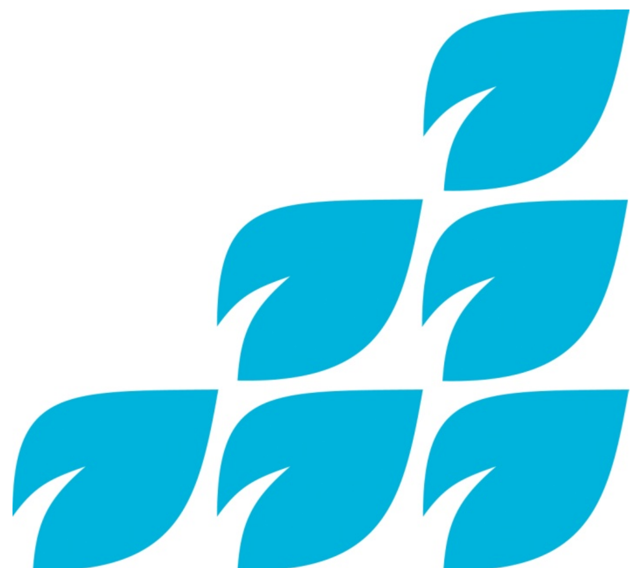
Guidance for Dietitians for Records and Record Keeping



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1 What is the purpose of this document?

Record keeping is a fundamental part of professional practice. Whatever the type of work you do you need to keep records. The purpose of this document is to provide record keeping guidance for the individual dietitian and other members of the dietetic team. It replaces the *Joint BDA/Dietitians Board Guidance on Standards for Records and Record Keeping* (2001)[1].

The principles are applicable to all areas of practice. The guidance does not define a rigid framework, nor is it designed as an auditable standard; it aims to inform you of key record keeping issues. The ultimate responsibility for record keeping lies with you, as an autonomous and accountable practitioner using your professional judgement, to decide what is relevant and what should be recorded.

A requirement of your professional practice is that that you must follow the relevant legislation. It is essential for you to be aware of the local organisational policies and procedures that apply to record keeping within your particular work setting.

You need to be aware of the range of individuals who could potentially access the record and read what you have written. These could include other members of the multi-disciplinary team, the patient, the patient's carers, social workers, audit staff, lawyers and their legal team and others. Remember that if you haven't written down what you have done it might as well not have happened.

The Health Professions Council (HPC) Standards of conduct, performance and ethics (2008)[2] states that:

> *"You must keep accurate records. Making and keeping records is an essential part of care and you must keep records for everyone you treat or who asks for your advice or services. You must complete all records promptly. If you are using paper-based records, they must be clearly written and easy to read, and you should write, sign and date all entries."*

The *BDA Code of Professional Conduct* (2008)[3] and *The BDA Professional Standards for Dietitians* (2004)[4] make reference to record keeping and underpin the HPC Standards.

2 What is a record?

Records are a reminder of what has happened. They must be accurate, up-to-date and accessible by those who need to see them at the time, and in the place where they are needed.

An NHS record is anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of NHS employees – including consultants, agency or casual staff. Records are not just patient (care) records but include patient cards, minutes of meetings, research and audit data, x-rays, personnel files, CPD portfolios, care plans, diaries and e-mails. A record may be in a paper, electronic (including memory stick) or other media format.

A **health record** is defined in section 68 (2) of the Data Protection Act 1998[5] as:

> *"A record consisting of information about the physical or mental health or condition of an identifiable individual made by, or on behalf of, a health professional in connection with the care of that individual."*

A **shared record** is a single record to which all members of the multi-disciplinary healthcare team involved in the care of an individual make entries. A **care record** is anything that makes reference to the care of an individual. There are no single templates or models for health, shared or care records.

Service users have the right to request access to their records and in healthcare should be made aware of their content by actively involving them in the planning and implementation of their care.

3 The purpose of a record

Record keeping is an essential, integral part of practice and is a legal requirement. Good record keeping helps to promote high standards of professional practice and is a reflection of a safe practitioner. Records must be:

- complete
- accurate
- relevant
- accessible (to those with the right of access)
- timely.

Any document that records any aspect of care (a record) can be used as evidence in a court of law, to investigate a complaint at a local level or at professional hearings, e.g. Public Inquiries such as The Kennedy Report (from the Bristol Inquiry)[6] and The Health Professions Council Fitness to Practise Hearings[7]. Courts of law tend to adopt the view that "if it is not recorded, it has not been done".

