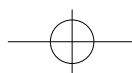
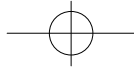


Division of Clinical Psychology

Clinical Psychology and Case Notes: Guidance on Good Practice



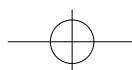
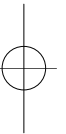
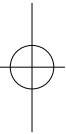


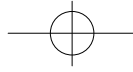
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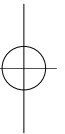
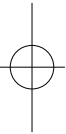
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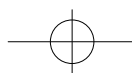


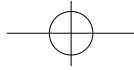
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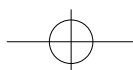
Background to this Guidance

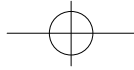
A contentious and continuing issue for many clinical psychologists concerns a broad sweep of problems relating to case notes, medical records, confidentiality, inter-professional communication and associated issues. This booklet is designed to give practising clinical psychologists guidance as to current best practice. As with any document of this type, it cannot cover all possible situations, but it has been written to cover common problems found in routine practice in a variety of settings. It should be noted that whilst this guidance is written primarily for clinical psychologists working in the NHS, the broad principles are applicable to a variety of different work settings and employment contexts, including private practice.

There is a wide range of publications concerning both what are requirements and what might be regarded as good practice. For example, the Division of Clinical Psychology (DCP) has produced two important sets of Guidelines which address explicitly issues of record-keeping and confidentiality. The *Professional Practice Guidelines* (1995) has clear statements of the general principles of access (Section 5) and confidentiality (Section 6). This Guidance does not conflict with any statements made in that document. The *Guidelines for Clinical Psychology Services* (1998) contains some explicit standards on record keeping (Section 2.2), although these latter may not be suitable for all service settings.

There already exist important pieces of legislation which impact on practice such as the Data Protection Act (1998), the Children Act (1989) and the Access to Health Records Act (1990), although this last will be replaced by the Data Protection Act 1998 as from 1 March 2000. Some existing guidance is being revised (e.g. HSC[96]18 – Department of Health Guidance on Confidentiality).

Additionally, the NHSE is producing a variety of strategic initiatives relating to the information needs of the current and future NHS (*Information for Health*, 1998) as well as developing new policies – for example, as a consequence of the Caldicott Report HSC 1999/012 (entitled *Caldicott Guardians*), all NHS organisations were required to have such “guardians” in place by 1 April 1999.





One of the most recent documents is HSC 1999/53 – *For The Record*. This Good Practice document has been issued to ensure that records of all types are:

- properly controlled;
- readily accessible;
- available for use;
- disposed of or archived properly.

HSC 1999/053 supersedes previous guidance relating to the preservation, retention and destruction of NHS records (specifically, circulars HC(89)20 and HSG(94)11).

Principles on which this guidance is based

Any guidance that the DCP issues must be grounded in the BPS *Code of Conduct* (1993) which sets a professional context for practice. This gives a clear statement of principle that psychologists will:

hold the interest and welfare of those in receipt of their services to be paramount at all times.

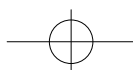
Likewise, on confidentiality, the *Code* states that psychologists will:

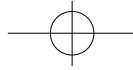
take all possible steps to preserve the confidentiality of information acquired through their professional practice.

However, as with all general statements, there will be exceptions and caveats. There are circumstances under which confidentiality will not be absolute (e.g. where there may be issues of over-riding public or personal safety, child protection). Sometimes the needs of service users will be at variance with professional codes. And there are specific legal contexts in which information may be required to be presented to the courts. However, it should be noted that these latter circumstances should not be regarded as typical of routine practice and each case must be argued on its merits.

Caveat as to applicability

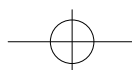
Currently, this guidance applies to England and it is not clear whether Scotland, Wales and Northern Ireland will have similar guidance issued. However, the DCP Guidance should be seen as applying to a clinical psychologist's practice wherever they work.

