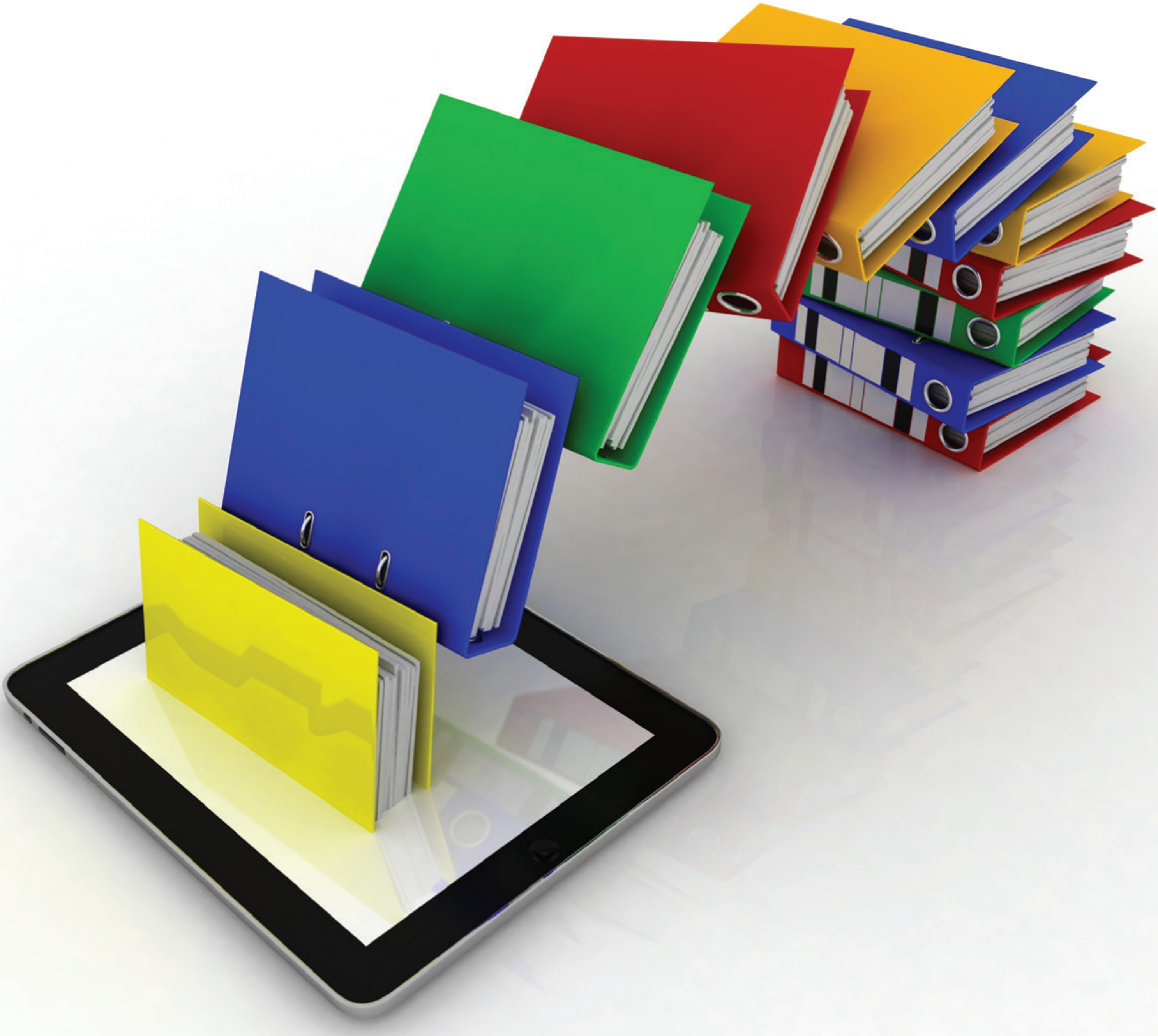
Keeping Records

Guidance for occupational therapists

Fourth Edition

Royal College of Occupational Therapists



Royal College of
Occupational
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About the publisher

The Royal College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. RCOT sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 10 accredited specialist sections support expert clinical practice.

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1 Introduction

Keeping records is an integral part of the practice of all practitioners in health, social and community care, education and research. It is an absolute requirement as part of your duty of care, and must be completed in line with relevant legislation, the standards of your registration and professional bodies, and local policy.

Your records primarily support and enable the provision of care to the service user, but they also demonstrate that you have carried out your responsibilities in line with legal, professional and local requirements. Care records are legal documents and may be used as evidence in an enquiry or court of law.

For the purposes of this guidance, the records kept by occupational therapy practitioners are called ‘care records’ and encompass those kept in all settings. People who receive occupational therapy services are called ‘service users’. This term encompasses all ages, groups and communities of people, and is applicable in all settings. Other terms may be used in quotations. The Royal College of Occupational Therapists may also be referred to as RCOT.

You are advised to use this guidance in conjunction with the *Professional standards for occupational therapy practice* (COT 2017) and the *Code of ethics and professional conduct* (COT 2015a).

1.1 Keeping records as part of your duty of care

> *A duty of care arises where there is a sufficiently close relationship between two parties … and where it is reasonably foreseeable that the actions of one party could, if carelessly performed, cause harm or loss to the other party. Discharging your duty of care requires you to perform your occupational duties to the standard of a reasonably skilled and careful practitioner.*
>
> (COT 2015a, section 3.1)

Your records are your evidence that you have met your duty of care within your practice, but the keeping of records is also part of that duty. It is reasonably foreseeable that your record-keeping, if carelessly done, could cause harm or loss to those for whom you provide a service.

You may be considered in breach of your duty of care if your records fail to show that you have performed your professional responsibilities, including record-keeping itself, to the standard expected of a reasonably skilled occupational therapy practitioner (COT 2015a, section 3.1.4). This guide defines certain key requirements for keeping records and explains some of the rationale that underlies them.

1.2 What constitutes a care record?

Care records include any material that holds information regarding an individual, collected as part of their care provision. Such material can be handwritten, digital, auditory or visual, and would include data held on a computer, a tablet or mobile phone. It would include images, auditory or visual recordings, forms, letters, notes, diary entries, emails, text messages and duplicate copies.

1.3 The purpose of care records

Care records serve many purposes. They are primarily a history of the assessment, decision-making, planning and care provided for a service user, along with the outcomes of that care. They may highlight problems and changes in a service user's condition. They are a record of the service user's objectives, preferences and choices, along with their consent to any intervention on their behalf. They protect the welfare of the service user by supporting high-quality, evidence- and rationale-based care, continuity of care and good communication between all those involved.

On a wider scale, the data recorded may be used for auditing practice and outcomes, service planning and business decision making. They may also provide documentary evidence in an investigation or court of law.

Care records are also your evidence of good, safe and effective practice, especially should your work ever be questioned. They define and explain the work that you do as an occupational therapy practitioner in your particular role.

1.4 Legislation, standards and policy related to keeping records

This guidance does not name every piece of relevant legislation, recognising that many differ across the four UK countries. It will only identify and discuss some of the more universal pieces of legislation that apply to keeping records across the UK.

You are expected to be familiar and comply with any UK or national legislation, policies and best practice standards, along with employers' policies and procedures that are relevant to your own field of practice, setting and country of practice. This includes compliance to local policy and legislation around cultural identity and language needs.

If you are an independent practitioner, you are advised to put in place your own policies which are compatible with legislation, your professional standards and standard practice.

If you are concerned that your local policy, or any local action that you witness, is causing you to fall short of your legal and professional duties in keeping records, or that it puts the welfare of service users, yourself or your colleagues at risk, you must raise this with your employer. Keep a record of your concerns. You are advised to contact your local union representative and the Royal College of Occupational Therapists' Professional Practice Enquiries Service in such situations, as each may be able to advise you.

Guides, standards and codes of practice set down by professional and regulatory bodies, and at a local level, aim to provide a structure and a universal standard for safe and good working practice. They are not in themselves legally binding, but a failure to follow this recommended practice, it could be argued, may constitute negligence or a breach of your duty of care (Lynch 2009, p10).