Records have a secondary function for audit, research, public health and service planning.

4 Who owns the record?

The ownership of the record depends on your particular work setting.

Records of NHS organisations (and those of predecessor bodies to NHS organisations) are defined as public records under the terms of the Public Records Act 1958[8] sections 3(1)-(2). NHS records are not owned by the NHS organisation that created them.

In England, The Secretary of State for Health owns all records, including GP records. The Personal Child Health Record (aka "The Red Book") belongs to the principle carer, e.g. the parent of the child. General practice notes are technically owned by the local health authority and/or by the Department of Health. Chief Executives and senior managers of all NHS bodies are personally accountable for records management within their organisation and have a duty to make arrangements for the safe-keeping of those records.

In Scotland NHS records are managed under the overall guidance and supervision of the Keeper of the Records of Scotland.

Where a professional is contracted to provide a clinical service to another organisation, contractual conditions will normally specify the legal owner of any records kept.

In the private sector, records are the property of the employer. Notes for private patients may be the property of the consultant or the private hospital.

For clinical records, if you have treated the patient and entered information into the record, you must have reasonable access to the record; particularly if, after leaving that employer, a complaint or allegation is made against you.

5 Quality of record keeping

In the NHS Chief Executives and Senior Managers are personally responsible for the quality of records management within their organisation.

The quality of record keeping is a reflection of the standard of professional practice. Good record keeping is the mark of the skilled and safe practitioner while careless or incompetent record keeping often highlights wider problems with the individual's practice (NMC, 2005).

> *"The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is a mark of the skilled and safe practitioner, whilst careless or incomplete record keeping often highlights wider problems with the individual's practice."*
>
> Nursing & Midwifery Council. Record Keeping Guidance. Advice sheet. Updated July2007

5.1 Good record keeping

Good record keeping ensures that:

- You can work with maximum efficiency without having to waste time hunting for information
- There is an audit trail which enables any record entry to be traced to a named individual at given date/time with the secure knowledge that all alterations can be similarly traced
- Those coming after you can see what has been done, or not done, and why
- Any decisions made can be justified or reconsidered at a later date.

5.2 Risk

If records are in a poor condition, mistakes are more likely to be made and any defence will be weaker in the case of litigation. Contemporaneous, clear and accurate notes/records will reduce this risk. The legal view is generally that if it isn't recorded there is no proof that it happened.

Using records as part of routine clinical supervision and regular audits of record keeping are ways of monitoring standards of record keeping.

Many Health Profession Council (HPC) hearings[7] have a record keeping element to them, referred to in the 2006 fitness to practise annual report[10], as a "misconduct" element including:

- Poor record keeping
- Failure in communication
- Breach of confidentiality – providing information to those who are not entitled to it
- Acting beyond scope of practice
- Failure to get informed consent.

The Healthcare Commission in 2007[11] highlighted that 3% of complaints were directly about record keeping and many more mentioned record keeping alongside other issues. In their response to this report, The Medical Defence Union (MDU)[12], commented that they were aware of a number of complaints where poor records have caused problems with continuity of patient care and have created difficulties with doctors in recalling their actions (for example, where advice given over the telephone is not recorded).

5.3 General principles for the completion of patient/care records

5.3.1 Style

You should:

- Use a style that is appropriate to the type of intervention/meeting
- Use factual, clear, accurate and unambiguous language
- Try to avoid using jargon
- Be objective and avoid casual subjective remarks
- Avoid abbreviations or terminology that might not be understood
- Remember that an individual has the right to request to see their care record.

5.3.2 Use of abbreviations in care records

The BDA does not have a definitive list of abbreviations. The use of abbreviations varies both nationally, regionally and locally and also among groups of different health professionals. Some NHS organisations have produced a locally agreed list of abbreviations. It is good practice to check with your line manager, healthcare records committee (or equivalent body), or clinical risk manager if your organisation has such a list.

