Osteopathic practice standards

Safety and quality in practice

'Safety and quality in practice' is the third of four underpinning themes that comprise the new *Osteopathic Practice Standards*, guiding osteopaths to deliver safe, ethical and effective healthcare through evaluation and considered treatment approaches that respect the patient's views, needs and dignity. But what does this mean in practice? Below are nine standards necessary for safe, high-quality patient care:

C1. You must be able to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan.

C2. You must be able to formulate and deliver a justifiable osteopathic treatment plan or an alternative course of action.

C3. Care for your patients and do your best to understand their condition and improve their health.

C4. Be polite and considerate with patients.

C5. Acknowledge your patients' individuality in how you treat them.

C6. Respect your patients' dignity and modesty.

C7. Provide appropriate care and treatment.

C8. Ensure that your patient records are full, accurate and completed promptly.

C9. Act quickly to help patients and keep them from harm.

Patient records – key to safety and quality in practice

Safety and quality are two sides of the same coin – and nowhere is this more evident than in your patient records. Were you to randomly select and review half a dozen sets of your patient notes, what would be your sense of the quality of your practice? Were a colleague to review these self same notes, would their quality rating match yours? Why not try this sometime – it could be illuminating. Be sure to have your patients' consent, though, before sharing their notes with a colleague.

In this issue we consider the basic elements of good record keeping – why accurate, comprehensive and easily understood patient records are a crucial tool in the provision of high-quality care.

As a clinician you recognise that a complete and accurate record of your patient's case history, your examination findings, and the treatment given, represents a vital aide-memoire at later consultations. The record affords you an objective measure of the patient's progress, enabling you to effectively monitor treatment interventions. The patient record helps you structure your thoughts and take appropriate clinical decisions. Conversely, if records are incomplete or inaccurate, future decisions about the patient's care may be wrong or even harmful.

Your patient records also allow you to provide accurate reports and information for third parties, which can be important for your patient. For example, the information you hold on your patient might support their claim for benefits or other social support. They might also provide important medico-legal evidence if your patient makes a claim against a third party or a claim against you. Your records should, therefore, provide a contemporaneous account of the consultation that takes place on a given date. Ensure that they also provide a clear indication of why a diagnosis was arrived at, the clinical reasoning supporting that diagnosis and the justification for the treatment that was given.

Patient records allow you to maintain, respect and protect vital patient information. Their security is paramount and access should only be given to authorised persons. Your patient has specific rights to access the information you hold about them (see page 7 for further information). As outlined in the Dec 2011/Jan 2012 issue of *The Osteopath* magazine, your patient records can support your own professional appraisal, revalidation or clinical audit.

When and how should my records be made?

It is important that you write your patient records contemporaneously – at the time of the event or as soon after the event as practicable. Your writing should be legible and in ink. If you use abbreviations, attach a glossary to help other readers understand your records.

If you make corrections or additions to your notes at a later date, these should be identified and carry the date of entry. Your original note should still be clear to read.

Should I use a template?

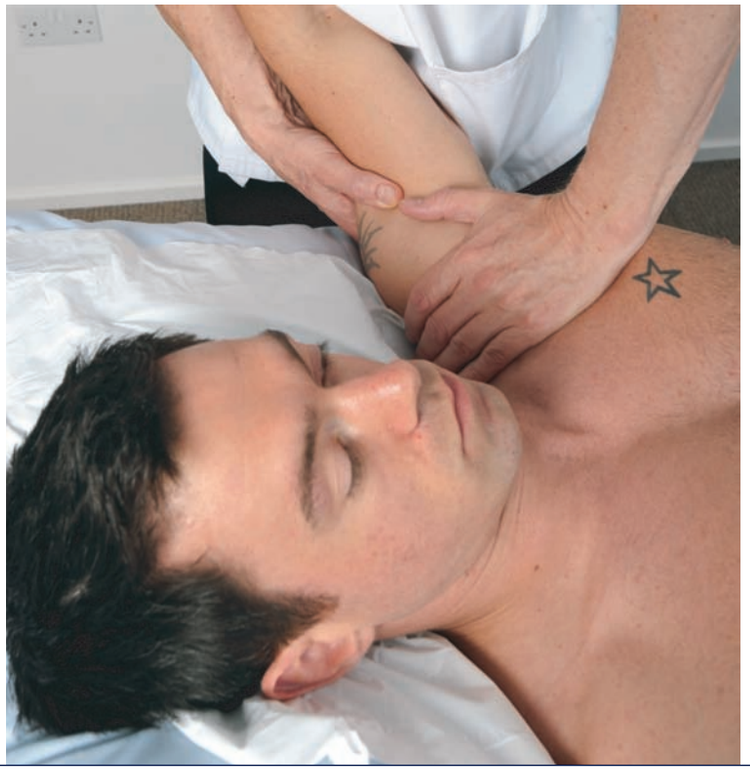
Some osteopaths use a template record card to assist them with the gathering and recording of a detailed case history and examination findings. Others rely on their own particular style of gathering and recording relevant information appropriate to their practice and patient type. It does not matter which approach you take as it is the content of your records that is important, not whether you have used a template.