1.4.1 *General Data Protection Regulation (GDPR) 2016*

The GDPR (Council of Europe, European Parliament 2016) is a regulation adopted into European Union (EU) law in 2016. It became enforceable across the EU in May 2018. A new UK *Data Protection Act 2018* (Great Britain. Parliament 2018) aims to clarify, or fill in any gaps in, the GDPR with particular reference to data processing and protection in the UK. It will ensure continuity of data protection requirements post Brexit.

The GDPR defines responsibilities for data ‘controllers’ and data ‘processors’:

- A controller determines the purposes and means of processing personal data, or decides what personal data will be collected and why. This may be an individual, organisation, authority, agency or body. A data controller can also process the data by their own means. An example of a controller might be a hospital, local authority, or the Royal College of Occupational Therapists, and would include its employees.
- A processor is an individual, organisation, authority, agency or body that provides a service to maintain and process personal data on behalf of the controller. The data processor does not control the data and cannot change its purpose. An example of a processor might be a mailing house, such as the one that sends out the Royal College’s *OTNews* magazine.

Health and social care organisations that are public authorities must appoint a Data Protection Officer (DPO). The DPO has an essential role in facilitating ‘accountability’ and the organisation’s ability to demonstrate compliance with the GDPR.

The GDPR applies to ‘personal data’ which means any information relating to an identifiable person (data subject). That person may be identifiable by any means including name, number, biometric data, location data, or online data. The GDPR also refers to sensitive personal data as ‘special categories of personal data’ which include health-related information. These require a higher level of data protection.

As with the former *Data Protection Act 1998* (Great Britain. Parliament 1998a), the GDPR applies to data held, or intended to be held, on computers or in a ‘manual filing system’ where personal information is accessible according to specific criteria. If your information is structured in such a way that specific information relating to a particular individual is readily accessible, it would be considered as a relevant filing system.

Contact details stored on a mobile phone, or identifiable addresses on a satnav system, would both constitute filing systems.

Even if data is anonymised by allocating a key-code (the term pseudonymised is used in the GDPR), perhaps for research purposes, it can fall within the scope of the GDPR depending on how easy it would be to identify the individual from the pseudonym. Occupational therapists involved in research should update themselves on changes made by the GDPR and new *Data Protection Act 2018*, to ensure that they are working with suitable safeguards.

The Controller must be able to demonstrate that they are compliant with Article 5 of the GDPR, which requires that personal data shall be:

a) Processed lawfully, fairly and in a transparent manner in relation to those individuals involved.

b) Collected only for specific, explicit and legitimate purposes and not further processed in any way that is incompatible with those purposes.

c) Adequate, relevant and limited to what is necessary in relation to those purposes.

d) Accurate and, where necessary, kept up to date. Every reasonable step must be taken to erase or rectify inaccurate personal data.

e) Kept in a form that permits identification of individuals for no longer than is necessary for the purposes for which the data was collected and processed. Personal data may be archived for longer if solely for the purposes of the public interest or scientific or historical research or statistical purposes.

f) Processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage.

You must have and record a lawful basis in order to process data. The GDPR recognises six lawful bases:

1. Consent: When you have consent. Blanket consent and default consent are not acceptable. (Please see section 4.2 on *Confidentiality, information sharing and consent*.) Consent should be kept under review.
2. Contract: When it is necessary to prepare for, or fulfil, your contractual obligation to the data subject.
3. Legal: In order to comply with a common law or statutory obligation.
4. Vital interests: When it is necessary to protect someone’s life. You cannot rely on this if the individual is capable of giving consent, even if they refuse consent. It will not apply if there is an alternative, less intrusive way to protect the person’s life.
5. Public task: When ‘in the exercise of official authority’ or when in the public interest. These are both set out in law.
6. Legitimate interests: When there is a necessary legitimate interest, e.g. commercial, the processing would be expected and would have minimal privacy impact.

The GDPR states that the processing of special categories of personal data is prohibited unless it is done under both a lawful basis and one of a number of identified conditions. These include but are not limited to:

1) When the individual has given consent for processing for a particular purpose.
2) When the processing is necessary for the purposes of carrying out the obligations or specific right of the controller, for example employment or social security.
3) For the protection of the individual when they are unable to give consent.
4) When in the public interest or for the purposes of public health.
5) For assessing working capacity, providing a medical diagnosis, the provision of health or social care or treatment, and the management of health and social care systems.

Where information is processed to support local clinical audit and other work to monitor the quality of care provided, the GDPR states that this must be done under both a lawful basis and a relevant condition.

The GDPR has also strengthened the rights of the individual with reference to their own personal data:

1. The right to be informed
2. The right of access
3. The right to rectification
4. The right to erasure
5. The right to restrict processing
6. The right to data portability
7. The right to object
8. Rights in relation to automated decision-making and profiling.

The Information Commissioner's Office (ICO) has an online *Guide to the General Data Protection Regulation* (GDPR) (ICO 2018). This provides definitions for all terms in the Regulation and explains in detail the requirements. It is available to download from the Information Commissioner's Office website along with a number of resources to help ensure compliance. The Information Governance Alliance has a range of guides with respect to the GDPR, available to download from the NHS Digital website.

1.4.2 *Human Rights Act 1998*

The *Human Rights Act 1998* (Great Britain. Parliament 1998b) implements the provisions of the *European Convention on Human Rights* (ECHR) (Council of Europe 1950). Article 8 of the ECHR ensures respect for a person's private and family life. Disclosure of personal information would be a breach of that right unless it was 'in accordance with the law', necessary 'in a democratic society for a legitimate aim (in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others), and proportionate' (House of Lords and House of Commons, Joint Committee on Human Rights 2008).

1.4.3 Mental health and mental capacity legislation

All occupational therapy practitioners will, at times, work with people who have mental health conditions, so should be aware of their duties with regard to mental health legislation (Great Britain. Parliament 1983, 2005, 2007). This is perhaps most pertinent with respect to capacity and consent, along with deprivation of liberty and safeguarding. Practitioners working with service users specifically subject to mental health legislation must ensure that they have a good working knowledge of the relevant law. Further information on recording consent and capacity can be found in section 2.1.2.

1.4.4 The Health and Care Professions Council requirements

The Health and Care Professions Council (HCPC) requires you to 'keep full, clear, and accurate records for everyone you care for, treat, or provide other services to', and that 'you must complete all records promptly and as soon as possible after providing care, treatment or other services' (HCPC 2016, section 10).

You must also 'be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines' (HCPC 2013, section 10.1). HCPC clearly states that your records must demonstrate your clinical reasoning, in that you must 'be able to make reasoned decisions to initiate, continue, modify or cease treatment or the use of techniques or procedures, and record the decisions and reasoning appropriately' (HCPC 2013, section 4.2).

The HCPC sees failures in keeping records as misconduct and/or a lack of competence. When activity on behalf of a service user is not recorded, it cannot be shown to have happened, therefore the practitioner may be considered as unfit or unsafe to practise. Poor record-keeping may be an indicator of a practitioner who is struggling in terms of their knowledge and skills, their attitude and confidence, or perhaps their personal wellbeing.

Case notes from HCPC occupational therapists' final hearings identify record-keeping shortfalls in detail. It has been noted when records:

- are incomplete or not made;
- are not clear and concise;
- use wrong terminology and clinical terms;
- are not completed in a timely manner;
- do not document clinical [professional] reasoning;
- demonstrate poor completion of assessments;
- do not identify goals, interventions and outcomes;
- do not link interventions to care plans;
- give no indication of whether plans have been carried out or goals met;
- do not record risk assessments and actions taken;
- do not record meetings or communication with others; and
- do not identify referrals made.

(HCPC ca. 2016)

1.4.5 Your professional requirements

As with the HCPC standards, the Royal College of Occupational Therapists' *Professional standards for occupational therapy practice* (COT 2017) provide statements which capture the over-riding requirements for your record-keeping (see below). You will need to look at each statement and consider what it would take, in terms of your practice and your workplace, to meet each of these.

7. You keep care records that are fit for purpose and process them according to legislation.

7.1 You provide a comprehensive, accurate and justifiable account of all that you plan or provide for service users.

7.2 You record the evidence and rationale for all that you do.

7.3 Your care records are written promptly, as soon as practically possible after the activity occurred.

7.4 You are aware of and meet all requirements in relation to record keeping, whether in legislation, guidance or policies.

