



Good record keeping

Staying patient focused



We all make records on a day-to-day basis, from telephone messages to a detailed personal diary. No one's memory is wholly reliable. Records, whatever form they take, are a useful reminder of a course of events, required actions, steps taken, outcomes and further action. As a consultant in independent practice, you may need to take on the added responsibility of managing your private patients' medical records.

GMC guidance

In a clinical context, records are essential and, *Good Medical Practice* (2013), outlines your responsibilities. The GMC explains that in providing care, you must keep clear, accurate, and legible records which report the relevant clinical findings, the decisions made, the information given to patients, any drugs or other treatment prescribed and who is making the record and when.

Records are primarily intended to support patient care and should authentically represent each and every consultation.

Records should be made straight away or as soon as possible after patient care. Records are primarily intended to support patient care and should authentically represent each and every consultation (including by telephone). Any other function for clinical records is secondary. Examples include protecting the practitioner against future claims or complaints, helping the police; or supporting or denying a patient's claim.

Clarity and accuracy of records

Records of patient consultations are now often held electronically. While entering the notes of a consultation on a computer may ensure they are legible, it also requires care. For example, it is clearly essential that the information must be attributed to the right patient's medical records.

Along with clarity and accuracy, details are also important to remind you, or another member of your multidisciplinary team, of your care and management plan. The notes may become important later on, if there is a complaint or claim, which will typically be made months or years after a consultation.

Storing records

If you are a consultant in independent practice, you are responsible for protecting the records of your private patients.

Records include:

- hand-written notes
- computer-generated notes
- blood test results
- x-rays
- copies of correspondence
- photos or slides
- theatre records.

They should be stored securely and protected against accidental loss, including corruption, damage or destruction.

All records need to be kept secure and confidential at all times. Technology is not foolproof and regular back-up should be made. It is advisable to consider keeping these securely at a different site.

Medical records for private patients are the property of the individual doctor although patients have rights of access under the Data Protection Act 1998. Make sure that patients know what will happen to the data held about them and that they agree to its processing or disclosure. You will also need to register with the Information Commissioner under the Data Protection Act 1998.

It is possible that private secretaries may work from home. Clinical records must be kept confidential at all times, including during transfer between sites. It would be important to ensure the secretary is aware of confidentiality obligations, for example, the need to avoid inadvertent disclosure of patient's information to family members or visitors. This would include locking paper records away in a suitable filing cabinet, and ensuring any computer systems are appropriately confidential and secure.

Retaining records

The Private and Voluntary Health Care (England) Regulations 2001, Schedule 3, lays down minimum periods for the retention of private records (see table below). We advise that records should be kept for as long as possible beyond the prescribed periods, as claims do sometimes arise after these timescales, and it may prove difficult to successfully defend a claim without the records.

Ideally, all records should be reviewed before they are destroyed, and it would be prudent to keep any patient records where there has been an adverse incident or complaint.

Disposal should be carried out in such a way that protects patient confidentiality, for example, by shredding paper records.

Make sure that patients know what will happen to the data held about them and that they agree to its processing or disclosure.

Computer-held records may be difficult to delete entirely from a hard drive and appropriate IT advice should be sought.

Period for which medical records must be retained

Type of patient	Minimum period of retention
(a) Patient who was under the age of 17 at the date on which the treatment to which the records refer was concluded.	Until the patient's 25th birthday.
(b) Patient who was aged 17 at the date on which the treatment to which the records refer was concluded.	Until the patient's 26th birthday.
(c) Patient who died before attaining the age of 18.	A period of 8 years beginning on the date of the patient's death.
(d) Patient who was treated for mental disorder during the period to which the records refer.	A period of 20 years beginning on the date of the last entry in the record.
(e) Patient who was treated for mental disorder during the period to which the records refer and who died whilst receiving that treatment.	A period of 8 years beginning on the date of the patient's death.
(f) Patient whose records relate to treatment by general practitioner.	A period of 10 years beginning on the date of the last entry.
(g) Patient who has received an organ transplant.	A period of 11 years beginning on the date of the patient's death or discharge whichever is the earlier.
(h) All other cases.	A period of 8 years beginning on the date of the last entry in the record.

Tips for good record keeping

Write legibly

You may be able to read your own handwriting, but can anyone else? Will you always be available to translate that indecipherable squiggle? Most records will now be computerised but there may still be occasions when you will need to hand-write patient records and if so, take a little extra time and care to write legibly.

Include the date and time

The delay between an incident and notification of a claim could potentially be several years. If handwriting records, your dated and timed notes will be invaluable in clarifying the sequence of events during your treatment of the patient, as by that time it is unlikely you will be able to remember clearly what happened. With electronic records, the time and date is automatically stored on the computer's hard drive.

Avoid abbreviations

What does PID mean? Prolapsed intervertebral disc or pelvic inflammatory disease? It may be clear to you, but could be ambiguous. If you must use abbreviations, limit them to those approved in your workplace.

Do not alter an entry or disguise an addition

Tampering with records has led to GMC investigations. Clinical notes should be made at the time of treatment or as soon as possible afterwards. If a new finding demonstrates that a previous entry in the notes is factually incorrect, for example, an entry has been made in the wrong patient's records, then the amendment must make this clear. As a rule of thumb, errors should be scored out with a single line so the original text is still legible and

the corrected entry written alongside with the date, time and your signature. Any new additions should be separately dated, timed and signed by the doctor who made them. Never try to insert new notes. It might appear easy to alter computer records, but computerised record systems have an audit trail that will allow alterations to be discovered.

Avoid unnecessary comments

Offensive, personal or humorous comments are unprofessional, often misunderstood and could damage your credibility. Remember, patients have a right to access their records and a flippant remark in a patient's notes might be difficult to explain to a judge or GMC fitness to practise panel.

Check dictated letters and notes

Typed letters and notes have the advantage of legibility, but do have problems of their own. Letters dictated and then typed up later by a secretary may contain errors due to problems with the quality of recording or simple misunderstandings of medical terminology. They should be checked, corrected and signed by the doctor who dictated them.

If you are using typewritten records, you may wish to make a contemporaneous handwritten note as well – these can be invaluable if the patient needs to be seen again before the notes are typed up or if the record of your dictation is accidentally lost.

Check reports

You will need to see, evaluate and initial every report or letter before it is filed in the patient's records. Most results come through electronically now, so care should be taken to record abnormal findings in the clinical records and document any appropriate action.



Be familiar with the Data Protection Act

All patients have the right to access their medical records and this right is defined in the Data Protection Act 1998, which allows patients access to view their records or to receive a copy, subject to exceptions.

For medico-legal queries

24-hour advisory helpline

Call **freephone 0800 716 646**

Email **advisory@themdu.com**

Visit **themdu.com**

This information is intended as a guide. For the latest medico-legal advice relating to your own individual circumstances, please contact us directly.

Our medico-legal team are available between 9am-5pm Monday to Friday and provide an on-call service for medico-legal emergencies or urgent queries 24 hours a day, 365 days a year.



Have you got
our app?



Corporate member of
Plain English Campaign
Committed to clearer communication

521