The British Osteopathic Association (BOA) provides Patient Record Cards for its members. These have been designed to encourage the recording of consent, clinical findings and tests, treatment plan and treatment/advice given. The BOA Record Cards also facilitate the collection of patient data that supports NCOR's Standardised Data Collection that is helping to nationally profile osteopathic practice. There is an accompanying video demonstrating how best to complete various sections of the record cards.

For further information, visit the BOA website (www.osteopathy.org), email: boa@osteopathy.org or call 01582 488 455.

How much information should I record?

Knowing how much information to record can be tricky. Too much information will take an unecessary amount of time out of your day and too little will result in records that are not fit for purpose. The guidance given in the *Osteopathic Practice Standards* (OPS) is the minimum information that should be recorded and you may want to record more.



When deciding how much to record, remind yourself of the purpose of your notes (see page 6). Think about whether the amount of information you have recorded will actually allow your notes to fulfil the various purposes and be understood by you or by another osteopath or health professional possibly even years after you last saw your patient.

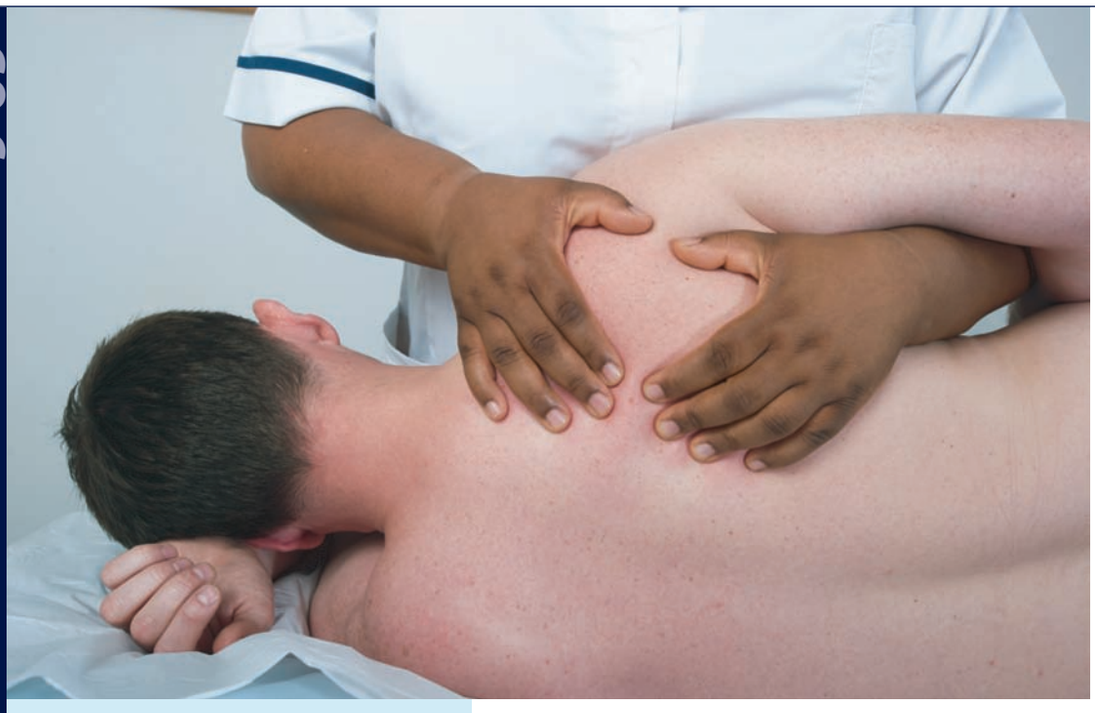
What should you record in your patient records?

The guidance in the OPS explains that you should at least include the following information in your patient records.

- The date of the consultation.
- Your patient's personal details.
- Any problems and symptoms reported by your patient.
- Relevant medical, family and social history.
- Your clinical findings, including negative findings.
- The information and advice you provide, whether this is provided in person or via the telephone.
- A working diagnosis and treatment plan.
- Records of consent, including consent forms.
- The investigation or treatment you undertake and the results.
- Any communication with, about or from your patient.
- Copies of any correspondence, reports, test results, etc. about your patient.
- Clinical response to treatment and treatment outcomes.
- The location of your visit if outside your usual consulting rooms.
- Whether a chaperone was present or not required.
- Whether a student or observer was present.

Ask a colleague to check a sample of your current patient records against this list to see if you are recording the essential information.

We have provided a more detailed checklist on the **o** zone that you could use to assess the contents of your own notes.



What is the purpose of patient records?