7.5 You comply with any legal and professional confidentiality, the sharing of information and service user access.

7.6 You keep your records securely, retain and dispose of them according to legal requirements and local policy.

(COT 2017, standard statement 7)

1.5 Competence and delegation

The Royal College of Occupational Therapists, *Code of ethics and professional conduct* states that:

> *You should be aware of and abide by the current legislation, guidance and standards that are relevant to your practice, remaining up to date with relevant training where necessary.*
>
> (COT 2015a, section 5.1.2)

This means that you must ensure that all care records that you create or use meet legal, national and/or local requirements. You should have access to appropriate training, professional guidance and support where and when necessary.

It also states that:

> *If you delegate interventions or other procedures you should be satisfied that the person to whom you are delegating is competent to carry them out. In these circumstances, you, as the delegating practitioner, retain responsibility for the occupational therapy care provided to the service user.*
>
> (COT 2015a, section 5.2)

If you supervise staff, delegating tasks and responsibilities to them, it is your responsibility to ensure that they are competent to carry out those tasks. This includes the keeping of records. Where they need additional help or guidance in record-keeping, it is your responsibility to provide this or arrange for it to be provided.

If you have a student, or new/inexperienced member of staff, you may take on some responsibility for teaching them good record-keeping practices. This may require you to directly oversee their record entries until such a time as they are deemed competent to carry them out unsupervised. You do not need to countersign entries unless your local policy requires this (see section 2.1.16).

If you are a student on placement and you are unsure of your record-keeping skills, you need to seek out guidance and support. This does not necessarily need to come from an occupational therapist, if one is not present. Use this published guidance alongside the support provided by other professionals in your location.

2 Records that are fit for purpose

Occupational therapists need to be able to show all that they have done for, with or in relation to a service user, including the clinical reasoning behind the occupation-focused care planning and provision. They also need to be able to demonstrate the outcomes of the care that they have provided, not only for the benefit of the service user and others in the care team with access to the records, but also as a testament to the value of occupational therapy.

When you consider the requirements of the HCPC and RCOT standards, there are key words that identify the necessary elements of quality which are required. Every service user with whom you have contact must have records that are:

- full/comprehensive;
- clear/comprehensible;
- accurate;
- promptly completed;
- demonstrating your clinical reasoning and evidence;
- compliant with legislation, guidance and policy on completion, confidentiality, sharing and service user access; and
- securely stored and suitably disposed of.

2.1 Requirements for best practice

To ensure that you meet legal, professional and registration body requirements, you are advised to take account of the following points.

2.1.1 Service user identifiers

The use of a consistent and unique identifier assists in the delivery of safe integrated care, data sharing and integrated digital care record systems.

A unique service user identifier should be used in all care records in all settings and in all UK countries. All information included in the care record should be identified by the service user's name, date of birth and unique identifier.
You are advised to follow local policy.

2.1.2 Recording capacity and consent to intervention

The Royal College of Occupational Therapists' *Code of ethics and professional conduct* states that:

> *Informed consent is a continuing requirement. Unless restricted by mental health and/or mental capacity legislation, it is the overriding right of any individual to decide for himself (herself) whether or not to accept intervention.*
>
> *A service user can only give informed consent if he or she has the mental capacity to do so … You must assess service users' mental capacity to make decisions in relation to occupational therapy provision, in accordance with current legislation.*
>
> (COT 2015a, section 3.3)

Informed consent is when a person gives consent, or agrees to a course of action, based on a clear understanding of the information given, and the implications and consequences of the proposed action.

When seeking consent, it is presumed that a person has capacity and does not have to prove otherwise. Capacity would only need to be assessed when a person is unable to make a decision at a specific time, because their mind is affected by illness or disability. It is understood that capacity is a fluctuating state and may need to be re-assessed.

The *Mental Capacity Act 2005* (Great Britain. Parliament 2005) enables those in health and social care to carry out capacity assessments. If you are unsure of your ability to do this, seek guidance and suitable training from your employer.

This guidance is not about how to assess capacity, but the importance of recording your assessment and its outcomes. If you think that an individual lacks capacity, you need to be able to demonstrate it. Your records should show that it is more likely than not that the person lacks the capacity to make a specific decision at the time that they need to. You should document how the service user's capacity was assessed and whether any lack of capacity is considered permanent or temporary. You must be able to record the rationale for any actions or recommendations taken following your assessment. Your records are your evidence of this and how any further action taken is in the individual's best interests. You should follow your local policies and procedures.

Your records need to demonstrate that you have provided enough information about your proposed intervention or action, including all options and possible risks. You need to ensure that this has been understood by the service user in order to make an informed and valid decision, whether to give or refuse consent. The nature and degree of any risks must be documented; it is not enough to write, 'advised of risks'. It should be immediately clear to any other person reading the records what information has, or has not, been given to the service user, along with any specific requests or concerns raised by the service user.

You should record the form in which consent is given, whether verbal, non-verbal or signed. If the gaining of consent is not recorded, you cannot state that consent was given.

Where valid consent is refused or withdrawn you must respect this and record it in the records, while informing the service user of any possible risks or consequences of their decision.

Signed consent is only necessary where there is a greater risk to the service user, or your proposed intervention may have significant consequences for the service user's employment, personal or social life (General Medical Council 2017). Where consent forms are used, be aware that they must enable you to enter all the necessary information.

2.1.3 Deprivation of liberty safeguards

The deprivation of liberty safeguards (DoLS) in England and Wales set out a framework whereby a person who lacks capacity to consent can be provided with care in a way that amounts to a deprivation of liberty. This can only happen if it is absolutely necessary and can only be done following a defined process.

In March 2017 the Law Commission produced a proposal to replace the DoLS and suggested amendments to the *Mental Capacity Act 2005* (Law Commission 2017). The changes to the Act would enable a new scheme called the Liberty Protection Safeguards (LiPS) and strengthen individuals' rights in areas such as best interest decisions.

The new scheme includes any health and social care setting and applies to anyone from age 16.

As a practitioner, you need to be aware when your practice may be affected by the DoLS/LiPS and what you may need to do to be compliant. Seek training if you are unsure of your responsibilities. Your records must demonstrate your reasoning and the evidence upon which you make your judgements. If you are stating that a certain course of action, perhaps using particular equipment which will restrict liberty, is in the best interests of the service user, you must be able to justify this.

The Social Care Institute for Excellence (SCIE) website provides comprehensive guidance on the current deprivation of liberty safeguards for England and Wales (SCIE 2011) and the proposed *Liberty Protection Safeguards* (SCIE 2017). Scotland and Northern Ireland are developing similar legislation and safeguarding systems.

2.1.4 Comprehensive records

A court of law will adopt the approach that 'if it is not recorded, it has not been done, has not been considered, or was not said' (Lynch 2009, p 45). A record of all occupational therapy activity should be kept, including everything that is planned, done or occurs with, or on behalf of, your service users. You should also record your professional or

> *If it is not recorded, it has not been done, has not been considered, or was not said.*
> (Lynch 2009, p45)
>
> A practitioner does not record details of the equipment safety information provided to a service user. An accident occurs. How does the practitioner prove that information was provided?

clinical reasoning. All communication and information relevant to the individual's care, given and received, must be recorded.

You need to record the outcome of your practice, which means you need to identify the status of the service user and how it changes. This might include problems and any actions taken to resolve them.

Your records should not contain material that is of no value to the care of the individual, such as speculation, subjective statements or personal opinions.

2.1.5 The occupational therapy process

When you look at the faults in record-keeping highlighted in HCPC cases (see section 1.4.4), you can see how important it is to follow through and record each stage of the occupational therapy process. Should another person be required to read your records, they should be able to identify the process that you have gone through and why. Keeping this process in mind will help you to demonstrate that you have performed your professional responsibilities to the standard expected of a reasonably skilled occupational therapy practitioner.

Your records are the evidence that you: understand and can properly use, record and interpret assessments; that you have agreed the service user's objectives; that you have planned intervention based on the assessments, the service user's objectives, available evidence and sound professional judgement; and that the outcomes of your intervention have been evaluated.

