Clinical Record Keeping

Guidance for graduate and allied health professional members

January 2013

Introduction

This guidance has been written to inform the membership of the standards expected by BASRaT with regard to clinical record keeping. A clinical record is any record which is made by or on behalf of a health professional with regard to their professional practice interaction with an individual or group. It contains and consists of information which relates physical or mental health, medical history and/or other health related information. The record may be a paper record, electronic record or mixture and may also comprise of other audio/visual data formats where appropriate.

The making of a clinical record is mandatory for all client interactions undertaken within the Role Delineation of a Sport Rehabilitator. Clinical record keeping is mentioned within the Standards of Ethical Conduct and Behaviour (Principle 1.3) a document which underpins the practice of Sport Rehabilitation in the UK. Failure to comply with this standard can lead to Fitness to Practise proceedings.

General guidelines

GSR's work in a variety of settings and are therefore required to maintain clinical records (paper or electronic) in a manner that not only meets the standards as laid out in Principle 1.3 but meets the requirements of their employer or situation.

GSR's should consider the process of clinical record keeping a professional tool which is essential to aid and facilitate the rehabilitation, care and training process. Clinical Record Keeping also underpins the professional practice of a GSR because it can:

- Demonstrate clinical reasoning and clinical decision making
- Encourage logical thinking, critical analysis and reflection
- Facilitate good communication between the multi-disciplinary team involved in client care
- Provide standardised information for all members of the multi-disciplinary team involved in client care
- Meet the regulatory requirements of BASRaT and applicable legal requirements
- Enable records to be considered legal documents which may form the basis of defense of fitness to practice or legal cases
- Provides a source of data for research, audit, planning or development purposes.
- Form the basis of future decisions regarding health and care
- Support continuity of care between health professionals

Legal Implications

GSR's must also maintain and demonstrate awareness of the legal context of their work and how this affects their clinical record keeping. A key part of this is ensuring compliance with the relevant legislation listed below:

- Data Protection Act (1998)
- Human Rights Act (1998)
- Access to Health Records Act (1990) NI (1993)
- Access to Medical Reports Act (1988)
- Freedom of Information Act (2000) Scotland (2002)

GSR's must also be aware that clinical records may be used as evidence in a court of law or to investigate a complaint. Clinical judgment should be used to decide what is relevant and should be included, however courts tend to take the view that 'if it is not written down, it did not occur'. This point is particularly pertinent in cases where the condition of a client is apparently unchanging though later chronic disability or dysfunction is diagnosed but no record of care/referral exists. Clinical record keeping must therefore demonstrate:

- A complete account of any assessment, intervention (planned or undertaken, including advice) and subsequent referral/continuing care

- All relevant information about the presenting condition and general medical condition of the client
- The measures taken to respond to the client's needs (as stated, assessed and agreed)
- Evidence that the GSR has undertaken and honored their reasonable duty of care, including evidence that actions or omissions taken by the GSR were taken in the clients best interest and have not compromised health and safety in any way.

Format and Content of Clinical Records

BASRaT accepts that the decision regarding the specific format of clinical records should be taken at a local level and depends upon the setting and context under which the GSR practices. However, the following recommendations apply regarding the content and style of all clinical records. Specifically, all records should include:

- Date and time of initial consultation and all following client interactions
- A suitable method for attributing the record to the member to ensure accountability and responsibility for the recorded information
- Legible, factual and accurate information particular to the client
- Evidence of clinical reasoning for decisions, interventions, and advice, documenting where appropriate the agreement and involvement of the client
- Only accepted and agreed abbreviations and short form language which should be readily understood by health professionals
- Amendments which are clearly noted and include a date and reason for the amendment

(as stated in principle 1.3 of the Standards of Ethical Conduct and Behaviour)

Further guidance is that the following is considered essential information to include as part of a clinical record.

- Client details (name, address, contact number, date of birth, gender, GP name and practice)
- Initial Referral Information (Self or other, copy of referral from another health professional which includes their details, date and status)
- Personal Information as appropriate (height, weight, physical activity status, vocational and recreational activity)
- Consent (to assessment, intervention and disclosure of information as needed)
- General Medical condition as relevant (drug history, social history, medical and injury history)
- Presenting condition or goal (subjective information, objective information, analysis, plan)
- Problem List and goals of intervention with appropriate outcomes
- Date and Time of Review Appointment, Discharge or Referral (copies of documents where appropriate)

Other Information

Retention and security of clinical records

Retention and security of clinical records is subject to the legislation as listed above, employers may also have relevant protocols and policies. The following general guidelines should also be observed:

- For adults retain records for 8 years since the last dated record.
- For children (U18) retain records until 25th Birthday or 26th Birthday if child was 17 at the conclusion of treatment.
- Clinical records must be securely stored (paper or electronic) to protect the clients right to confidentiality (this includes protecting: passwords, portable data or other storage

devices, not removing notes from premises or making notes viewable upon social networking forums).
- Confidentiality must also be maintained when disposing of clinical records

Deceased Individuals

In the case of deceased individuals records should be retained according to the timeframe as outlined above. However it should be considered that the individual's clinical records form part of their estate upon death. As such GSR's should only release clinical records to the person who has the authority to manage that estate on behalf of the deceased individual. This may be a legal executor, administrator or beneficiary of the estate. Any applications should be checked for their veracity and legitimacy and should be made under the relevant legislation (Access to Health Records Act (1990) NI (1993))

Student access and contribution to clinical records

In the case of student supervision, the supervisory GSR maintains overall responsibility for all aspects of their professional practice, including the management of clinical records. However there may be times when a student is asked to, or should contribute to a clinical record. In this incidence BASRaT recommend a counter-signatory scheme is employed. This scheme should be explicit in that:

- The counter-signatory must be the clinician responsible for the clients care.
- The meaning of the counter-signatory act must be clearly stated (i.e. observation of students practice and therefore a signature of authentic, or review of the students stated practice but not directly observed). This determination should obviously be made with regard to the task undertaken by the student and their competency and skills demonstrated.

This document was compiled using guidance from the Health and Care Professions Council, The Chartered Society of Physiotherapy and the British Association of Prosthetics and Orthotists. Their intellectual property is acknowledged.