PSYCHOLOGICAL PRACTICE – RECORD KEEPING GUIDANCE

Additional procedural guidance on Record Keeping for Psychological Practice

Trust standards for record keeping are set out in the body of the Health Records Policy & Procedure (IT06). Further procedural guidance can be found in the trust's "A Guide to Good Record Keeping" available via the trust's intranet or in a paper booklet available from the trust Health Records Manager.

Specific standards on record keeping for psychological practice are set out by the British Psychological Society's Division of Clinical Psychology – (available on the BPS website), also professional standards for note keeping can be found within the codes of practice of professional and regulatory organisations, for example HCPC, RCN, BMA, BABCP.

IN VIEW OF THE MANY AND VARIED RECORD KEEPING SYSTEMS ACROSS OUR TRUST, DIVISIONAL LEAD PSYCHOLOGISTS HAVE JOINTLY RESPONDED TO

FREQUENTLY ASKED QUESTIONS ABOUT RECORD KEEPING FOR PSYCHOLOGICAL THERAPY

1.What is the procedure for storage and archive of written case-notes that exist in addition to electronic records?

In **ANY** service setting, an electronic entry must be made every time a person is seen. In some specialist services e.g HSS, MSU and Rodney Street, EDS, Psychotherapy an additional formal paper file for written psychological therapy notes is opened. Any such additional formal paper records must be written up as a contemporaneous record, then filed within an official trust case-file. These must be stored in a locked filing cabinet, in locked offices, on trust premises (accessed only by designated clinical and administrative staff). They are then archived via the appropriate system, e.g. Alchemy or WINDIP, once the service user is discharged from the psychological therapy. The physical file along with all paper records are then confidentially destroyed .

2.What is the agreed procedure for utilising and disposing of " rough" process notes taken during therapy sessions?

Rough process notes are intended to be an aide memoir for the clinician, but must be regarded as a part of the service user's record, albeit a temporary one. They should be stored for the shortest possible time to allow the clinician to transfer the information into the electronic case records – then paper notes destroyed.
Where rough process notes need to be stored for longer, e.g. until a final report is written, then they should be kept in the service user's formal case file (if there is one) or in a temporary individual file. These must be stored in a locked filing cabinet, in locked offices, on trust premises (accessed only by designated clinical and administrative staff). When the report or therapeutic contact is completed, the

information is transferred to the report and/or electronic record archived via WINDIP/ Alchemy etc. The paper record is then confidentially destroyed .

3.What should be stored where?- for example where do we store consent/confidentiality agreements, therapy contracts, psychometric tests, formulations, reports, sensitive history, letters, drawings, photographs etc…?

Records of confidentiality agreements , consent to treatment and therapeutic contracts should be scanned into the electronic records where they can be accessed by any sanctioned staff involved in the service user's care.

Raw psychometric test data should not be open to general access but stored behind a veil in a restricted section of the electronic database. A summary offering a professional interpretation of raw scores should be in the accessible body of the electronic record.

Working formulations can be considered rough process notes and managed as per guidance in section 2 above. Agreed formulations should be dated and scanned into the electronic records where they can be viewed and of benefit to any sanctioned staff involved in the service user's care.

Formal reports should be in the reports section of the electronic record. If they are psychological reports containing very sensitive information, they should be scanned into restricted section of the electronic record. The existence of any psychological report produced must be referenced in the main body of the electronic record when it has restricted access.

Sensitive information about the service user's history should be scanned into restricted section of the electronic record.

Service user's contributions to records e.g. letters, written narratives diaries, photographs, drawings deemed by the clinician as necessary to retain, should be scanned in to the electronic record as soon as possible, either to the main notes or the restricted access section depending on the sensitivity of content. If retention is not necessary, they should be returned to the service user (e.g. photographs, letters) or confidentially destroyed.

4.Are there any legitimate reasons to take any paper records off trust premises , also what is the protocol for security in those circumstances?

Formal case files should be securely stored at the trust premises where the service user is seen and should not be taken off trust premises by clinical staff. Where they need to be moved e.g. to new estates or for legal purposes there are clear protocols for their transportation**.** (Guidance is available from our Information Governance Lead).

Temporary hand- written notes taken during clinical sessions that occur off trust premises eg home visits, must be anonymous and treated as an aid memoir (as set

out in section2), therefore transferred to the electronic case records within the shortest possible time, then paper notes confidentially destroyed.

5.What is the process for countersigning trainees case records ?

At induction, trainees should be given clear advice about the required standards of record keeping. They are responsible for their own clinical record keeping. A random audit of the quality of record keeping should be undertaken as part of their regular clinical supervision. All letters and reports should be countersigned by the qualified supervising clinician prior to scanning. *Please refer to Section 6 of this Policy and the relevant training documentation within the appropriate Clinical Information Systems in respect of recording countersignatures.*

6.What is the procedure for recording clinical supervision ? What should happen to any content or process notes made by a clinical supervisor?

Clinical supervisors should utilise the electronic supervision notes system.(This can be used separately for both management and clinical supervision). Supervision notes should not refer directly to or identify a particular service user. The electronic supervision record demonstrates attendance (that this governance is in place) also should contain a general outline of the clinical issues discussed. As clinical supervision constitutes a reflective guide, it should not routinely form part of the service user's case record, as it is not a direct intervention or communication to the service user. Supervisees will make reference to the guidance from clinical supervision where it is deemed important to have sought guidance from a senior clinician.

Any paper notes made during supervision should be appropriately transferred to the electronic supervision record, then be confidentially destroyed.

7.What should happen to notes made on flipcharts during group sessions?

Flip chart material from group work does not have to be archived as contemporaneous notes. Relevant information from the group should be summarised for each service user and transferred into their respective notes, as soon as possible. If this is not immediate, flip chart paper should be securely stored in a locked filing cabinet, in locked offices, on trust premises (accessed only by designated clinical staff).

Any record of the structure of group session (e.g. for replication) should be typed up separately.

All flip chart paper records should then be confidentially destroyed.

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