If you are in a diverse setting where keeping records is not common practice, you must still keep a record of your activity and the rationale for your actions, even if you do not have direct contact with service users. Use the occupational therapy process to structure your actions and your record-keeping. It provides a guide for the format and content of your records.

> You may be a student on placement with a private fitness company. You are asked to look at the equipment with a view to its use by people with learning disabilities.
> Your records can follow through your information gathering, your assessment, your evaluation and professional reasoning, your planning, actions or recommendations, the outcome and review.

Always consider the purpose of your records in terms of the service user/s, your employer/organisation/business and yourself. Are you fulfilling your duty of care and meeting your standards as a registered professional?

2.1.6 Professional/clinical reasoning

You are required to record why you have chosen to carry out, or perhaps not carry out, a particular task or activity with, or on behalf of, a service user.
You will probably be carrying out professional reasoning in your mind continually, for example, selecting suitable activities or equipment based on your assessments. You must record this process in your records so that your choice of actions is justified should it ever be questioned.

2.1.7 Evidence-based care

Care records should show that the care provided is appropriate, in accordance with current best practice of the time and based on evidence, where evidence is available. There is a benefit to following national, professional or local guidelines, procedures, or care pathways, etc. because the evidence base is integral to them and will be demonstrated in the record, but any variance must be explained.

2.1.8 Official or unofficial discussions concerning a service user

Whenever a service user is discussed, in a team meeting, in the course of a phone call or even in an unplanned situation, the occurrence, the content and any outcomes of the discussion should be recorded in the care records.

Decisions made in a team meeting, or as part of supervision, concerning the care provided to an individual can be seen as part of the care process. Such decisions need to be recorded.

2.1.9 Frequent and repetitious activities or standard practice

Where activities are frequent and repetitious, it is tempting to think that minimal or no records are required. However, legally, if an activity is not recorded, it cannot be proven to have occurred. All activity should be recorded fully, including the activity, the rationale for it, the service user's response and any other outcomes.

You must always record what you do for every service user, even if it is standard or routine practice. If you do not, you have no evidence that the action was done.

Perhaps you always refer the service user to the social worker for a follow-up assessment. What if no further action occurred, but you have no record of your referral? The responsibility would be seen to remain with you.

2.1.10 Service user non-attendance

If a service user is unable to attend an appointment, or if a planned intervention does not occur, this should be recorded in the care records, with an explanation. Including this in the record demonstrates that the therapist's planning and care was disrupted for unavoidable reasons, rather than being withheld, or not provided, because of disorganisation or incompetence.

2.1.11 Information provided to the service user

Any verbal or printed information or advice given to the service user or their carer(s) should be appropriately recorded. It is not enough to write 'Advice given'; the nature and level of information given should be documented.

2.1.12 The source of information about a service user or their circumstances

It is important to record the source of any information gathered about the service user, especially if the accuracy of the information is uncertain, or circumstances around the individual's care change. The information about the service user may have come from medical notes, another professional's notes, from a carer or member of the family, or from the service user him or herself.

If you are given information by a third party, you must record the source, worded as 'reported by xxxxxx', giving their full name and job title/role, with their contact details if possible. Choose your wording carefully. You do not know it to be fact, but you need to make others aware, especially if there may be risk involved. Remember it could be challenged by the service user.

You might record:

> *Mary Jones, Social Worker (Tel 222 2222) reported that Mr X said he has not been taking his medication for the last week. Mary Jones reported that he appeared restless, agitated and unkempt.*

2.1.13 People present

There may be times when the occupational therapist sees the service user when others are present (for example, students, colleagues, family members).

The service user's consent should be sought for this. Having others present may have an effect upon the nature of the care given; the conversation held, if confidentiality is a concern; or it may have an impact on the effectiveness of care.

2.1.14 Legibility

Written care records need to be legible in order to be safe and of any use. If care is delayed, miscommunication occurs, or a service user is ultimately harmed because your handwriting is illegible, you could be accused of professional negligence and be held liable as a result.

2.1.15 The use of acronyms and abbreviations

There is published evidence that a significant proportion of the acronyms used are either ambiguous or poorly understood, with many misinterpretations of the abbreviations across professions, posing imminent risk (Parvaiz et al 2008, Rees 2013).

The Nursing and Midwifery Council (NMC ca. 2015, section 10.4) and the *Record keeping guidelines* (NHS Professionals 2010, section 1.10) state that abbreviations should not be used in care records. This said, it is common practice. Some key organisations, for example NHS Digital, have produced online glossaries for acronyms to attempt a common use and understanding (NHS Digital ca. 2016).

It is vital that all members of a care team can read and correctly understand the care records. Service users are entitled to access their records upon request and should be able to read and understand what is written in them. It should also be recognised that terms and acronyms may change over time and that these differ across service providers.

If you continue to use acronyms, the meaning must be unambiguous. Practitioners within services or teams should use a limited number of acronyms or abbreviations and should ensure that these are defined in full within each set of care records. This should be monitored and enforced.

2.1.16 Signing and countersigning record entries

When you sign a care record, or an entry is made into a digital record system under your access code/password, you are confirming that it is an accurate account of any communication, planning, intervention or outcomes related to the care of an individual service user. Unless otherwise indicated, you are identifying yourself as the individual responsible for the action(s) defined in the record and for the entry itself. Thus the person who carries out the intervention should be the person who writes/enters the record and signs the entry.

Your signature should be legible. It is essential that you are clearly and easily identifiable. Anyone making an entry to the records should be identifiable to another person reading the records at a later date. You should sign and print your name and give your designation when completing written entries, additions and amendments to records.

If using digital records, each practitioner should have their own access code/password on the system. This should never be used by another practitioner. Local procedures should be in place for students and temporary staff.

Occupational therapists should know and follow their local policy on countersigning records. Unless local policy differs, you are not required to countersign records created by occupational therapy students or therapy assistants, but you are responsible for ensuring the competence of any practitioner before you delegate any task to them, which includes keeping records (see section 1.5).

2.1.17 Timing and dating record entries

As with any aspect of care provided to an individual, the day and time that it occurred is important. Recording the date and time of an event demonstrates that your care was appropriate and as planned. It also enables monitoring of the frequency of care and the timeframe for the progress, or deterioration, of the service user. Should the care provided be examined at a later date, the time and date of an event may be a vital piece of evidence.

The date should be given in full, including the day, month and year. The time should define morning or afternoon. The time and date given should reflect when the service user was seen, or an event occurred. If records are written retrospectively, the time must be given when the service user was actually seen, and a time and date given when the record was entered.

2.1.18 Amending or erasing a record

Under Article 16, the GDPR gives individuals the right to have inaccurate personal data rectified, or completed if it is incomplete. You can refuse a request to amend or complete a record if it is manifestly unfounded or excessive.

If you disagree with another professional's recording, it is suggested that you discuss this with the practitioner, raising your concerns and giving your rationale. You must not change or delete another person's records for any reason, unless you know and can justify that they are factually inaccurate.

Where the information given is inaccurate in written records, the material that is incorrect should be scored out with a single line, then signed, timed and dated by the person who made the amendment. The original entry must remain and be clear to read. Similarly, a digital system should allow you to add to, or be re-directed from, any section which is shown to be inaccurate. Information should never be completely erased from a digital record, or over-written, but the system should automatically keep an audit trail of any changes: what was changed, when and by whom. The reason for the amendment should be given, for example if the patient's date of birth was entered incorrectly.

Under the *Mental Health Act 1983* (Great Britain. Parliament 1983), there are limitations on what may be amended in mental health records, and errors may only be changed in specific circumstances. Mental health practitioners should familiarise themselves with the relevant legislation.

The GDPR (Article 17) also introduces a right for data to be erased. The 'right to be forgotten'. The right to make this request applies in a number of situations, including when:

- The data is no longer necessary for the purpose it was originally collected for.
- The individual withdraws their consent for the data to be used/processed.
- There is no longer any overriding legitimate interest for the processing.
- You have processed the data unlawfully.
- You have to erase the data as a legal requirement.

Further information is available on the Information Commissioner's Office website: *Guide to the General Data Protection Regulations (GDPR)/ Individual rights*.