Your patient records:

- Facilitate the clinical care of your patient.
- Assist you to structure your thoughts and make appropriate clinical decisions.
- Provide an aide-memoire to you at subsequent consultations.
- Enable you to effectively monitor treatment interventions.
- Allow you to maintain, respect and protect vital patient information.
- Provide sufficient information for colleagues to understand the care you have given to your patient.
- Provide medico-legal evidence (for your patient's claim against a third party or to defend yourself against any claim).
- Support your patient's claims for benefits or other social support.
- Enable you to provide reports and information to third parties (e.g. insurance companies).
- Enable you to meet the requirements of specific legislation on subject access to personal data and health records.
- Support your clinical governance activities.
- Support your professional appraisal and revalidation.

Recording consent

It is important that within your patient records you make a note of the consent you receive from your patient for their examination and/or treatment. It is also important that you record a patient's withdrawal or refusal of consent for any particular procedure.

It may well not be possible for you to record all of the consent received, as this will be given by your patient in various ways throughout the course of their consultation. You will therefore need to make a decision about what elements of your patient's consent you need to record in your notes. As a guide, we would say that it not necessary, for example, to record implied or verbal consent for removing clothing or changing position to allow you access to examine a particular area of the patient's body. You will, however, want to make a note that your patient agreed to specific treatment procedures, such as an HVT. Consent for treatment is likely to be given verbally by your patient, and at some point during the consultation you should make a note in your records that the patient consented to the treatment.

When you have explained the benefits and risks associated with a proposed treatment, you should record the risks that you have discussed with the patient.
Then make a note of the patient's consent if this is provided, or, if not, a note that the patient did not consent. You will want to record enough information to demonstrate (possibly years later) that the patient was advised of the risks and did or did not consent to the treatment.

Standard D6: Respect your patients' rights to privacy and confidentiality

Your patients will entrust you with sensitive information about their health and personal circumstances. They do so in confidence and they have a legitimate expectation that you and any staff will respect their privacy. As mentioned previously, patient records allow you to maintain, respect and protect this vital information.

Do you think your patients would be surprised to learn how you use the information in their records?

- Do you have a receptionist and does s/he have access to and use information in your patients' records?
- Do you share the care of your patients with other colleagues and do your patients understand that their notes might be seen by these colleagues?
- Do you use your patients' records for research, audit or revalidation purposes?
- Are you an associate and do your patients understand that your principal has access to their records?
- What if you stop practising or move to a new area – do your patients know what will happen to their records?

This is an aspect of practice that is a very high priority for your patients. The GOsC's Osteopathic Patient Expectations (OPEn) study highlighted that patients want reassurance from you that the information they provide to you will be kept confidential. The study found that the handling of personal information raised significant concerns among respondents, particularly lapses associated with support staff (receptionists discussing other patients or leaving notes unattended). As a comparison, in terms of confidentiality, patients rated GP practice more highly.

This highlights how important it is for your patients to know who uses and has access to the information held on their records. Your patient should also be given an opportunity to withhold permission for you to share information about them.

The full report of the OPEn study is available on the 'Research' page in the 'Resources' section on the **o** zone.

Disclosing patient records

When you want or need to disclose information about your patient to a third party, you will need to ask your patient for their consent. In that case, you should:

> Explain to the patient the circumstances in which you wish to disclose the information and make sure they understand what you will be disclosing, the person you will be disclosing the information to, the reasons for its disclosure and the likely consequences.

> Allow them to withhold permission if they wish.

> If they agree, ask them to provide their consent in writing or to sign a consent form.

> Advise anyone to whom you disclose information that they must respect the patient's confidentiality.

> Consider whether it is necessary to disclose all the information you hold on the patient. For example, does the recipient need to see the patient's entire medical history, or their address, or other information which identifies them?

Patients' access to their records

It is important that you respect your patients' rights to access the information you hold about them. You are the safekeeper of their information. Patients' rights to access the information you hold about them are contained in the:

> Data Protection Act 1998, which gives living patients (or an authorised representative) the right to access their records.

> Access to Health Records Act 1990, which gives rights of access to deceased patients' records by specified persons.

> Access to Medical Reports Act 1988, which provide specific rights for patients to access reports relating to them that have been written by medical practitioners.

Where and for how long should I keep my patient records?

Patient records should be kept in a secure place and access should be limited to only necessary personnel. If kept electronically, access should be protected by a secure password.

As a minimum, you should keep your patient records for:

> Adult patients – eight years from the date of your patient's last appointment or entry in the record.

> Child patients – until the child's 25th birthday.

Further information is available on the Information Commissioner website (www.ico.gov.uk). The following information is available from the Department of Health website (www.dh.gov.uk):

***Guidance for Access to Health Records Requests,* February 2010.**

***Confidentiality: NHS Code of Practice*, November 2003.**

***Confidentiality: NHS Code of Practice – supplementary guidance: public interest disclosures*, November 2010.**