after date of last contact between the patient/ client/ service user and any health/ care professional employed by the mental health provider, or 3 years after the death of the patient/ client/ service user if sooner and the patient died while in the care of the organisation.
Maternity Records	25 years after the birth of the last child

Scotland: Records Management best practice in relation to the creation, use, storage, management and disposal of NHS records

Security of records

Good practice in relation to keeping patient information secure can be found in **Department of Health. Confidentiality: NHS Code of Practice**. Records must be stored securely (whether they are in paper or electronic format) to ensure patient confidentiality is upheld. Records must also be stored in such a way that they are easily accessible when required i.e. filed in a systematic way to aid swift retrieval.

Specific information on electronic records and security can be found in the sections:

- The move to electronic records
- Electronic Record keeping and the cloud
- Documenting a health record

Dealing with a data breach

The Information Commissioner's Office has a useful publication on **managing a data breach** . Depending on the size and nature of the data loss, the data controller may need to:

- notify the patients affected about what was lost, how it was lost, and what the organisation is doing to rectify the situation
- notify the insurer of the loss in case any patient decides to take action at a future date because of the loss
- contact the Information Commissioner and report the data loss;
- engage with software developers to resolve the problem if the problem was caused by a software issue;
- contact the recipient of the data to see if it can be retrieved

Damage to data

Where notes are damaged, such as by fire or flood, there are companies which can restore/repair original records as far as is possible. The original record (or aspects of it) should be retained as far as is practicable. Where records are totally irretrievable, they should be recreated.

The following points should be considered:

- As far as reasonably possible, a list of the names of patients whose records have been destroyed should be made and new records created for them.
- A statement should be included that "original notes destroyed by <reason> (for example flood) on <date>; notes recompiled from memory on <date>"
- For some patients it may only be possible to recreate name and (approximate) dates of treatment, but if any clinical detail can be remembered it should be recorded where possible, accepting the limitation of memory; members should not 'make up' or 'invent' records.

Deliberately destroyed data and the law

If records have been deliberately destroyed and are not available to present as evidence to a court, then this may count against the person or organisation that caused the loss. In cases where records are lost or misplaced by accident, the law looks to other forms of evidence to make appropriate judgements.

When patients hold their own records and damage or lose the records by their own actions, the individual circumstances of any claim would need to be considered.

Legal, regulatory and employer responsibilities

Physiotherapy staff that are recording, accessing, and storing health records must be aware of the legal context within which they work, and comply with regulatory, national, professional body and local employer guidance on record keeping.

The **Code of members' professional values and behaviour** states that all members are responsible for 'adhering to all legal, regulatory and ethical requirements.'

Health records and the HCPC

In the UK, the Health and Care Professions Council (HCPC) regulates all Allied Health Professionals (including physiotherapists). Two HCPC documents set out the responsibilities that all physiotherapists have in relation to meeting regulatory obligations in their record keeping practice:

1. **Standards of conduct, performance and ethics**
2. **Standards of proficiency: physiotherapists** (This sets out the minimum standards the HCPC consider necessary to protect the safety of the public. Standard 10 ‘Be able to maintain records appropriately’ should be reviewed in relation to record keeping.)

As part of the HCPC registration process, all physiotherapists must sign a declaration to confirm that they have read and will work to these standards in their practice. Lack of adherence to these standards can lead to a physiotherapist being called to defend themselves in a HCPC Fitness to Practise hearing, and could ultimately lead to being struck off the HCPC register.

Health records and the law

Physiotherapy records are legal documents that may be called upon for a range of legal purposes. The purpose of the physiotherapy record is to allow a third party reader to make a judgment based on the content of the record and therefore, the physiotherapy record may be the only robust defence against any claim or error, omission, act or negligence in the course of clinical practice.

The physiotherapy notes must be an accurate account of events at the time they are recorded. The assessment/intervention recorded must be factually correct at the time. The burden of proof will depend on the specific setting and circumstance in which the notes are being scrutinised.

Patient access to records

The following Acts govern how a patient may request access to their records:

- **Data Protection Act 1998**

  The Data Protection Act 1998 regulates the use of information about living individuals in relation to obtaining, processing, using and disclosing information.

  It also sets out the right for living individuals to be informed that information is being held about them, and for what purposes the information will be processed. Review the **eight Data Protection Principles.**

- **Access to Health Records Act 1990** and **Access to Health Records (Northern Ireland) Order 1993**

  The Access to Health Records Act 1990 and Access to Health Records (Northern Ireland) Order 1993 gives the right of access to a deceased patient's health records by specified persons

- **The Access to Medical Reports Act 1988**

  The Access to Medical Reports Act 1988 governs release of commissioned reports of living patients for employment or insurance purposes.

If a third party (for example an employer or solicitor) requires access to a patient's health records, including occupational health records, then application must be under the Data Protection Act and can only be made with the patient's express written permission, except where permitted by law, for example if the patient lacks the mental capacity to make a decision about releasing the records.

Health professionals: handling and use of information

The following Acts govern how a health professional must handle and use information:

- **Data Protection Act 1998**

  Organisations, including self-employed individuals must be registered with the Information Commissioner and comply with the Act including the Data Protection principles and retention requirements.

  The Information Commissioner's Office has published useful **guidance on the Data Protection Act**, how to manage data losses, and good practice in capturing professional opinions in health records.

- **Freedom of Information Act 2000** and **Freedom of Information (Scotland) Act 2002**

  The Freedom of Information Act 2000 and Freedom of Information (Scotland) Act 2002 gives people the right to access official information from public medical/health organisations. These Acts apply to public authorities (for example, the NHS), companies that are wholly owned by public authorities, or any person or organisation exercising a 'public function', including voluntary organisations providing services under contract with local authorities and trusts. There are time frames to be adhered to in providing a response to a freedom of information (FOI) request. There are also some exceptions where information does not have to be supplied (repetitious or vexatious requests; information that is already in the public domain; commercially sensitive information; or patient record information that is protected under the Data Protection Act.

The **Information Commissioner's website** has further details about FOI requests.

- **Computer Misuse Act 1990**

  The Computer Misuse Act 1990 makes it an offence to gain unauthorised access to computer materials (including using another person's username, password, login ID or smartcard without their permission to gain access to records).

- **Human Rights Act 1998**

  The Human Rights Act 1998 sets out the 'right to respect for private and family life'. The contents of health records are classed as private and so are covered by the Act.