SENr
The Sport and Exercise Nutrition Register

Record Keeping Guidance

October 2015

Contents

1.0 Introduction

The purpose of this document is to provide record keeping guidance for registrants in Sport and Exercise Nutrition.

Record keeping is a fundamental part of professional practice and a legal requirement. The principles set out here are applicable to all areas of practice. This guidance does not define a rigid framework, nor it is designed as an auditable standard but aims to inform you of record keeping issues.

The SENr Code of Professional Conduct states in performance standards that:

You must always keep accurate user records.

The SENr Competency Framework (2014) underpins this for Full and High Performance Registrants

Competency B2.1.6: Maintain appropriately detailed written/ electronic records of client care, prescribed diets and advice issued such that it can support and justify the rationale for ones actions should it be required in a court of law. Use terminology and abbreviations in client records with caution'

The ultimate responsibility for record keeping lies with you as an autonomous and accountable practitioner using your judgement to decide what is relevant and what should be recorded.
A range of individuals could potentially access the record and read what you have written. These could include other members of the multi-disciplinary team, the client, audit staff, lawyers and their legal teams.

Remember that if you haven't written down what you have done it might as well not have happened.

2.0 What is a record?

A record is a reminder of what has happened. It may be paper, electronic or other media format including memory stick. Records are not just athlete records but include minutes of meetings, care plans, diaries, research and audit data, CPD, portfolios emails etc.

Section 68 (2) of The Data Protection act 1998 defines a health record as:

A health 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 the individual.

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

3.0 The purpose of a record

Record keeping is an essential, integral part of practice. Keeping records 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. Courts of law tend to adopt the view that “if it is not recorded, it has not been done”, therefore good record keeping not only protects the client but also the SENr registrant.

Records can also be used for audit, research, athlete health and service planning.

Good record keeping ensures:

- You can work with maximum efficiency without having to waste time hunting for information.
- There is an audit trail
- Those covering you or coming into your job after you have left can see what has been done, not done and why
- Any decisions can be justified or reconsidered at a later date

4.0 How to keep good records

4.1 Style

- Use a style that is appropriate to the type of intervention/meeting
- Use factual, clear, accurate and unambiguous language
- 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.

4.2 Content

A care record should contain:

- Accurate current and comprehensive information concerning the condition and care of the athlete and associated observations
- A record of any problems that arise and actions taken.
- Chronological evidence of the care required, action taken by the team member and athlete response
- Any factors physical, psychological or social that appears to affect the athlete
- The sequence of events and reasons for the decision taken
- Athlete details should be recorded in as much detail as possible. As a minimum, this should include:
    - Full name
    - Address
    - Date of Birth
    - Contact details
    - Sport
    - Date of Consultation
    - All clinical/ medical and social details as appropriate
    - Each entry must include an assessment, summary and plan and should follow the guidance detailed in the ABC method of documentation (see appendix)
- Any form of correspondence should be attached to the athletes record

4.3 Process

- **Complete the record as soon as is possible after the consultation or event. Good practice is for you to do this by the end of the working day. Remember that "not having time" is not a defence**
- **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**
- Sign in full the first time you make an entry then subsequent entries can be initialed
- **Keeping an up-to-date departmental log sheet of staff names and signatures is recommended**
- Write neatly and legibly and use black ink or type in black if electronic. 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.

4.4 Mistakes/ amendments

Any error should remain legible

- 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.

4.5 Countersigning

There may be occasions where team members who are undergoing training, or who are not judged to be competent, complete athlete records. These could be students, support staff, new staff or dietitians working under HCPC Conditions of Practice.

In such situations, the SENr registrant may decide to countersign any record that is made by other such team members in line with local policy.

The HCPC Standards of conduct performance and ethics state that:

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

5.0 Confidentiality and Security

The SENr full and high performance competencies include

'Adhering to the principles and practice of confidentiality, recording and sharing of information.'

The ability to maintain confidentiality is also a requirement of HCPC registration.

You must be vigilant in safeguarding records and take all reasonable steps to ensure this.

- Care should be taken to protect confidentiality when leaving messages on answer phones, in message books or responding to requests for information by telephone.
- Follow local policy for storage, transport and security of care records. In the absence of any policy guidance should be sought from your line manager
- Records must be stored securely (locked).
- Do not leave records unattended.
- If records are left in a vehicle they should be locked in the boot and ensure they are not visible. Under no circumstances should records be left in vehicles overnight.
- Maintain confidentiality at all times, do not leave client records of display when seeing another client

- Log in and out when accessing electronic records.
- Use passwords appropriately.
- Ensure information displayed on computer screen is not visible to those who do not have authorisation to view.
- Ensure personal storage systems that contain client information such as laptops or memory sticks are stored securely.
- If you are using identifiable information from care records for a secondary purpose e.g. for audit or research within the work setting, you must anonymise your data by removing individuals identifiable details.

6.0 Retention and disposal of records

All UK records are subject to the requirements of the Data Protection Act 1998

- Follow organisation guidance on how long to keep records. If self-employed you need to keep all adult records for 8 years and children until they are 21 years old.

Appendix A

ABC Record Keeping – Taken from English Institute of Sport

Performance Nutrition – record keeping **ABC guidance**
(Include date of assessment/review in the margin)

Athlete assessment/review for .....
Athlete referred by ..... on (date)

Relevant medical/social history:

ASSESSMENT: At the end of each of these sections, make an interpretative statement about what you have observed

ANTHROPOMETRY:
Weight (date) BMI (if appropriate)
Height Skinfolds
Girth changes

BIOCHEMISTRY:
(Relevant or abnormal) include the date

CLINICAL OBSERVATIONS: (include as appropriate)
These are symptoms and signs affecting nutritional intake as observed or as reported by the athlete

nausea	constipation	sore mouth (ulcers)	other ....
vomiting	diarrhoea	dental	
cramping	bloating	fatigue	

Also consider: lean muscle and adipose stores, hydration, skin condition, hair and nails.
Consider medication that may influence/interact with nutrition

DIETARY: (include as appropriate)
Current Nutritional Intake as per:
Diet History 24hr Recall Food diary

ESTIMATED NUTRITIONAL REQUIREMENTS:
(Show calculations where appropriate)

SUMMARY: 3 to 4 sentences which summarise the current situation which are relevant to The nutritional management of the athlete

PLAN:
Numbered intervention strategies
(Include who you have informed about your intervention plan and plans to review)

Signature Surname in BLOCK capitals Title

References

1. SENr ‘Code of Professional Conduct’ (2010)
2. SENr ‘Competency Framework for Full and High Performance Registration’ (2014)
3. The Data Protection Act (1998)
4. HCPC ‘Standards of conduct, performance and ethics’ (2012)
5. England Institute of Sport ‘Performance Nutrition record keeping standards (2014)
6. BDA Code of Professional Conduct (2008)
7. HCPC Standards of Proficiency for Dietitians (2007)
8. The BDA Professional Standards for Dietitians (2004)
9. BDA Guidance for Dietitians for Records and Record Keeping (2008)

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