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Health Records & Communication Practice Standards Group

Health Record and Communication Practice Standards for Team Based Care

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Amendment History:

Version	Date	Amendment History
0.1	2 April 2004	First draft for review.
0.2	15 April 2004	Minor amendments to introduction wording and footnotes.
0.3	5 May 2004	Consolidated standards list and reworking of contextual sections.
0.4	18 May 2004	Regulatory Body feedback incorporated into the document.
0.5	24 May 2004	Further Regulatory Body feedback incorporated into the document.
0.6	28 May 2004	Further revisions following the May HR&CPS Group Meeting. This revision includes a renaming of this document to "Health Record & Communication Practice Standards for Team Based Care - v0.6".
0.7	22 September 2004	Revisions following GMC Committee comments.
1.0	7 December 2004	Final Agreed Version.

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CONTENTS

1. Introduction

Health record and communication practice standards for all healthcare professionals are essential for safe and effective practice. Within the NHS in England, a single model for documenting and communicating that information which forms the patient health record does not currently exist. It is recognised that a proportion of regulated professionals work outside of the NHS and that the standards, advice and guidance issued by their regulators are equally applicable to their practice.

Existing standards relating to health record and communication practice are those given by the individual healthcare professional regulatory bodies. In the current climate of inter and intra disciplinary working and the objectives set out in National Programme for IT, particularly the NHS Care Records Service, standardisation to support team based professional care - across the many health and social care professions and health and social care settings - is essential.

To this end, the Health Records and Communication Practice Standards (HR&CPS) Group has undertaken a review of those existing standards relating to health record keeping and communication of practice published by the healthcare professional regulatory bodies. The review has taken place in partnership with the regulatory bodies, identifying where commonality invariably lies across the current standards and bringing them together to produce a distillation of high level standards.

1.1. Purpose of this Document

This document provides the context to and sets out the final outcome of the work undertaken by the HR&CPS Group, ie. the set of standards common to the three regulatory bodies .

Further contextual documents to support the work of the HR&CPS Group are:

- "HR&CPS - Team Based Professional Care - v0.2" - Beverley Scott - 23 February 2004.
- "Review of Existing Professional Standards - v0.2" - Nancy Wolstenholme - 30 January 2004.

1.2. Scope

The scope of the work completed by the HR&CPS Group to date has been limited to:

1.2.1 Reviewing existing standards relating only to health record and communication practice for healthcare practitioners who are professionally regulated.

1.2.2 The review has taken place in liaison with three regulatory bodies:

- General Medical Council (GMC);
- Health Professions Council (HPC); and
- Nursing and Midwifery Council (NMC).

1.2.3 Therefore, to date, the scope of the review excludes:

- Health record and communication practice standards identified within other regulatory bodies for healthcare professionals, such as the Royal Pharmaceutical Society of Great Britain (RPSGB).
- Guidelines issued by non-regulatory organisations such as the Royal Colleges for healthcare professionals.

1.2.4 This review does not make a distinction between health record and communication practice standards between manual, ie. paper or other types of documented patient information, such as the electronic or taped patient record.

1.2.5 It is crucial to make the distinction that this review is based on existing standards and guidance within the three named regulatory bodies and does not, therefore, attempt to develop new standards. The overall purpose of the work carried out to date is to find commonality in order to guide team based professional care in today's inter and intra professional working.

1.3. Terms and Acronyms Used in this Document

1.3.1 It is recognised that there are various terms used to describe the recipient of health/social care services, ie. the patient; client; service user, etc. This review does not suggest that one term is more appropriate than the other, acknowledging the subjective meaning of each. However, for the purposes of this document, the terms 'patient(s)/client(s)' refers to any person who receives a health/social care service.

1.3.2 Where the term 'health care professional' is used in this document, this means any person who records patient specific information, that has a professional healthcare qualification to practice and is registered by their relevant regulatory body. This does not, therefore, include students or support workers, for example.

1.3.3 Where the term 'standards' is used, this refers to standards relating to healthcare record keeping and communication practice, unless otherwise specified.

1.3.4 For a list of terms and definitions relating to health record and communication practice standards, please refer to the glossary of terms on the NHS Information Standards Board website - www.isb.nhs.uk

1.3.4 Acronyms:

HR&CPS Group	Health Records and Communication Practice Standards Group
GMC	General Medical Council.
NMC	Nursing and Midwifery Council.
HPC	Health Professionals Council.