Under Article 18 of the GDPR, individuals have the right to request the restriction or suppression of their personal data, in effect limiting the way an organisation uses their data, usually for a specific time. This may be because they disagree with the content of the data or the way it is being processed. The organisation holding the data has one month in which to respond.

2.1.19 Recording when asked not to

If a service user discloses information that may have an impact upon their, or another person's care or safety, and then asks that this information is not recorded, the practitioner has a professional obligation to record the information. The service user should be informed of this. If, when warned that any disclosed information will be recorded, the service user chooses not to then share, this occurrence should also be recorded, in case it has future significance. You should consider sharing this information with your supervisor or another appropriate person.

You might record:

> *During the assessment Y said that she wanted to share some personal information with me. On stating that I would have to record this information she declined to say anything more. She did not identify the topic of the information she originally wished to discuss.*

If another member of staff asks you not to record information, the same principles apply. Your professional responsibility to record should not be negatively influenced by another person. If you are concerned, you are advised to contact the Royal College of Occupational Therapists' Professional Practice Enquiries Service for further advice.

2.1.20 Recording risk

You must record the outcomes of any risk assessments you carry out, or any risk factors that you identify in the course of your work. You should identify the hazard, the potential for harm and the action taken to control the risk.

Moving and handling assessments and equipment provision are a key part of some practitioners' work. You are required to carry out a risk assessment in all moving and handling situations where there is potential risk of harm. Record your assessment and any necessary risk control measures in the care records. Information on generic and individual risk assessments in relation to moving and handling is available on the Health and Safety Executive (HSE) website (HSE n.d.)

Further information is available from the Royal College of Occupational Therapists' guidance *Embracing risk; enabling choice* (RCOT 2018).

2.1.21 The use of hazard or violent warning markers

Where it is known that there is a potential hazard in relation to a particular service user or their environment, it is your responsibility to ensure that this information is shared and highlighted in records. Your employer will have a system for this, whether paper or digital systems of recording are used.

In 2006 the Information Commissioner's Office produced a Data Protection Good Practice Note on *The use of violent warning markers* (ICO 2006). It emphasised that the use of markers must comply with the then current *Data Protection Act 1998* (Great Britain. Parliament 1998a). It provided guidance when trying to balance employee safety with fairness to service users. It is still available to download from the Social Care Institute for Excellence website (*www.scie.org.uk*).

When considering the advice in the light of the *General Data Protection Regulation* (Council of Europe and European Parliament 2016), the principles remain the same.

Training should be sought for new employees and students on the local use and understanding of hazard or violent warning markers.

2.1.22 Recording medication

Named occupational therapists may, under Patient Group Directions, supply and administer limited medications. Further information is available from the RCOT website (*www.rcot.co.uk)*.

Registered and non-registered practitioners may give non-injectable prescribed medicines, provided they are suitably trained. The medicines must be given to the person that they were intended for, when this is strictly in accordance with the directions that the prescriber has given.

It is vital for you, if in this situation, to maintain clear, accurate and immediate records of all medicines administered, following local policy and ensuring that you are clearly identified. Any decision not to supply prescribed medication, or any refusal to take supplied medication, should also be recorded and accompanied by a full explanation.

Where the task of collecting, transporting or administering medicines has been delegated to you, the records must include the identity of the person delegating, the full details of any medication, the action taken and any outcomes.

2.1.23 Discharge/case closure

You must record the point at which you discharge the service user, or close the case, and the reason why. This may be because the service user has met their objectives, has been transferred to another professional or service, refuses further input, or perhaps moves away. Any action which occurs after you discharge the individual must still be recorded (for example, a phone call from a service user with an enquiry).

2.1.24 Timely record-keeping

It is vital that records are complete and accurate. The longer the time that has elapsed between an event occurring and it being recorded, the greater is the likelihood of inaccuracies or omissions in the records. Records should be written as soon as possible after the activity/event occurred.

During assessments and interviews, information may be shared by the service user that is important to the current and future care of the individual, including particular wishes or requests. It is important that such information is recorded promptly, to ensure that the information is shared as necessary and/or ongoing care is appropriate.

There are situations when events occur or a record needs to be made when practitioners do not have access to the main care records. Practitioners should have access to appropriate means of recording information in various settings. This might be portable digital equipment for use in the community, or telephone message recording notebooks in an office. Any notes made, whether digital or on paper, become part of the care record and need to be treated as such in terms of confidentiality and security, for the time that they exist. The contents of the note should be transferred into the care records as soon as possible and with complete accuracy and consistency. Depending on its nature and format, the original note needs to be destroyed or kept securely if required.

If a service user in a palliative care setting informs you that they intend to follow a path of voluntary euthanasia, you must immediately record this and inform relevant people in the care team.

A delay in recording this type of information would not be acceptable in an enquiry or court of law.

As stated above, if records are written retrospectively, the time must be given when the service user was actually seen, or the event occurred. The date and time of recording should also be entered. If the delay is significant, an explanation should be given in the records.

2.1.25 Making your record-keeping a priority

A concern is often raised that practitioners have insufficient time to complete their records in a timely way. This cannot be used as an excuse for failing to complete care records and would not be acceptable in an enquiry or court of law. The keeping of records should be seen as an integral and equally important part of the delivery of care as any contact or activity time.

It is recognised that maintaining records which meet all the requirements takes time. Support should be given within a service to enable practitioners to complete their records in a timely manner. It may be possible to introduce systems and practices which facilitate more time-efficient working, but still maintain the standards, or it may be necessary to introduce protected time for the purpose of keeping records. Where an individual practitioner requires additional time or facilities to complete their records, perhaps due to dyslexia or other needs, this should be accommodated wherever reasonably possible.

Failure to complete records may be an indicator of a practitioner who is struggling in terms of their knowledge and skills, their attitude and confidence, or perhaps their personal wellbeing. Considering the responsibility that goes alongside any delegated task (see section 1.5), the relevant supervisor should raise this as a concern in supervision, providing support when required.

Further information on providing support is available in the RCOT's most recent guidance on supervision (COT 2015c).

3 The format and structure of care records

Occupational therapy care records are kept in a variety of ways: paper or electronic, from specific occupational therapy files to shared rehabilitation notes, or fully integrated into medical or social care records. The format of records can be varied, provided that the principles and standards for keeping records are maintained and that current government or local policy is being followed. The use of integrated digital systems will bring greater consistency in terms of format, structure and content across many occupational therapy services.

3.1 Digital care records

There is a common strategic intent across the UK to support integrated health and social care through better digital information systems. Shared recording systems are a necessity for the delivery of integrated health, social and community services.

The current strategies for the four UK nations are described in the following documents:

- Health and Social Care Board (2016) *eHealth and Care Strategy for Northern Ireland: improving health and wealth through the use of information and communication technology*. Belfast: Health and Social Care Board.
- National Information Board (2014) *Personalised health and care 2020: using data and technology to transform outcomes for patients and citizens: a framework for action.* [s.l.]: NIB.
- NHS Scotland (2015) *eHealth strategy 2014–2017*. Edinburgh: Scottish Government.
- Welsh Government (2015) *Informed health and care: a digital health and care strategy for Wales.* Cardiff: Welsh Assembly Government.

Facilitating effective digital records requires information to be recorded using a standardised structure, such that it can be shared and re-used safely in an electronic environment. Record heading standards aim to reflect the way that service users and practitioners work together, with a common goal of best practice and high-quality care (Health and Social Care Information Centre, Academy of Medical Royal Colleges 2013, p2). Record headings provide the context for record entries and a number of national standards for record headings have been published and endorsed by professional bodies/royal colleges.

The Professional Record Standards Body (PRSB) for health and social care, set up in 2013 by the Academy of Royal Medical Colleges, is a membership collaboration of groups who both provide and receive health and social care across the UK, as well as those providing IT systems that support care. Its aim is to develop standards for high-quality, consistent care records and to promote their use. The Royal College of Occupational Therapists is a member of this body and signatory to a PRSB consensus statement, setting out their ambitions for the shared use of health and social care information contained in records in common use in the NHS and social care.

The PRSB Clinical and Professional Leadership Programme supports the effective implementation of PRSB standards. Online information packs are available containing materials to support individuals and organisations in this purpose. The consensus statement and other publications from the PRSB are available on its website (PRSB ca. 2017).