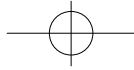




Summary guidelines

- There is a distinction to be made between the formal shared record and records for which the clinical psychologist is primarily responsible.
- You must be clear about the purpose of keeping notes and what functions note-taking and record keeping serve.
- It is essential to good professional practice to keep such notes and records as may be required to inform and guide your work with clients.
- It is a professional obligation to inform the care process by communicating with colleagues involved in the clinical management of clients, although access to such information should be on a strict “need to know” basis.
- The only information that should be available in the shared record is that which directly relates to the care of the individual to whom that record applies.
- Generally, clinical psychologists are expected to keep their own notes of sessions, the results of psychological assessments and client-generated material separate from the shared record.
- All material must be kept in a safe and secure manner with a clearly stated “right of access” procedure.
- Clients and colleagues should be informed as to disclosure policies.
- Unless there are legal issues or matters of over-riding public interest, material about clients must not be disclosed to others without the client’s consent.





Guidance on good practice

What is a record?

In this context a record is:

anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of NHS employees

[HSC 1999/53, Appendix A, para 5.1]

Key points here are that

- all and any material can be part of the record;
- audio and video recordings are included.

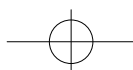
In our view a record is the formal, institutional record held on an individual – usually called the medical record. This may be paper or electronic. Such a record is designed to be a shared document the function of which is to facilitate inter-professional communication to ensure the safe and effective delivery of high quality care.

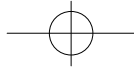
*Records have a number of functions. These may include informing, instructing and interpreting. **Informing** may be letting other members of at team know what you have said to a client. **Instructing** might be communicating a task for an Assistant Psychologist (or other member of the team) to perform on your behalf. **Interpreting** would include summarising the results of an intervention or an assessment procedure. In the view of the DCP, only material which clearly fulfils such functions should be placed in the formal patient record for the purpose of sharing with others.*

It is also important to distinguish between multi-user, multi-access records (as might be found in an MDT) and single-user, single-access notes (perhaps a clinical psychologist working sessionally in a local GP practice). Different procedures will apply in different settings, although confidentiality issues and rights of access apply equally to all records.

Can clinical psychologists keep separate notes?

In general, and with certain exceptions – yes. It is expected that clinical psychologists will make more or less contemporaneous notes of contacts with clients. These are not written for permanence





nor for direct communication with others. They are the raw material on which more formal, public communications will be based. It is not expected that such notes would, under any circumstances, be part of the shared record.

The notes that we might keep may be an *aide-mémoire* of sessions, client-generated diaries, raw data from psychological tests or letters and other material generated by the client to the clinical psychologist. Such material will not be accessible to anyone other than the responsible clinical psychologist and the client, unless there are specific legal issues. However, even in these instances, clinical psychologists are expected to negotiate with lawyers as to the necessity of such information being revealed.

Should clinical psychologists contribute to the shared record?

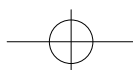
Good practice requires clear communication between professionals, and clinical psychologists are expected to contribute relevant information to help to ensure the delivery of high quality clinical care. What is written in such notes should conform to local institutional rules about annotating records. It is important that the institution has a clear policy as to the function of the record.

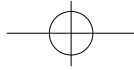
In most acute settings, patients will have a number of investigations including perhaps, X-rays, scans or EEGs. Traditionally these are not filed in the patient's records but are kept separately by the relevant department. What goes in the record is a summary report. In our view, material collected during the course of an interview can be treated similarly.

There may be situations where you want to keep some information private even though you are contributing to the MDT notes. For example, you are seeing the husband of a client in order to both assist in your assessment of her condition and to check out his willingness to support therapeutic change. He is a local GP. In the assessments of both, reference is made to the state of their marriage. In this situation, it might be prudent to be circumspect in what you write in the MDT notes.

What might be the exceptions to contributing to the shared record?

There will be instances when information is given with additional constraints on confidentiality. A client may request that information





is not written down at all, or is not written down in the shared notes, or is not communicated to the referring agent. These are difficult situations both for the clinical psychologist, the client, the team and the employer. The reason for such a request must always be established and the professional obligations of the clinical psychologist must be made clear as to why this might not be possible (e.g. child protection issues, over-riding concerns for personal or public safety). If the clinical psychologist is happy that the client has good reason for making the request and is comfortable that it breaches no other legal, professional or moral obligation, then it would be appropriate to accede to the request. However, in the interests of good inter-professional relationships, it would be advisable to inform other members of the team (if appropriate) that this is happening and that key information will only be made available to the team if this contributes to the best clinical management of the client and after discussion with, and the consent of, the client.

