# CHECKLIST FOR KEEPING RECORDS

You can use this checklist to ensure that you are meeting the most important requirements in keeping records.
Further information is available in the full guidance document: ***Keeping records: guidance for occupational therapists*** (RCOT 2018).
This checklist is written in line with Standard 7 of the *Professional standards for occupational therapy practice* (COT 2017).

| 7. You keep care records that are fit for purpose and process them according to legislation* | Yes | No | Comments |
|---|---|---|---|
| **7.1 You provide a comprehensive, accurate and justifiable account of all that you plan or provide for service users*** | | | |
| You identify every page/item in your records by the service user's name, date of birth and unique identifier | | | |
| You gain and record consent (and whether verbal or written) for assessment, intervention, information gathering and sharing | | | |
| Your records are legible | | | |
| Your records are clear in terms of their meaning | | | |
| You explain acronyms and abbreviations | | | |
| You date and time all entries | | | |
| You sign all entries | | | |
| You as author and your role are clearly identifiable | | | |
| You record all assessments and their outcomes/implications | | | |
| You record capacity assessments and their outcomes/implications | | | |
| You record risk assessments and their outcomes/implications | | | |
| You record the service user's stated wishes/goals | | | |
| You record the objectives of intervention | | | |
| You record the intervention/action plan | | | |
| You record any intervention carried out | | | |
| You record any recommendations made | | | |
| You record the administration or management of medication | | | |
| You record the outcomes of intervention | | | |
| You record/keep all communication concerning the service user, e.g. reports, letters, emails, phone calls | | | |
| You record all discussions concerning the service user | | | |
| You record any referrals to another service, and the reason why | | | |
| You record the case closure/discharge and the reason why | | | |

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| 7. Checklist for keeping records (continued) | Yes | No | Comments |
|---|---|---|---|
| **7.2 You record the evidence and rationale for all that you do*** | | | |
| You record your professional/clinical reasoning | | | |
| Your records refer to any care pathways or evidence used | | | |
| **7.3 Your care records are written promptly, as soon as practically possible after the activity occurred*** | | | |
| You complete your records as soon as possible after the activity/event | | | |
| **7.4 You are aware of and meet all requirements in relation to record-keeping, whether in legislation, guidance or policies*** | | | |
| You make yourself aware of all requirements in relation to record-keeping, whether in legislation, guidance or policies | | | |
| You fulfil all requirements in relation to record-keeping, whether in legislation, guidance or policies, that are under your control | | | |
| Where you have others under your supervision, you provide training and support to enable them to meet these requirements | | | |
| **7.5 You comply with any legal and professional confidentiality, the sharing of information and service user access*** | | | |
| You have a protocol for secure information-sharing with other organisations | | | |
| Your records show evidence that consent is gained before written or digital information, images etc are shared | | | |
| You have, and abide by, a system to allow service users access to their own records, according to legislation and local policy | | | |
| **7.6 You keep your records securely, retain and dispose of them according to legal requirements and local policy*** | | | |
| All your records are, at all times, secure from opportunistic viewing, inappropriate access, theft, loss and damage | | | |
| All personal data kept on digital systems is secure, with passwords and encryption | | | |
| You do not keep service users' personal data on your own digital devices | | | |
| You have a system that enables all information to be stored and retained securely for an appropriate length of time, according to any legal requirements and local policy | | | |
| You have a system that enables all information to be destroyed after an appropriate length of time, according to any legal requirements and local policy | | | |

College of Occupational Therapists (2017) *Professional standards for occupational therapy practice.* London: COT.
Royal College of Occupational Therapists (2018) *Keeping records: guidance for occupational therapists.* London: RCOT.

(*COT 2017, p12)

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