Record keeping

Part 1 — The sword of Damocles

In the first of two articles, Professor Nizar Hirji discusses why record keeping is so important and the legal requirements and implications of keeping clinical records. Module C12108, one general CET point suitable for optometrists and dispensing opticians.

Records are the most basic of clinical tools. They consist of information relating to an individual who can be identified from that information, or from that and other information in the possession of the health professional and that has been made by or on behalf of a health professional in connection with the care of that individual. They may comprise text and/or sound and/or images, either in electronic or hard copy (manual) format or both, and contain sufficient information to support any diagnoses/assessments, justify the actions of the health professional and facilitate the care of the patient to which they refer. They are a permanent documentation of patient contacts and state the basis for the decisions that flow from these encounters and consultations. This is not best practice but a minimum standard expected from good clinical records.

The General Optical Council’s fitness to practise (FTP) committees have repeatedly criticised the quality of optometric record keeping and the resulting failings of care to the point that it is a regular theme in FTP hearings.

The scope of optometric practice continues to expand (for example changes in medicines legislation in the UK which have broadened the opportunities for optometrists to use and supply therapeutic drugs, diagnosis and therapeutic interventions at entry level). Furthermore, significant numbers of community optometrists are managing a range of common ocular conditions.

Inevitably, optometric records both paper and electronic have to evolve to accommodate this evolving nature of contemporary optometric practice. This, coupled with patient safety and the demands of clinical governance, make attention to record keeping a high priority for optometry.

This first article on the subject presents an overview of the purpose of primary care record keeping, along with some guiding principles. It also reviews the key legal aspects that impact on confidentiality of information on health records and access by patients and others. Some generic tips on good record writing/keeping are also given.

The need for good records

Good contemporaneous optometric records are essential to good optometric patient care—the two go hand in hand. Records are the most tangible evidence of the authors’ clinical practice, and in litigation—the sword of Damocles for practitioners—they may ‘illuminate’ or ‘cast a shadow’. They are the most significant documents for the clinician’s defence if clinical decisions and actions are under scrutiny. Recent material from DOCET and the AOP makes that point very clear.

However, the prime purpose of record keeping is to enable clinicians to communicate and assist the sharing of information between practice team members, where appropriate, in the best interest of patient care. Clinical records act as a working document for recording this patient care. They store a chronological account of the patient’s life, visual and general health, its context, their attendances or contacts with the practice/practitioner and who did what and to what effect. They enable continuity of approach when a condition needs managing or monitoring over a longer period and requires more frequent visits to the practice. They record any special factors that appear to affect the patient or the patient’s response to optometric intervention or treatment. They note factors that might render the patient more vulnerable to an adverse reaction to investigation, management or treatment. They are there to record risks and to protect the patient and others. Advice given to patients, their families, carers etc. is also recorded. They include communications to and from others such as other clinicians, carers, educational establishments, employers, and other agencies. They record advice and information received and given. They hold data collected before, during and after patient consults. Records are often used for clinical audit, governance and for accreditation purposes as appropriate. Good clinical records can also provide information for research and enable more accurate analyses of clinical activity. Finally, records contain information that patients along with authorised persons have a right of access to and may well want to exercise this right.

Holding and transferring information

In an effort to address record keeping in hospital settings where multidisciplinary interventions are commonplace, the Royal College of Physicians through its Health Informatics Unit has produced some generic record keeping guidelines. Similarly primary care trusts and the NHS Information Standards Board have also produced guidelines, as has the College of Optometrists for good record keeping. There are some generic principles that apply to all clinical record keeping, including optometric records, whether in electronic or manual format.