5.3.3 Content

You must:

- As a minimum follow local policy and guidance
- Maintain records to an agreed standard of good practice
- Complete the record as **soon as is possible** after the consultation or event. Agreed local policy or procedure should be followed. Good practice is for you to aim to do this by the end of the working day, where individual circumstances allow. Remember that "not having time" is not a defence for not maintaining the record
- Date and sign each new entry; there must be a means of identifying the signature and designation of the person making the entry to the record. Keeping an up-to-date departmental log sheet of staff names and signatures is recommended
- Sign in full the first time you make an entry to a record. Subsequent entries can be initialled

- Write neatly and legibly and use black ink (this photocopies clearly unlike coloured inks). Never use pencil as this can be erased or fade over time
- Record details of information given
- Rough notes are part of the record unless their contents are transcribed into the main body of the record. After transcription the rough notes can be destroyed using the disposal process for confidential waste.

Specific to clinical records

You must:

- Document the evidence for, or the reasonable basis for, any decision that you have taken relating to the individuals care in order to justify the decisions you have taken
- Document the source of referral
- Document relevant conversations with other healthcare professionals and family/carers.

The notes are an accurate record that should not be modified. A correction may be added to at a later date if this is necessary.

5.3.4 Mistakes/amendments

You must follow local policy. The following is good practice:

- Draw a single line through the entry so that the original entry is still clearly visible
- Initial and date the amendment
- Make a margin note against the entry explaining the reason for the amendment
- Never use eraser/white out liquid, or permanently remove the original entry on a patient record in any way
- If a major correction is necessary you should explain the reason for this.

6 Making a care record: responsibility of the individual dietitian

The HPC standards of conduct, performance and ethics[2] state that:

> *"Making and keeping records is an essential part of care and you must keep records for everyone you treat or who asks for your advice or services."*

If you are employed by the NHS, you are responsible for any records which you create for use in the performance of your duties. All individuals who record, handle, store or otherwise come across information, have a personal, common law duty of confidentiality to patients and to their employer. The duty of confidence continues even after the death of patients and after you have left the NHS.

You are required to provide accurate, current, comprehensive and concise information which justifies the decisions you make for the treatment, care and support provided or planned for the patient/client, by providing:

- Accurate, current and comprehensive information concerning the condition and care of the individual and associated observations
- A record of any problem that arises and any actions subsequently taken
- Chronological evidence of the care required, action taken by the dietetic team member and the patient/service users response
- A record of any factors e.g. physical, psychological or social that appears to affect the service user
- A record of the sequence of events and the reasons for any decisions made
- A way of capturing data which can be used to support a number of secondary purposes e.g. quality assurance, research and clinical audit, service management and public health information
- A baseline record against which improvement or deterioration may be judged
- A demonstration of evidence-based practice
- A vehicle for good communication and dissemination of information within the multi-disciplinary team
- A basis for continuity of care
- Proof that legislation has been met.

Additionally, the information contained in a record is only of use if you have:

- Accurately recorded the information in the first place
- Ensured that it is available to those who need to see it
- Written it in such a way that others can understand your actions so they can act appropriately.

6.1 Delegation and counter-signing

The HPC Standards (HPC) standards of conduct, performance and ethics[2] state that:

> *"Whenever you give tasks to another person to carry out on your behalf you must be sure that they have the knowledge, skills and experience to carry out the tasks safely and effectively. You must not ask them to do work which is outside their scope of practice.*
>
> *"You must always continue to give appropriate supervision to whoever you ask to carry out a task. You will still be responsible for the appropriateness of the decision to delegate. If someone tells you that they are unwilling to carry out a task because they do not think they are capable of doing so safely and effectively, you must not force them to carry out the task anyway."*

The decision to delegate and countersign must be a reasoned, individual decision, taking account of country, regional or local practice, policy and guidance. The ultimate responsibility about when and how delegation and countersigning takes place lies with you as the supervising dietitian.

Countersigning does not absolve you of your responsibility. Supervision records are important and should be documented to the same standards as care records.

If you delegate activities to another person (e.g. student, support worker or health trainer) you should:

- Ensure that they have received appropriate training and are sufficiently competent to do the delegated task
- Ensure that supervision is adequate
- Ensure that there is a system in place to ensure the accuracy of the record (medical/multi-disciplinary (shared)/dietetic), i.e. that what has been done has been accurately recorded.

You may decide that the delegation includes them documenting their actions without the requirement to have their records countersigned. Alternatively you may decide to countersign their entries. This may not necessarily mean that their records require countersignature on a daily basis. It may be more appropriate for this to take place at the time when you routinely review their work.