The RCOT has a ten-year strategic vision for occupational therapy informatics, *Managing information*: *a 10-year strategic vision for occupational therapy informatics* (COT 2014), and an implementation plan (COT 2015b), part of which is the use of digital care records.

Integral to the development of shared digital records is the development of, and agreement to, a standard set of nationally shared record headings and coded professional terminology to use in keeping records, with universally understood meanings for occupational therapists.

The RCOT, in collaboration with its members, has developed a number of occupational therapy-specific sets of professional terms, namely assessments, problems, findings, goals and interventions. Occupational therapy practitioners are encouraged to use these terms where possible in their records, whatever their work setting. They can also be used by occupational therapists when working with their local information management and technology department to agree sets of coded terms for use by occupational therapists in their care records. Consistency in the application of coded terms means that in addition to the primary recording of direct care, information can be used for secondary purposes such as: reporting on service activity, commissioning, clinical audit, service evaluation and clinical research.

The occupational therapy terms have been published as occupational therapy ‘subsets’ in SNOMED CT (Systematised Nomenclature of Medicine Clinical Terms). SNOMED CT is a national vocabulary of clinical phrases for use within health and care systems, to support the recording of information in the service user record. NHS England has mandated for NHS organisations to have SNOMED CT embedded in Primary Care systems by 1 April 2018 and in all NHS systems by 1 April 2020.

Further information is accessible from the RCOT website (*www.rcot.co.uk*).

3.1.1 Your involvement with digital record systems

The RCOT’s informatics strategy states that:

> *Members will need to try to influence the agendas of their local service and service commissioners, to ensure that informatics-related developments fully support the practice and record keeping of occupational therapists.*
>
> (COT 2014, p14)

You and/or your service will need to be in dialogue with your local information management and technology department to ensure that the recording systems being developed, or currently in place, meet your local practical requirements and include the appropriate professional coded terminology. This will assist in ensuring that you meet your legal, professional and registration body standards. The same principles for using and managing paper record systems in respect of content and security apply also to digital ones. Digital records should provide a complete picture of the care you provide, and your rationale, just as with any written record. Generic systems do not always provide a neat 'fit' but with consistent use of occupational therapy terms and the mandatory use of SNOMED CT terms, this may become easier.

Where your current systems do not meet your requirements, you are advised to talk to your digital services provider, giving them the information they require in order to understand your requirements for your daily practice and the national standards you have to meet. Care records need to fulfil their purposes to support the care of the service user, but also to evidence your duty of care.

If you are experiencing ongoing local difficulties, you may want to consider contacting the Royal College of Occupational Therapists' Professional Practice Enquiries Service.

3.2 Care records held by service users

Service user/patient/person-held records are primarily in use in the community in the care of pregnant women, people with cancer and those with long-term conditions.

Service user-held records have been shown to be useful in providing information and encouraging communication (Sartain et al 2015). They have also been shown to promote lifestyle changes (Jerdén and Weinehall 2004). However, their effectiveness is largely dependent upon their uptake from service users and practitioners alike (Sartain et al 2015).

The NHS Modernisation Agency publication *Patient-held records toolkit*, developed by the Cancer Services Collaboration 'Improvement Partnership' (2003), is still available online. This provides very practical advice and resources for those who wish to develop a service user-held record in cancer services and considers some concerns, such as the duplication of information.

The use of service user-held records may change with the full development of digital records, when people can have access to their own records and are able to add their own comments alongside the professional records.

Where service user-held records are used locally, you need to be sure that you are still meeting your legal and registration/professional body requirements. You are advised to follow your local policy. Influence and improve local practice as you are able. If you have concerns, raise this with your management or employer. You are advised to contact the Royal College of Occupational Therapists' Professional Practice Enquiries Service for further advice.

3.3 Systems for keeping records

There is no ‘one size fits all’ system for recording the stages of occupational therapy. The content and format of records may change according to the setting and nature of the service users. Some examples of systems are given here.

Problem-oriented recording (POR)/problem-oriented medical record (POMR), originally developed by the American physician Lawrence Weed (1970), enables structured record-keeping, formatted by the service user’s problems and the intervention to resolve the problems. Each problem is numbered, with an action plan and a record of its implementation.

SOAP notes are used to structure the planned intervention and the rationale. They can be used within the POR system, or independently. The acronym SOAP is usually defined as:

- **S**ubjective information – this is usually the service user’s representation of the problem. It may take the form of a direct quotation of the service user’s words. It cannot necessarily be proved but is taken into account.
- **O**bjective information – this is the material collected through observation, assessment, data collection, etc. This information should be verifiable.
- **A**ssessment – this is the practitioner’s conclusions taken from the information they have collected. It is the basis of their rationale.
- **P**lan – defines the proposed intervention that will resolve the identified problems.

The rigid format of SOAP notes is less usable with the introduction of structured multiprofessional care plans and care pathways. It does not suit every situation, especially where problems often overlap, but it does provide a systematic way of considering and recording care.

The COAST format, developed by Gateley and Borcherding (2012), is a system for writing objectives. It encourages the practitioner to identify and record all the elements of goal-setting.

- **C** – Client – the client will perform
- **O** – Occupation – what occupation?
- **A** – Assist level – with what level of assistance/independence?
- **S** – Specific condition – under what conditions?
- **T** – Timeline – by when?

The SMART format similarly provides a structure for recording objectives:

- **S** – Specific – a clear statement of the objective.
- **M** – Measurable – how will you measure change and achievement?
- **A** – Achievable – how is this objective achievable? Do you and the service user have the resources and support necessary for the achievement of the objective?

- **R** – Realistic or relevant – How does the objective fit in with the overall aims for the service user? Is the desired outcome relevant/useful to them?
- **T** – Timely – an agreed target date for achieving the objective.

As stated, there is no one particular system of keeping records that will meet everyone's needs or personal preferences. Systems such as those above do help the practitioner to remember all the necessary elements of the different stages of input and then present the information in a structured way. Practitioners need to consider whether using systems like these helps them to be efficient and concise. It is important that the system doesn't cause unnecessary work.

The development of fully digital records may help in the standardisation of record-keeping. Systems like those above, or elements of them, may be transferable into digital records, depending on their format and flexibility.

4 The handling and management of care records

Under the law, and in respect of your duty of care for your service users, you need to handle any information that you hold with due respect for your service users' confidentiality, consent, right to access and overall best interest.

4.1 The information governance review 2013 (Caldicott)

In 2013 Dame Fiona Caldicott was asked to look again at the state of information governance across health and social care in England. Information governance is seen as 'how organisations and individuals manage the way information is handled' (Caldicott 2013, p9). Following her earlier review in 1997, Caldicott devised six general principles of information governance. In 2002 the Caldicott principles were extended into social care, providing a shared basis for joint working between health and social services. These principles were reviewed in 2013, with the inclusion of an additional principle identifying the importance of sharing information when in the best interest of service users.

The revised list of Caldicott principles reads as follows:

1. ***Justify the purpose(s)***
   Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

2. ***Don't use personal confidential data unless it is absolutely necessary***
   Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. ***Use the minimum necessary personal confidential data***
   Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

4. ***Access to personal confidential data should be on a strict need-to-know basis***
   Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

5. ***Everyone with access to personal confidential data should be aware of their responsibilities***
   Action should be taken to ensure that those handling personal confidential data – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. ***Comply with the law***
   Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

7. ***The duty to share information can be as important as the duty to protect patient confidentiality***
   Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

(Caldicott 2013, p118)

4.2 Confidentiality, information sharing and consent

Service users have the right to know when information about them will be recorded, how it will be recorded and how it will be used. They should be made aware that the information they give may be shared in order to provide them with care. Where an individual refuses to allow information to be disclosed, this may limit the care that they receive. Service users must be informed of the potential outcomes of refusing to allow the sharing of such information.

The 2013 Caldicott review highlighted the need for information sharing as part of the care of individuals. You have a duty to share information appropriately and when in the service user's best interest, for their safe and effective care. This should be limited to the information that is necessary and shared only with those who need to know. This does not remove the duty of confidentiality, so the principle of gaining consent to share information should always be maintained.