It is generally accepted that in a healthcare context there is a common law duty of confidentiality. Patients thus have a right to expect that information...
about them will be held in confidence by their optometrists. All information about patients must be treated as confidential, even after a patient is deceased. This duty of confidentiality is explicit in the NHS General Ophthalmic Services Contracts introduced in October 2008 within the framework created by the NHS Act 2006. The obligation is quite clear and practitioners and their practice teams have to be careful not to breach this confidentiality inadvertently by, for example, discussing patients with colleagues within earshot of others not part of the practice team, leaving records, filing cabinets etc unattended; and placing computer screens with patient information within view of the public etc. All records have to be stored securely and safely. Access to the information contained therein for processing and submission to other people and organisations can only be done with the consent of the patient. This consent has to be explicit and best noted on the records at the outset, so that patients are alerted to this and are in a position to ask questions for clarification and can decline if not satisfied with the information provided. Thus all optometric records need to have a section at the outset that deals with this. In December 1997, the Caldicott report, with input from a variety of organisations including the College of Optometrists, was published. Dame Fiona Caldicott stated in that report that it was important confidentiality did ‘not impede the provision of prompt and effective patient care. But at times there is a tension between the needs of the service for patient information and the expectation of patients that information about them will be kept confidential. It is not uncommon for the NHS to have to balance conflicting needs of this kind; this can be done by adhering to explicit and transparent principles of good practice.’ These principles include:

- Justify the purpose for using patient information
- Use only patient information when absolutely necessary
- Use the minimum information required
- Access to patient information should be on a strictly ‘need to know’ basis
- All staff handling patient information should understand their responsibilities
- All staff handling patient information should understand and comply with the law relating to patient information.

Data Protection Act 1998

The Caldicott principles relate to patient information and good practice in patient information handling – it is a voluntary code. The Data Protection Act 1998 (DPA 1998) enacted in March 2000 covers the handling of all records electronic or manual, and places legal obligations on information holders. The DPA 1998 gives living individuals the right to know what information is held about them. It provides a framework to ensure that personal information is handled properly. The Act works in two ways. First, it states that anyone who processes personal information must make sure personal information is:

- Fairly and lawfully processed
- Processed for limited purposes
- Adequate, relevant and not excessive
- Accurate and up to date
- Not kept for longer than is necessary
- Processed in line with the rights
- Secure
- Not transferred to countries outside of the European Economic Area (EEA) without adequate protection.

The second area covered by the Act provides individuals with important rights, including the right to find out what personal information is held on computer and paper records.

Should an individual or organisation feel they are being denied access to personal information they are entitled to, or feel their information has not been handled according to the eight principles, they can contact the Information Commissioner’s Office (ICO) for help. The ICO has legal powers to ensure that organisations comply with the requirements of the DPA 1998. It is important to note that these powers are focused on ensuring that organisations meet the obligations of the Act.

The provisions of the Access to Health Records Act 1990 (AHRA 1990) are subsumed under the DPA 1998 save for section 3(t) of the AHRA 1990 which deals with access to information about patients who are deceased.

The DPA 1998 allows patients or their bona fide representatives to access health records. Any request for access to health records should be made in writing or electronically to the record holder, with the patient’s signature. In cases where consent can only be taken verbally, then the details of this consent should be recorded on the individual’s file. Electronic requests should only be accepted with an electronic signature. If this is not possible, the applicant should be advised to fill in a manual consent form within the practice. Once an access request is received, the record holder must be able to verify the consent of the applicant by the following being made available:

- A signature from the patient to the release of their records
- If a patient’s bona fide representative, ie solicitor, is applying for access, a signature of the patient to do this. In some circumstances, it may be prudent for the record holder to contact the patient to clarify that they fully understand they will be consenting to the release of their ophthalmic records to a third party
- If a parent or a person authorised with parental responsibility is applying for access to their child’s health records. The optometrist should consider if the child is capable of making his or her own judgement on their healthcare (Gillick competent). If they are, consent should be sought before the application is accepted.

After obtaining patient consent for an access request, enough information should be gathered to identify the data relating to the subject. Such details could include:

- Full name – including previous names
- Date of birth
- Full address – including previous address(es).