It is advisable to use your full signature when countersigning rather than initialling.

6.1.1 Team members undergoing training/assessment of competence

These include dietetic students, support workers, junior workers, returnees to the profession and dietitians working under HPC Conditions of Practice. Local policy should be checked as there may be formal arrangements for new staff, returnees and those who are on a career break etc.

6.1.1.1 Support worker

Whilst the support worker is being trained, or whilst their competence is being assessed, i.e. work has not yet been fully delegated to them, you may take the decision to countersign any record that they make until they have been assessed and deemed competent.

6.1.1.2 Student

The HPC Standards of conduct, performance and ethics[2] state that:

> *"You have a duty to make sure, as far as possible, that records completed by students under your supervision are clearly written, accurate and appropriate."*

A student is not formally judged to be competent until the end of their placement. The registered dietitian is still accountable for all patient care that a student undertakes whilst under supervision. Supervision can be carried out at a distance; where the student is not directly observed but reports back to the supervisor on a regular basis. You may decide to countersign any record that they make in line with local policy.

7 Responsibility of the organisation

7.1 Care records

All NHS records are public records under the terms of Public Records Act[8] and must be kept in accordance with a number of statutory and NHS guidelines. NHS organisations must have policies

and procedures in place governing access to information, and for the storage, retention and destruction of records. These will apply whether the record is paper-based, electronic or stored in other formats such as memory sticks, CD, DVD, tapes, microfiche, etc.

The employing organisation is the owner of the record. The information contained within the record remains confidential and the individual whose record it is has the right to limit access to specific categories of information recorded about them.

7.1.1 Private sector

In the private sector, records are the property of your employer. However if you have treated the patient you must have reasonable access to that record; this is particularly important if, subsequent to leaving this employment, a complaint or allegation is made against you.

8 Security

8.1 General principles

You must be extremely vigilant in safeguarding records and take all reasonable steps to ensure this (also see section 11.0) including:

- Following local policy for the storage, transport and security of care records. In the absence of any policy guidance should be sought from your line manager
- Storing records safely (e.g. in a lockable filing cabinet)
- Using filing systems to enable easy retrieval
- Where it is not possible for NHS community staff to return records to the staff base/records department at the end of a working day, they should be stored overnight in their home. Under no circumstances should records be left in vehicles overnight.
- When records are left in a vehicle you should lock them in the boot and ensure that they are not visible
- Maintaining confidentiality at all times. Do not take other patients'/clients' records into the home of another
- Do not leave records unattended in insecure areas
- Informing the organization's Caldicott Guardian immediately of any loss or misplacement of any document that is used to record patient information.

8.2 Electronic and computer records

You must safeguard records by following national and local policy. This includes:

- Logging in and out of sessions
- Using passwords appropriately. You must not share these with other people; this may result in disciplinary action being taken against you
- Regularly changing your password in accordance with local policy
- Ensuring the information displayed on the computer is not visible to those who do not have authorisation to view
- Do not store unencrypted patient information on personal storage systems such as laptops or memory sticks.

8.3 Retention and disposal of records (NHS)

Each organisation must have a retention/disposal policy covering all records held by the organisation, including electronic records. The length of retention varies according to the type of record and its importance to the organisation's business. All records must be stored securely until minimum retention periods have expired. Retention periods are listed in national guidance (see further reading).

If you are self-employed, then any record you have made relating to the care of a patient should be retained for at least eight years for an adult and until the date of a child's 21st birthday.

Under the Freedom of Information Act 2000 (see further reading Section 9: The legal status of a record), procedures for the disposal of records must be documented. Records of disposal must be kept indicating what has been destroyed/transferred, when and by whom. This is to ensure that the organisation is aware of those records that have been destroyed and are therefore no longer available.

Most NHS records are confidential records and it is vital that confidentiality is safeguarded at every stage. It is the responsibility of the NHS organisation to ensure that the methods used throughout the destruction process provide adequate safeguards against the accidental loss or disclosure of the contents of the records.

9 The legal status of a record

All UK records are subject to the requirements of the Data Protection Act 1998[5]. The Data Protection Act 1998 is not confined to NHS health records – it applies equally to the private health sector and to health professionals' private practice records.

