Briefing

Record keeping

Good records set out the service user's situation at the time of the consultation and inform treatment in the future.

They are a critical component in providing good care to service users. They also assist the service provider if there are ever any queries about the care that has been provided. The HCPC Standards of conduct, performance and ethics require that you:

- keep full, clear, and accurate records for everyone you care for, treat, or provide other services to (standard 10.1)
- keep full, clear, and accurate records for everyone you care for, treat, or provide other services to (standard 10.2)
- keep records secure by protecting them from loss, damage or inappropriate access (standard 10.3).

The recommendations of the College are based around the "SOAP" which is set out in more detail in section 5 of the College of Podiatry's Clinical Standards. The recommended format will help you to structure the records in a logical manner. Greater detail can be found in the guidance provided by the College, but in summary the recommended format is based around recording:-

- The Subjective information from the service user - what is their complaint or presenting problem
- Your Objective findings from your observations which set out your objective findings about the service user's status
- The Action taken to address the service user's presenting problems, recording all the details of the treatment provided, and any treatment that was not agreed to by the service user
- The Plan for the future such as follow up arrangements, advice, safety netting advice etc.

In general terms the College recommends that the records can be handwritten on paper or maintained electronically but they must be:-

- Clear, unambiguous and written in plain English, with minimal use of abbreviations
- Set out in a logical format
- Professional in tone and content – remember the patient has a right to see the records made about them.

Continued over

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Briefing

Record keeping continued

- Accurate
- Dated, timed and signed, or locked if electronic records
- Contemporaneous
- Kept confidential at all times, and stored in a secure manner
- Kept for an appropriate period, which is suggested as:-

  - Adult - 8 years following the last attendance

  - Children – until the patient's 25th birthday (or 26th if they were 17 at the time of the last treatment)

  - Mentally disordered patients – 20 years after their last treatment

- Destroyed to the expected standard, that is incinerated, pulped or shredded under confidential conditions
- Separate to any financial records, such as patient payments which should be kept separately in an anonymous form
- Legible!

Particular care must be taken to record the patient's consent to an examination and any treatment, particularly where there may be uncertainty about the capacity of the service user, when care must be taken to record why you were satisfied they had capacity, or the source of any consent from a family member or carer. In short, if you are unsure you should record how you obtained informed consent in more detail than would usually be required.

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