Once the record holder has all the relevant information and files where relevant, they should comply with the request promptly, within 21 days and by no later than 40 days after the request has been made. In exceptional circumstances if it is not possible to comply within the 40-day period the applicant should be informed.

Under the Data Protection Act 1998 there are certain circumstances in which the record holder may withhold information. Access may be denied, or limited, where the information might cause serious harm to the physical or mental health or condition of the patient, or any other person, or where giving access would disclose information relating to or provided by a third person who had not consented to the disclosure. Remember that the author of the record may be required to explain the content of the record and any abbreviations to make it understood by the patient or their bona fide representative. If the applicant considers the record to be incorrect, misleading or incomplete, the applicant can request that the records be amended accordingly. If the record holder disagrees with the proposed amendment(s), the applicant has the right to note this in the record. For employed practitioners, it is the employing organisation that is considered to be the record holder.
Essential points to consider

It is essential when writing records that practitioners and their practice teams should ensure their records are:

- Factual, consistent and accurate
- Written in preferably black ink (indelible)
- Written during the patient contact time or consultation, or as soon as possible after and certainly no later than 24 hours if the date and time differs significantly from that of when the patient contact or event occurred, then this should be clearly noted under the signature of the author, his/her printed name and position
- Written clearly, legibly and in such a manner that they cannot be erased
- Not altered with erasers or liquid correction fluids to delete errors. A single line should be used to cross out and cancel mistakes or errors and this should be signed and dated by the person who has made the amendment
- Dated, timed and signed
- Written with minimal use of abbreviations
- Consecutive
- Collated and stored so that loss of documentation is minimised
- Without unnecessary jargon
- Restricted to professional judgements on clinical/relevant matters.

The above, where appropriate, apply to records on electronic media and additionally practices that use such media and associated technology should:

- Have protocols in place to clarify access, ensure security and ensure confidentiality
- Show the date and time of the record entry and identify the member of staff making the record entry in the absence of a signature
- Ensure the original information can still be accessed when additions or alterations are made
- Have a mechanism to lock down and clear screens when not in use automatically after a very short period. Patient information is easily visible and accessible from a computer screen and care should be taken not to leave the screen unattended.

Good record keeping is essential to good patient care. Optical practitioners are responsible for what they write or for what they choose not to write. It is good practice to assume when writing records that the notes and entries made may well be scrutinised. This usually improves record keeping, but, more importantly, improves patient care through improved communications between clinicians and their practice staff.

References

12. Gillick v West Norfolk and Wisbech Area Health Authority (1985) 3 All ER 402 (HL).

Multiple-choice questions

1. Records can include the following information:
   A. Data collected during a patient consultation
   B. Risk of angle closure
   C. Advice received from the patient’s neurologist
   D. All of the above

2. Confidentiality of optometric records is covered by:
   A. Acts of Parliament
   B. Common Law
   C. EEC regulations
   D. Health and Safety regulations

3. Disclosure of patient information to third parties requires:
   A. Explicit consent
   B. Implicit consent
   C. Caldicott consent
   D. NHS consent

4. The Data Protection Act 1998 applies to:
   A. All patient information held in an optometric practice
   B. Only patient information held on computers
   C. Only patient information held on paper
   D. Only information about deceased patients

   A. Does not apply to optometric patient information
   B. Applies only to those patients who are living
   C. Has been subsumed entirely by the DPA 1998
   D. Is applicable to deceased patients

6. Contemporaneous record keeping means:
   A. Writing records in good common language
   B. Record keeping that is relevant to the patient’s complaint
   C. Recording details at the same time as the patient contact and no later than 24 hours
   D. Writing records that are factual, consistent and accurate

Successful participation in this module counts as one credit towards the GOC CET scheme administered by Vantage and one towards the Association of Optometrists Ireland’s scheme.

The deadline for responses is October 22 2009