In England the Public Records Act 1958[8] requires all NHS employees to be responsible for any records that they create or use in the course of their duties and these are public records.

In Scotland all NHS records are owned by Scottish Ministers on behalf of the Crown. They are therefore subject to the provisions of the Public Records (Scotland) Act 1937[13].

In Northern Ireland all HPSS records are public records under the terms of the Public Records Act (Northern Ireland) 1923[13a].

10 Information governance

Information governance provides a framework for handling and protection of personal information, paper or electronic, in a confidential and secure manner to appropriate ethical and quality standards. In summary:

- The interests of service users come first.
- People's information should be stored in a secure manner – this includes any rough/working notes relating to their care.
- Service users have a right to confidentiality – informed consent and personal autonomy should underpin the provision of health and social care.
- If you are providing care you must comply with legislation and meet the HPC standards.

10.1 Consent

The ability to obtain informed consent is a requirement of both the HPC Standards of Proficiency for Dietitians and the HPC Code of Conduct, Performance and Ethics[2]. The BDA documents *Good practice in consent: A guide for dietitians* (BDA 2002[14] – under review 2008) and *Code of Professional Conduct*[3] underpin these documents.

Consent to treatment does not necessarily have to be given verbally, i.e. formally, but can be implicit e.g. as shown by a patient co-operating with being weighed.

You must make sure that service users are fully aware if, and why, any information about them is to be shared or disclosed and to whom that information will be given. You should also tell them what the likely impact of not doing this will be upon their care or the services they will receive.

You must take particular care not to disclose health information about any third parties when this is shared or disclosed without their specific informed consent.

10.1.1 Mental Capacity Act (England and Wales) 2005[15]

This has wide ranging consequences for all health and social care practitioners who work with people who may lack capacity to make specific decisions. If patients lack the capacity to make specific decisions you are required to record if, how and why they reached a decision, how they are involved in the decision making process and you need to be able to justify your actions in relation to those decisions.

10.1.2 Children

Personal information about children and families held by professionals is subject to a duty of confidence, and should normally not be disclosed without the consent of the subject. However, the law permits the disclosure of confidential information necessary to safeguard a child.

The BDA Code of Professional Conduct (2008)[3] and the BDA Guidance on Consent (2008)[14] provide more detailed guidance on consent.

10.2 Confidentiality

The ability to maintain confidentiality is a requirement of both the HPC Standards of Proficiency for Dietitians[16] and the HPC Code of Conduct, Performance and Ethics[2].

The HPC's *Confidentiality: Guidance for Registrants* (2008)[17] provides advice to registrants about some of the issues around handling information and advises that it is your duty as a registrant to respect and safeguard the confidentiality of service users at all times. This is both:

- A professional responsibility because the HPC standards are there to protect the public. Breaches of confidentiality can affect your HPC registration.
- A legal responsibility because of principles established by law which say that professionals have an obligation of confidentiality to those with whom they have a professional relationship. Legislation also states how information should be kept, handled and disclosed.

On NHS premises confidential records should be kept in a locked cupboard or filing cabinet, and the room should be locked when not in use. Access should be limited to designated staff and movement of records tracked either manually or electronically. Care records should not be left unattended in public areas.

Security and confidentiality must be maintained when transporting records and local policy must be always be followed. Good practice includes:

- Not leaving records on display in a vehicle but locking them securely in the boot
- Use of a lockable container when transporting records, such as a briefcase, to physically protect the record from damage and to prevent unauthorized access
- Not taking a service user's record into the home of another.

Care should be taken to protect confidentiality when leaving messages on any answer phones, in message books or responding to requests for information by telephone.

If you are using identifiable information from care records for a secondary purpose, e.g. for audit or research within the work setting, you should make your data anonymous by removing the individual's identifiable details. The use of anonymised data will not breach confidentiality or other legal requirements. Under these circumstances use of data that does not identify an individual is not regarded as confidential.