Who can access the record?

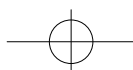
In the case of multi-access records, authorised members of the team may have access, assuming that the client is informed that this is the case. Notes kept by clinical psychologists are not designed for public access and should be treated as such. Material should not be made available to others without the explicit consent of the individual about whom the notes are written. Issues of confidentiality are discussed below.

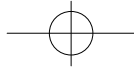
Clients can only see notes made about themselves, and not those made about others (e.g. a husband would not be allowed to see notes written about his wife).

What guarantees can and should be given about confidentiality?

The principle of confidentiality is one to which clinical psychologists pay particular respect. As a general rule we must respect our client's wishes. This is enshrined both the BPS Code of Conduct and in HSC 1999/053 [see para 4 – specifically 4.1 and 4.2]. The reality is somewhat different and contradictory – according to the guidance:

all records are public records [*HSC 1999/53, Appendix A, para 2.1*].





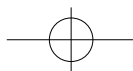
It is likely that the Department of Health will revisit its guidance on confidentiality in the light of the new Data Protection Act and other developments. Access to clinical psychology notes should be restricted to the client and the responsible clinical psychologist, and only revealed to named others with the explicit permission of the client. In those cases where the client may not be able to give "informed" consent (e.g. children, people with severe learning difficulties or cognitive impairments) then such permission must be gained from competent others. Remember that no one can consent on behalf of an adult. If an adult client is unable to give consent you must act in the best interests of the client, taking the views of relatives and carers into account. In cases where your notes (as opposed to the record) are requested, it is important to negotiate with the person making the request exactly what they require and why. This should not be done in an obstructive way, but rather with the aim of protecting the client.

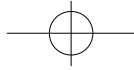
Many clinical psychologists will see members of staff or relatives of staff members as part of their routine practice. This raises issues of control and access. Psychological problems are not the same as medical ones, and the information needed to help solve these problems is often complex and personally sensitive. In our view, such information should be treated with additional safeguards and (unless there are legal or public protection issues) and should not be in the public domain.

Courts can issue a demand (or sub poena) for material relevant to a court hearing and clinical psychologists should generally comply with such requests. Again, it is important to clarify what information is wanted and why, so some discussion with the lawyers might be helpful. However, it is important to remember that this is not everyday practice for most clinical psychologists for the majority of their time. In routine practice, confidentiality should be protected.

Are there special issues with children?

This is complex question and not one that can be answered with a brief general answer. However, it is essential that all clinical psychologists, whether their practice involves working with children or not, familiarise themselves with the relevant parts of the Children Act (1989), or its national equivalent, and local child protection procedures. If there is any doubt or question on the part of the clinical psychologist as to whether they need to act on issues





relating to child protection, they must get advice from an appropriately competent colleague.

How should psychologists' notes be managed?

All notes kept by clinical psychologists should be kept physically secure and access must be restricted. All members of clinical psychology services, whether clinical psychologists or not, must be informed of the importance of maintaining confidentiality, and it is the clinical psychologist's responsibility to ensure that clear policies and practices are in place. As from 1 March 2000, all paper records will be covered by the new Data Protection Act 1998.

Can letters form part of the record?

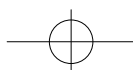
Many clinical psychologists, in the interests of efficiency and speed, may forgo written notes in favour of letters to referring agents. For communicating clinical information these may be an adequate substitute for writing in the record.

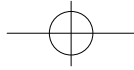
What if a client requests that their notes be destroyed at the end of treatment?

The Circular states clearly:

personal information (e.g. about a patient) processed/kept for any purpose should not be kept for longer than is necessary for that purpose (*HSC 1999/53, Section 2.4*).

This gives some flexibility and you will need to make a professional judgement about how long is "necessary". Under some circumstances you may be asked to destroy, for example, letters that a client wrote as part of your intervention. Likewise, your *aide-mémoire* may be needed for only a short time. It is important to remember that there is a minimum period set down for the retention of records – eight years generally; 20 years in the case of those "mentally disordered persons within the meaning on the mental Health Act (1983)". Likewise, litigation may occur some time after your contact has finished. Any destruction of material must be considered carefully if it is to be carried out before the minimum time period. Any such actions may need to be justified to others, including the client. It is advisable for clinical psychologists to have a clear policy on retention of notes. This guidance can only apply to notes kept by clinical psychologists and does not apply to the shared record.