The General Data Protection Regulation (Council of Europe and European Parliament 2016), *Data Protection Act 2018* (Great Britain. Parliament 2018) and the *Human Rights Act 1998* (Great Britain. Parliament 1998b) place statutory restrictions on the management and use of personal information. A duty of confidentiality arises when a service user shares personal information with you. Confidentiality is a legal obligation, and a

You are aware that a service user is still driving against medical advice and that they have not informed the Driver and Vehicle Licensing Agency (DVLA) when advised to do so.

You ask for the service user's consent to share this information with the DVLA. Even if not given, it is in the public interest, on the basis of public safety, for you to contact the DVLA, but you must have a clear and evidence-based rationale for doing so.

requirement established within professional codes of conduct and employment contracts. Information provided in confidence should not normally be disclosed without the service user's consent.

The GDPR has the following definition:

'Consent' of the data subject means any freely given, specific, informed and unambiguous indication of the data subject's wishes by which he or she, by a statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her (Council of Europe and European Parliament 2016. Article 4, point 11).

There are a number of consent formats for the use and disclosure of information which are integral to health and social care, from assumed to explicit. Some consent practices do not necessarily meet the requirements of the GDPR.

All health and social care providers are subject to the statutory duty to share information about the service users in their care under the *Health and Social Care Act 2012* (Great Britain. Parliament 2012). This is currently generally done under the basis of implied consent which may include administrative processing, where the service user is informed, or it is within their reasonable expectation.

Under the GDPR data controllers must establish, record and inform individuals about the lawful basis that they are relying on to process personal data. Consent is one of the ways to comply with the GDPR, but it is not the only way. If health and social care professionals or organisations choose to rely on consent as their lawful basis for the processing of data, they must then ensure that they meet the requirements for the GDPR as detailed in Article 4(11).

All publically funded health and social care organisations may process information for administrative and care purposes under the Article 6 condition 'for the performance of a task carried out in the public interest or in the exercise of official authority…'. Health data is a special category, but would be covered by Article 9 'medical diagnosis, the provision of health or social care or treatment or management of health or social care systems…'.

(Adapted from Information Governance Alliance 2018, Section 6)

When you do not have consent to share information, you must meet one of the other lawful bases for processing data. For example, as a legal obligation for a court case, or as a legitimate interest when there is a third party or public interest such as a safety issue or safeguarding concern.

The Health and Care Professions Council has a document entitled *Confidentiality guidance for registrants* (HCPC 2017) available on its website.

If a person lacks capacity to decide, a judgement may be made based on their best interests (Health and Social Care Information Centre 2013, p14). If there is a friend or family member who has lasting power of attorney, they can be involved.

The Information Commissioner's Office provides some specific guidance on the application of the GDPR to children. Children have the same rights as adults over their data. Children have the right to be informed about how their data is going to be used. Any information given to a child must be 'using clear and plain language.' There must be a lawful basis for the processing of their data.

Information needs to be shared between all those involved in a child's care. It will also need to be transferred, with parental consent, if a child moves across services, or into a different area. *The Children Act 2004* (Great Britain. Parliament 2004), which applies throughout the United Kingdom, provides a legal framework to enable practitioners to share early information. It aims to ensure that children and families are getting benefit from services such as education and healthcare, and to enable them to get the support they need at the right time.

Therapists who work across public and independent sectors, and may see the same individual in both contexts, should not transfer or share information from one context to another without meeting one of the six lawful bases and an appropriate condition for data processing.

There is a range of information online about data sharing. Some of this is listed in the resources section of this publication.

Under the GDPR (Article 20) service users now have the right to data portability. This means that an individual may obtain and reuse their personal data for their own purposes across different services. The individual can request that the data is transferred from one data controller directly to another. The data must be transmitted securely in an accessible format. This right only applies to digitally held data. This might apply to an occupational therapist who is asked to transfer assessment outcomes.

4.3 Service user access to care records (subject access request)

The GDPR gives an individual the statutory right to have access to their own health and social care records, upon request, whether they be held on computer or manually (with some conditions). In effect this gives the individual the right to confirmation that you are processing their personal data, a copy of that data and any other supplementary information; such as what you are doing with their data, who has been a recipient of the information, any retention periods you have and confirmation of their other rights in relation to their personal data.

If the information requested contains information about a third party, it does not need to be released, unless the third party has given consent or it is reasonable to comply with the request without consent. An organisation can also refuse to comply with a request if it is manifestly unfounded or excessive.

If a service user asks to see the records you have made about them, there is nothing in law to prevent you from informally showing them to the service user. You can only provide copies if a formal written application has been made. You are strongly advised to follow local policy.

The organisation holding the data has one month in which to respond. In most cases a fee cannot be charged, unless the request is excessive or further copies of data are requested.

Under equality law an organisation has a duty to make sure that its services are accessible to all service users. The GDPR does not specify how to make a request valid. An individual can request a response in a particular format that is accessible to them.

Access to the care records of the deceased is currently governed by the *Access to Health Records Act 1990* (Great Britain. Parliament 1990) and the *Freedom of Information Act 2000* (Great Britain. Parliament 2000).

Currently, you can only access the deceased's health records if you are either:

- a personal representative (the executor or administrator of the deceased person's estate); or
- someone who has a claim resulting from the death (this could be a relative or another person).

If you are an independent practitioner you must follow legislation and are advised to develop your own policy.

Further information is available on the Information Commissioner's Office website.

4.4 Secure storage of care records and personal data

All records, whether paper or digital, should be secure from opportunistic viewing, inappropriate access, theft, loss or damage.

Practitioners need to be aware that they have a responsibility for any records they create or use and have joint responsibility for shared records. Records may be kept within the department, room or service responsible for the related work, but must always be kept securely. Storage equipment or facilities and data protection measures should be secure, but records should be accessible to those who need the information for their work.

A practitioner is writing records on computer when a colleague brings a visitor into the office. Service user information is clearly visible on the computer screen.

A practitioner has saved a number of service user reports on a personal memory stick. This gets lost. It is not encrypted or password protected.

Both these situations are in breach of the *Data Protection Act 1998*.

The movement and location of all records should be controlled to ensure that a record can be retrieved at any time. When paper records are taken from the central storage there should be an auditable tracking system in place to ensure that they are not lost. If digital data is held on portable devices, including mobile phones, tablets, DVDs or memory cards, they must also be trackable, or recorded and secure at all times. Personal data should always be secure and encrypted. The tracking system should identify who is in possession of the records and where they are being taken. When transporting records, the principles of data protection remain. The information within the records must be kept safe, therefore practitioners should ensure they are not accessible to others outside of the direct care team, and that records in any format are not left unattended anywhere that is potentially insecure, for example, in a car.

You should not hold information about your service users on your personal digital devices, including mobile phones or memory sticks. If you require such devices for your work, you should be supplied with them by your employer and you should follow local associated procedures. If you are self-employed, you will need to purchase devices specifically for your work.

If you are an independent practitioner with computer-held records or files, you must ensure that no other person has access to the material you hold. You must protect the information with suitable security and data protection.

4.5 The use, transfer and security of digital images and films

Informed consent must be gained before any digital images or film are taken of a service user, whether by the practitioner or any other person present. The service user needs to understand why the image is being taken and what it will be used for. A record of any digital images or films made should be held. Check your local policy as written consent is usually required.

Digital images or film should be stored on a secure central system and not remain on any portable devices. They must be fully deleted on these. If you use social media or back-up sites, you must be sure that images do not automatically upload to them. Information on how to do this is widely available on the internet.

You may only transfer an image or film to another professional or service with the service user’s informed consent. Any transfer must be done in a fully secure way. All personal data should be secure and encrypted when it becomes mobile.

There is nothing in law to say that a service user, or a parent of a child, cannot make a digital image or film, or a sound recording, of meetings or the care they receive. A practitioner should not be saying anything or providing any care that they do not wish to be recorded, unless the privacy and dignity of the service user is put at risk. A friend, carer or family member cannot make a digital image, film, or sound recording of a service user without their informed consent.