2. Assumptions

2.1 In conducting this review, it became apparent that those standards common to all three regulatory bodies could be represented here within four categories:

- Confidentiality and Disclosure.
- Communication of Information.
- Process Principles.
- Personal and Professional Knowledge and Skills.

2.2 It is important to note that the review did draw attention to standards relating to the systems provided to healthcare professionals to record information about patients/clients by their employing organisations. This document does not attempt to address those standards here, however, it is assumed that healthcare professionals should expect such systems to enable them to practice safely and meet the standards expected of them by their regulatory bodies and employing organisation.

2.3 These standards are not intended to be best practice, but minimum standards to be attained.

2.4 There is an assumption that whilst this common set of standards is intended for the multi disciplinary team, healthcare professionals need to be cognisant of their own regulator's standards, advice and guidance provided for their specific profession. These standards in no way replace any such standards by the regulatory bodies or guidance provided by the professional organisations such as the Royal Colleges, however, they are intended to complement each other.

3. Health Record and Communication Practice Standards - Distillation

3.1 Confidentiality and Disclosure

- You must maintain the confidentiality of all patients/clients and, working in partnership with patients/clients, understand and uphold the principles of informed consent and disclosure of confidential information in accordance with all relevant law and guidance produced by the professional regulatory bodies and others.

- Patients/clients have a right to know when information is recorded about them and their care, how the information will be recorded and how their information may be used in the future.

- Patients/clients have a right to access their own records. You must respect their right to limit your or another healthcare professional's access to their information, however, exceptions may apply where, in your professional judgement, to restrict or withhold information would cause serious harm to the patient or others.

- When you are responsible for personal information of patients, you should - taking reasonable measures - assure yourself that the system provided by your organisation to record patient/ client information is effectively protected against loss, damage and security, ensuring that you use the system appropriately.

- You should keep up to date, and adhere to, law relating to information and record keeping, eg. Access to Health Records (1990), Access to Medical Reports Act (1998), Data Protection Act (1998) and the Freedom of Information Act (2000).

3.2 Communication of Information

- You must ensure that the information you give to patients/clients information is presented in a way they can understand.
- You have a duty to maintain effective and appropriate communication with your colleagues.
- You should maintain knowledge and develop your abilities in team based communication, being aware of the reliance placed on your communication and recording of information.

3.3 Process Principles

- All encounters and interventions made relating to a patient/client must be recorded. This includes when a patient has not been involved directly.
- All entries to patient/client records should be clear, accurate, legible and contemporaneous and attributed to a named person with an identified role.
- You should not include in the patient record - unnecessary abbreviations or jargon, meaningless phrases, irrelevant or offensive speculation or irrelevant personal opinions regarding the patient.
- Any justifiable alterations to your own or another healthcare professional's documentation should usually be clearly attributed to a named person with an identified role, with the original documentation and alterations clearly legible and auditable.
- Patient/client records should contain details of any assessments and/or reviews undertaken and clear evidence of the arrangements you have planned for their future and continuing care, including the details of information given to them about their care and treatment.
- Should there be any problems relating to access and keeping of patient/client records, ie. missing records or inability to access records, you should identify the problem and take action.

3.4 Professional and Personal Knowledge and Skills

- You have a duty to keep up to date, and adhere to, relevant legislation, case law and national and local policy relating to information and record keeping.
- You have a duty as an individual healthcare professional to keep up to date about best practice for health record and communication practice standards.
- You have a duty as an individual healthcare professional to be proficient in the system you use to record and communicate patient/client information.

4.0 References

GMC:

- Good Medical Practice, 3rd edition, May 2001.
- Confidentiality: Protecting and Providing Information, April 2004
- Seeking Patients' Consent: the ethical considerations, November 1998

NMC:

- Guidelines for records and record keeping, April 2002.
- Guidelines for the administration of medicines, April 2002.
- Code of professional conduct, April 2002.
- Midwives rules and code of practice, April 2002.

HPC:

- Standards of Conduct, Performance, & Ethics, July 2003.
- Distillation of standards relating to record keeping, November 2003.
- Standards of Proficiency, July 2003.

Department of Health:

- Confidentiality: NHS Code of Practice, DH 2003.