EMT Record Keeping

Guidance for associate and full Registrants of the UKREMT.

January 2020

Does not replace your company or service record keeping polices, and should be used for guidance only.

Introduction

This guidance has been written to inform those maybe new to Fitness to Practice (FTP) and/or new to the industry of the standards expected by UKREMT with regards to clinical record keeping. A clinical record is any record which is made by or on behalf of a health professional with regard to their professional practice interaction with an individual or group. It contains and consists of information which relates physical or mental health, medical history and/or other health related information. The record may be a paper record, electronic record or mixture and may also comprise of other audio/visual data formats where appropriate.

The making of a clinical record is mandatory for all client interactions. Failure to comply with this standard can lead to Fitness to Practise proceedings, please see the UKREMT FTP Policy.

General guidelines

Registrants work in a variety of settings and are therefore required to maintain clinical records (paper or electronic) in a manner that not only meets the standards as laid out in a varity of UKREMT documents such as the EMT Code and FTP Policy but meets the requirements of their employer or specific situation they are in.

Registrants should consider the process of clinical record keeping a professional tool which is essential to aid and facilitate the care process. Clinical Record Keeping also underpins the professional practice of a registrants because it can:

- Demonstrate clinical reasoning and clinical decision making
- Encourage logical thinking, critical analysis and reflection
- Facilitate good communication between the multi-disciplinary team involved in client care
- Provide standardised information for all members of the multi-disciplinary team involved in client care
- Meet the regulatory requirements of UKREMT and applicable legal requirements
- Enable records to be considered legal documents which may form the basis of defence of fitness to practice or legal cases
- Provides a source of data for research, audit, planning or development purposes.
- Form the basis of future decisions regarding health and care
- Support continuity of care between health professionals

Legal Implications

Registrants must also maintain and demonstrate awareness of the legal context of their work and how this affects their clinical record keeping. A key part of this is ensuring compliance with the relevant legislation listed below:

- Data Protection Act (1998)
- Human Rights Act (1998)
- Access to Health Records Act (1990) NI (1993)
- Access to Medical Reports Act (1988)
- Freedom of Information Act (2000) Scotland (2002)

Registrants must also be aware that clinical records may be used as evidence in a court of law or to investigate a complaint. Clinical judgment should be used to decide what is relevant and should be included, however courts tend to take the view that 'if it is not written down, it did not occur'. This point is particularly pertinent in cases where the condition of a client is apparently unchanging though later chronic disability or dysfunction is diagnosed but no record of care/referral exists. Clinical record keeping must therefore demonstrate:

- A complete account of any assessment, intervention (planned or undertaken, including advice) and subsequent referral/continuing care

- All relevant information about the presenting condition and general medical condition of the client
- The measures taken to respond to the client's needs (as stated, assessed and agreed)
- Evidence that the registrant has undertaken and honoured their reasonable duty of care, including evidence that actions or omissions taken by the registrant were taken in the client's best interest and have not compromised health and safety in any way.

Format and Content of Clinical Records

UKREMT accepts that the decision regarding the specific format of clinical records should be taken at a local level and depends upon the setting and context under which the registrant practices. However, the following recommendations apply regarding the content and style of all clinical records. Specifically, all records should include:

- Date and time of initial examination / treatment and all following client interactions
- A suitable method for attributing the record to the registrant to ensure accountability and responsibility for the recorded information
- Legible, factual and accurate information particular to the client
- Evidence of clinical reasoning for decisions, interventions, and advice, documenting in all cases the consent (verbal or nonverbal) of the client
- Only accepted and agreed abbreviations and short form language should be used and which could be readily understood by follow peer health professionals
- However, the UKREMT "highly recommends" that NO abbreviations are used at all
- Amendments must be clearly noted and include a date and reason for the amendment

Further guidance is that the following is considered essential information to include as part of a clinical record.

- Client details (name, address, contact number, date of birth, gender, GP name and practice)
- Initial Referral Information (Self presented, at Event or via 999 System etc or other, copy of referral from another health professional which includes their details, date and status)
- Personal Information as appropriate (height, weight, physical activity status, vocational and recreational activity)
- General Medical condition as relevant (drug history, social history, medical and injury history)
- Presenting condition or goal (subjective information, objective information, analysis, plan)
- Problem List and goals of intervention with appropriate outcomes
- Date and Time of Review Appointment, Discharge or Referral (copies of documents where appropriate)

Other Information

Retention and security of clinical records

Retention and security of clinical records is subject to the legal legislation as listed above, employers may also have relevant protocols and policies in addition to the legal minimum. The following general guidelines should also be observed:

- For adults retain records for 8 years since the last dated record.
- For children (U18) retain records until 25th Birthday or 26th Birthday if child was 17 at the conclusion of treatment.
- Clinical records must be securely stored (paper or electronic) to protect the clients right to confidentiality (this includes protecting: passwords, portable data or other storage

devices, not removing notes from premises or making notes viewable upon social networking forums).
- Confidentiality must also be maintained when disposing of clinical records, it is the view of the UKREMT that all clinical records should be cross shredded and then disposed of in a correct manner.

Deceased Individuals

In the case of deceased individuals' records should be retained according to the timeframe as outlined above. However, it should be considered that the individual's clinical records form part of their estate upon death. As such registrants should only release clinical records to the person who has the authority to manage that estate on behalf of the deceased individual. This may be a legal executor, administrator or beneficiary of the estate. Any applications should be checked for their veracity and legitimacy and should be made under the relevant legislation (Access to Health Records Act (1990) NI (1993))

Student access and contribution to clinical records

In the case of student supervision, the supervisory registrant (mentor) maintains overall responsibility for all aspects of their professional practice, including the management of clinical records. However, there may be times when a student is asked to, or should contribute to a clinical record. In this incidence UKREMT recommend a counter-signatory scheme is employed. This scheme should be explicit in that:

- The counter-signatory must be the clinician responsible for the client's care.
- The meaning of the counter-signatory act must be clearly stated (i.e. observation of students' practices and therefore a signature of authentic, or review of the students stated practice but not directly observed). This determination should obviously be made with regard to the task undertaken by the student and their competency and skills demonstrated.

This document was compiled using guidance and extracts from the Health and Care Professions Council, The Chartered Society of Physiotherapy and the British Association of Prosthetics and Orthotists.

Their intellectual property is acknowledged here within.