Information kept for statistical or audit purposes only must be suitably anonymised.

How long should material be retained after a client's death?

Again, there are no hard and fast rules other than those set out in the paragraph above. Judicious use of informed clinical judgement should guide decisions about the relevance of what material should be retained for the minimum period and what should be destroyed.

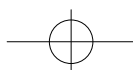
Can clients see their own records and notes?

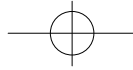
As regards the shared record, this will be covered by your employer's policy which is, in turn, subject to national legislation (e.g. Access to Health Records Act [1990]). In our view, clients should always be able to access information about themselves, although you need to bear in mind that the right to withhold information (where disclosure is likely to cause serious harm to the physical or mental health of the client or any other individual) is set out in the Access to Health Records Act and will be replicated in the Data Protection Act 1998. It should go without saying that clients may only see information about themselves and not about anyone else. You must also remember that information should be recorded legibly and in an understandable manner.

It is good practice to keep notes as if a client was going to ask to read them. However, not all professionals may have the same view, so it is good practice not only to inform the client, but also your colleagues that letters that they write may be seen by the client.

Does audit raise any problems?

There is no reason why it should. All information for audit or statistical purposes must be anonymised. Protecting information about clients takes precedence over data collection, and your duty of confidence applies equally to such anonymised information. Any audit should have a clear specification of what the audit is about, what it aims to achieve and how clients' and patients' interests will be served by, and protected within, the audit. What you may need to be careful about is allowing those without a direct clinical interest in the client access to non-anonymised personal information about a client. Clients should be informed as to how information about them, anonymised or not, may be used.





Audit should not focus on individual clients, but rather the processes which they experience when receiving a service. There can be few - if any - audits which require the auditor to have personal information about clients.

What should you write, when and where?

There are no hard and fast rules. Professional judgement, assisted by guidelines and some modicum of common-sense should mean that most situations are soluble. It may help your thoughts to ask yourself (and your colleagues) “What would you like recorded about you in these notes – and what would you like to be omitted”.

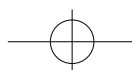
Different work settings will require different solutions. In a good, well-knit CMHT where the team meets regularly and there are formal opportunities to exchange clinical information publicly, your need to write lengthy annotations in the record will be less than when working in a less cohesive team which meets only infrequently. The clinical psychologist working in a primary care setting may be the only professional (other than the GP) with an active interest in the client. Your own notes may be the primary source of information with occasional letters to the referring GP. In a busy acute medical setting where much technical information needs to be communicated because the client is being seen by a number of different specialist teams, what you write in the shared record may need to be brief and circumscribed, whilst your own notes may be more detailed

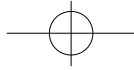
What should we tell clients?

It is recommended that all clinical psychology services have clear, published statements about their record-keeping procedures which are available to clients at the start of any contact. These should be reviewed regularly and be informed by feedback from users. It should be part of routine practice to ask clients about what information they do and do not want to be included in notes, letters or reports.

What about supervision tapes?

Strictly, these still form part of the record. However, we would argue that their function is entirely educational and part of a quality assurance process, and thus has no direct function in the provision of care for a particular client in the same way as other parts of the record. However, such material must be kept with the same care

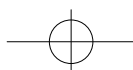
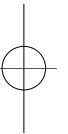
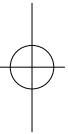


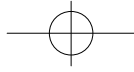


and confidentiality as other material. No such material should be collected or kept without the explicit consent of the client. Clients must be aware of whether they are identifiable (or need to be identified), the purpose of the recording and for how long it will be kept. It is recommended that such material be kept for as long as is necessary for the purpose required: thus, supervision tapes might be kept for the duration of treatment or of a training course if some developmental process were being monitored, or could be erased immediately after the relevant supervision session.

What about activity recording?

Employers have a right to information about the workload of clinical psychologists and it is a professional responsibility to collect such information. However, such information would be in the form of counts and should normally be anonymised. Use of patient-identifiable information for activity recording would need to be fully justified.





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