In this situation, you are advised to discuss any implications of taking digital images or sound recordings. Ask what the image/film/recording is going to be used for. Work co-operatively, discussing how it might be a helpful way to remember any information or instructions given. If you are at all concerned that there may be any elements of risk, for example for vulnerable adults or children, or the confidentiality of the information may be in question, you are advised to stop the intervention/meeting and seek help/advice from your employer, or seek legal advice.

If you are an independent practitioner, you may wish to consider what you would do in a situation like this before it arises. You may find it helpful to have a policy and consent form which you can use as standard practice, if required.

4.6 Retention of records

The GDPR Principle 5 requires that you retain personal data no longer than is necessary for the purpose for which it was obtained. The length of time a record is held depends upon the nature and purpose of the record, the person concerned and the nature of their condition or circumstances and possibly any legal considerations.

The Information Governance Alliance for England has produced the *Records management code of practice for health and social care 2016*, which includes a general retention schedule. It is now common practice for local authorities and health providers to define and produce their own schedules, which are usually available online.

Practitioners can gain advice from their local data or information manager on the retention or destruction of care records. The Information Commissioner's Office website gives information about the GDPR requirements and the deletion of personal data. If you are an independent practitioner, you are advised to seek legal advice, especially if there has been any adverse incident which may increase the risk of action being taken against you.

4.6.1 Retention of diaries

Paper and digital diaries of health visitors, district nurses and allied health professionals should be retained for two years after the end of the year to which the diary relates, if the relevant service user-specific information is transferred to the service user's care record. If the information is not transferred the diary must be kept for eight years (Information Governance Alliance 2016, p60).

Data from a digital diary must be transferred to a secure central system, where it can be stored for the relevant length of time.

A diary should be kept for as long as necessary if it contains particular details concerning an ongoing enquiry or concern, for example, a service user complaint or incident. Advice should be sought from those leading the enquiry or looking into the concern.

Resources

All websites correct at time of publication

Acronyms

NHS Digital [ca. 2016] *Glossary of acronyms and abbreviations.* Leeds: NHS Digital. Available at: *http://webarchive.nationalarchives.gov.uk/20180328135645/http://content.digital.nhs.uk/article/2994/Glossary-of-acronyms*

Assessing capacity

Social Care Institute for Excellence (2015) *Mental Capacity Act (MCA) directory: assessing capacity*. London: SCIE. Available at: *http://www.scie.org.uk/mca-directory/assessingcapacity/index.asp*

Data sharing

Please note: At the time of updating this document, most of the documents referenced here have not yet been updated in line with the GDPR.

Centre of Excellence for Information Sharing *http://informationsharing.org.uk*

Department for Children, Schools and Families, Communities and Local Government (2008) *Seven golden rules for information sharing*. London: Department for Children, schools and families. Available at: *http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/Info-sharing_poster.pdf*

HM Government (2015) *Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers*. Available at: *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf*

You are advised to refer to the Information Commissioner's Office website for the most up to date information on data sharing. Available at: *https://ico.org.uk*

Skills for Care (2017) *Information sharing for social care employers*. Leeds: Skills for Care. Available at: *http://www.skillsforcare.org.uk/Documents/Topics/Digital-working/Information-sharing-for-social-care-employers.pdf*

Information governance

You are advised to refer to the Information Commissioner’s Office website for the most up to date information on information governance. Available at: *https://ico.org.uk/*

NHS Digital (2016) *Information governance toolkit.* Leeds: NHS Digital. Available at: *https://www.igt.hscic.gov.uk/*

Record-keeping

Lynch J (2009) *Health records in court*. Oxford: Radcliffe Publishing.

NHS Professionals (2010) CG2: *record keeping*. Watford: NHS Professionals. Available at: *https://www.nhsprofessionals.nhs.uk/en/members/elibrary/publications/cg2%20record%20keeping*

Professional Record Standards Body *http://theprsb.org*

Royal College of Physicians (2015) *Healthcare record standards*. London: RCP. Available at: *https://www.rcplondon.ac.uk/projects/healthcare-record-standards*

Royal College of Physicians (2013) *Standards for the clinical structure and content of patient records.* London: RCP. Available at: *https://www.rcplondon.ac.uk/projects/outputs/standards-clinical-structure-and-content-patient-records*

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Cancer Services Collaboration 'Improvement Partnership' (2003) *Patient-held records toolkit.* Leicester: NHS Modernisation Agency. Available at: *http://www.qualitasconsortium.com/index.cfm/reference-material/service-transformation/patient-held-records-toolkit*

College of Occupational Therapists (2017) *Professional standards for occupational therapy practice*. London: COT.

College of Occupational Therapists (2015a) *Code of ethics and professional conduct.* London: COT.

College of Occupational Therapists (2015b) *Managing information implementation plan 2015–2025*. London: COT.

College of Occupational Therapists (2015c) *Supervision: guidance for occupational therapists and their manager*s. London: COT.

College of Occupational Therapists (2014) *Managing information: a 10-year strategic vision for occupational therapy informatics.* London: COT.

Council of Europe, European Parliament (2016) Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation). *OJL119/1*. Available at: *https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32016R0679*

Council of Europe (1950) *European Convention on Human Rights.* Rome: Council of Europe.

Gateley CA, Borcherding S (2012) *Documentation manual for occupational therapy: writing SOAP notes.* 3rd ed. Thorofare, NJ: SLACK.

General Medical Council (2017) *Consent guidance: expressions of consent*. London: GMC. Available at: *http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_expressions_of_consent.asp*

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Great Britain. Parliament (2012) *Health and Social Care Act 2012*. London: Stationery Office.

Great Britain. Parliament (2007) *Mental Health Act 2007*. London: Stationery Office.

Great Britain. Parliament (2005) *Mental Capacity Act 2005*. London: Stationery Office.

Great Britain. Parliament (2004) *Children Act 2004.* London: Stationery Office.

Great Britain. Parliament (2000) *Freedom of Information Act 2000*. London: Stationery Office.

Great Britain. Parliament (1998a) *Data Protection Act 1998*. London: Stationery Office.

Great Britain. Parliament (1998b) *Human Rights Act 1998*. London: Stationery Office.

Great Britain. Parliament (1990) *Access to Health Records Act 1990*. London: HMSO.

Great Britain. Parliament (1983) *Mental Health Act 1983*. London: HMSO.

Health and Care Professions Council (ca. 2016) *Hearings: advanced search*. London: HCPC. Available at: *http://www.hcpc-uk.co.uk/complaints/hearings/advancedhearingsearch*

Health and Care Professions Council (2016) *Standards of conduct, performance and ethics*. London: HCPC. Available at: *http://www.hcpc-uk.org/publications/standards/index.asp?id=38*

Health and Care Professions Council (2013) *Standards of proficiency: occupational therapists*. London: HCPC. Available at: *https://www.hcpc-uk.org/assets/documents/10000512Standards_of_Proficiency_Occupational_Therapists.pdf*

Health and Care Professions Council (2012) *Confidentiality: guidance for registrants*. London: HCPC. Available at: *http://www.hcpc-uk.co.uk/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf*

Health and Safety Executive (n.d.) *What you need to do: moving and handling*. Available at: *http://www.hse.gov.uk/healthservices/moving-handling-do.htm*

Health and Social Care Board (2016) *eHealth and care strategy for Northern Ireland: improving health and wealth through the use of information and communication technology*. Belfast: Health and Social Care Board.

Health and Social Care Information Centre (2013) *A guide to confidentiality in health and social care*. Leeds: HSCIC.

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Information Governance Alliance (2018) *The General Data Protection Regulation: Guidance on consent*. London: IGA. Available at: *https://digital.nhs.uk/binaries/content/assets/legacy/pdf/2/9/igagdprconsent.pdf*

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Keeping Records

Guidance for occupational therapists

Fourth Edition

Keeping records is a necessary and integral part of practice in health, social and community care, education and research. It is an absolute requirement as part of a practitioner's duty of care, and must be completed in line with relevant legislation, the standards of registration and professional bodies, and local policy. Care records are legal documents and as such may be used as evidence in an enquiry or a court of law.

Produced for occupational therapists working across the UK, this fourth edition has been updated to include information on the General Data Protection Regulation. This guidance is an essential reference point in ensuring that occupational therapists keep care records that are fit for purpose and process them according to legislation.

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