11 The NHS Electronic Record

11.1 General principles

- Electronic health records have the potential to improve the accuracy of healthcare documentation and information transfer.
- Healthcare professionals need comprehensive and accurate data on service users at the point-of-care if they are to provide a high quality service. Electronic health records can aid in this by replacing difficult to access, and often illegible, paper-based records.
- The improved record keeping, legibility and access of electronic records can help to avoid the inconvenience of lost records, data recapture and re-entry and reduce the risk of recording errors.
- The introduction of the electronic record offers many potential benefits for the NHS, including a reduction in clinical errors and improved patient safety
- The primary purpose of recording information is to support patient care. Holding and accessing information about service users and their interactions with clinical teams is critical to providing safe and effective care

11.1.1 Security and Confidentiality

- The NHS has a duty to ensure the personal information it keeps is held securely and handled in accordance with both the Common law duty of confidence and the Data Protection Act 1998[5].
- Security is a major concern. Any system which makes it easier to access data inevitably make it easier for unauthorized individuals to gain access. Similarly, the more people that access a record increases the risk of breaching confidentiality.

- For the most part the principles that underpin the legal and professional aspects of record keeping are similar for paper and electronic patient records. You should only access a record if you have a legitimate right to do so.
- Computerised health records are documents under law and as such are disclosable.

The risk of error increases if both paper and electronic records co-exist as this raises issues about keeping both sets of records up to date. However the reality is that parallel records may remain for some time. Where both computer and paper systems are maintained, the information held must be consistent.

The British Medical Association and NHS Connecting for Health (England) have produced joint guidance on protecting electronic patient information[18]. This guidance is applicable to all healthcare professionals across the UK and covers:

- Use of e-mail – only NHS mail accounts should be used for exchanging confidential patient information unless it is encrypted. For sensitive information, delivery and read receipts should also be requested so that you can ensure the information has been received safely.
- Using a laptop or mobile device – you have a duty to ensure that you take appropriate precautions to protect the laptop and the data it contains. This includes reducing the risk of theft, using passwords and installing encryption software to protect sensitive data.

11.2 National development of the electronic record

The UK countries are taking different approaches to development of the NHS Electronic record. A brief overview is given below. More detail can be found on the national websites listed in the references.

11.2.1 England

The NHS Care Records Service (NHS CRS)[19] will deliver an individual electronic record for each patient to ensure that:

- All the records of an individual patient's care are kept in one place
- The record can be securely shared between different parts of the local NHS
- The record will be available to the authorised health and social care professional at the time and place that the patient is seen.

For each individual the NHS Care Records Service will develop:

- A Detailed Record (held locally)
- The Summary Care Record (held nationally) which will be available to authorised NHS staff across the NHS in England.

The Care Record Guarantee, launched in 2004[20], sets out the commitments that will govern information held in linked electronic record systems across England.

- Access will only be possible with an NHS Smartcard, with a Pass code.
- Access will only be allowed following appropriate training and is dependant upon your role.

- You will only be able to access a care record if you are involved in that patient's care (this is called a legitimate relationship).
- Every time someone accesses a patient's record, a note will be made automatically of who, when and what they did (an audit trail).
- Alerts will be triggered automatically both to deter misuse of access privileges and to report any misuse when it occurs. When access is not justifiable, the person responsible for overseeing patient confidentiality in your NHS organisation, "the Caldicott Guardian"[21], will take action, which may include disciplinary procedures, and telling the patient where appropriate.
- Disciplinary action may also lead to an HPC hearing.
- Patients can access this information through a formal "data protection subject access request". Patients will also be able to access their Summary Care Record using the secure website Health-Space.

11.2.2 Northern Ireland

The Informatics & Communications Technology (ICT) Strategy[22] has two major, interlocking themes for ICT development:

- Electronic Care Records
- Electronic Care Communications.

The emphasis of the Strategy is on these themes, but the importance of ICT as a means to access other information and the need to sustain and modernise ICT in other areas is also recognised.

11.2.3 Scotland

Scotland's national e-Health programme[23] is focusing on delivering a comprehensive health information system built around the electronic health record (EPR). E-Health includes a wide range of ICT applications and uses, from health information on the Internet through to tele-health.

11.2.4 Wales

Informing Healthcare[24] is a Welsh Assembly Government programme set up to improve health services in Wales by introducing new ways of accessing, using and storing information. Informing Healthcare will:

- Introduce new ways of working
- Contribute to an increase in staff time (less time wasted via paper-based activities)
- Provide an opportunity for all to acquire new skills
- Allow staff to access and use the latest evidence and best practice routinely
- Ensure communication with other NHS colleagues across geographical areas will be easier and more effective
- Reduce the risk of errors with improved Information Technology systems support
- Improve the flows of information
- Enable access to computer based tools, freeing more time for service improvement and patient care.

12 FAQ Section

12.1 I am a private practitioner

The principles are the same whatever your work setting. The Data Protection Act 1998[5] is not confined to NHS health records. It applies equally to the private sector and to health professionals private records.

12.2 Do I still have to keep my own dietetic records?

There must be a complete record of the patient episode. NHS dietitians have often kept their own detailed records in addition to the main multi-disciplinary patient record. You do not need to keep a separate dietetic record unless there is a specific need to, e.g. if it is not feasible to remove the multi-disciplinary single patient record from the hospital for community use, or because insufficient detail can be recorded in the single multi-disciplinary record. It may not be necessary to record all the details already in the patient record on the additional dietetic record, e.g. duplicating a patient's past medical history word-for-word may be inappropriate. You do need to ensure that an accurate summary of the care/advice given is recorded in the main patient record. If you are keeping separate dietetic records, although you do not need to record all details word for word, there needs to be sufficient detail for another dietitian to be able to use the record effectively.

Professional colleagues are responsible for recording your advice but you should also keep a record of this.

12.3 What is my obligation to ensure that the advice and input to clinical and other records that I give on a consultative basis is comprehensively and accurately recorded? Should I rely on my professional colleagues to do this?

There is a difference between giving informal advice, e.g. one to one with a colleague, and giving advice as a result of a formal request for a second opinion.

If you have given informal advice it may not be practical for you to document that you have done this directly into the patient/service user record – after all, your advice is not necessarily the only appropriate course of action. Ultimately, as an autonomous practitioner, each dietitian is responsible for their own actions and competence, and whilst consulting others can be extremely helpful, it is the responsibility of the dietitian caring for the patient to make their own final decision.

You may wish to record details of such advice in a personal log or diary as a personal record.

If you are asked to give a formal second opinion you will be asked to do this in writing and will have access to all the information relating to that individual. In this case you should document the advice you give in their record.

12.4 Telephone advice to service users

You should not leave advice for a service user on an answer phone. This can breach confidentiality and what you have said may be misinterpreted by the service user or a third party.

12.5 Who owns the patient record?

All NHS records are public records under the terms of Public Records Act[8] and must be kept in accordance with a number of statutory and NHS guidelines.

In the private sector, records are the property of your employer. However if you have treated the patient and entered information into the record you must have reasonable access to the record; particularly if, after leaving the employing organisation, a complaint or allegation is made against you.

12.6 Can patient information be reproduced and used for training purposes, e.g. for inclusion in a student portfolio?

The HPC Standards of conduct, performance and ethics (2008)[2] gives clear guidance stating that:

> *"You must treat information about service users as confidential and use it only for the purpose they have provided it for. You must not knowingly release any personal or confidential information to anyone who is not entitled to it and you should check that people who ask for information are entitled to it."*

Students should not remove and use confidential material from their work placement outside the workplace.

12.7 I work for an independent organisation, outside the NHS. How does this guidance apply to me?

This guidance is to support best practice when keeping clinical records. In the private sector, all records are the property of the employer. If you are required to keep clinical records as part of your job it is your responsibility as an HPC-registered professional to keep these records up to date and complete them accurately. You should use your employer's guidance and clinical judgement to determine the level of information you need to record.

Be aware that if you are questioned about your record keeping your answers may be used as evidence in a subsequent disciplinary against you.

13 References and further reading

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2. The Healthcare Professions Council Standards of conduct, performance and ethics July 2008 www.hpc.uk.org
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2.0 What is a record?

5. Data Protection Act 1998 www.opsi.gov.uk/Acts

3.0 The purpose of a record

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4.0 Who owns the record?

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9.0 The legal status of a record

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13a. Public Records Act (Northern Ireland) 1923.

www.opsi.gov.uk/RevisedStatutes/Acts/apni/1923/capni_19230020_en_1

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- Access to Healthcare Records 1990
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- The Access to Health Records (Northern Ireland) Order 1993
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10.0 Information Governance

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- Department of Health (England) 2006. Records Management: NHS Code of Practice. The Stationery Office, London
  www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747
  The Code offers detailed guidance on:
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  - the day-to-day use of NHS records,
  - minimum retention period schedules for NHS records.

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11.1 General principles

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