

Patient records

There is a strong link between poor record keeping and successful claims against members for clinical negligence.

Optometrists need to be able to provide evidence that a full eye examination has been carried out and this should be contained within the patient's record card.

A good record should include what the patient reported, the results of the tests performed and what you advised.

Record keeping is crucial for defending claims for clinical negligence and defending patient complaints, either direct or via the GOC, the Optical Consumer Complaints Service or Primary Care Organisations. In addition, under the GOS Terms of Service, there is a contractual obligation imposed on contractors to keep proper records for NHS patients. Likewise, there have been a number of cases before the GOC where a Registrant's record keeping has been considered even in the absence of any complaint relating specifically to the issue of records.

Data Protection Act 1998

The Data Protection Act 1998 requires the consent of patients in order for their records to be kept. At the outset of the examination, the optometrist should seek, obtain and note the patient's consent for a record to be made and retained. The Act also requires the secure retention of the records and provides patients with a right of access to the records (see also page 22).

Disclosure of patient records

Patients are entitled to **a copy** of their records under the Data Protection Act 1998. If a patient asks for a copy of their records, you should ask them to put their request to you in writing and keep this written request on file. You should then photocopy the records and send these to the patient within 40 days of their request. You are entitled to charge a reasonable fee for the disclosure to a maximum of £50 for manual/paper records or a maximum of £10 for electronic records, or up to £50 for a combination of both. You may be requested to explain your records to a patient and you cannot charge for this service.

Before disclosing records to any **third party** you must be satisfied that the patient has provided you with appropriate authority. Requests for disclosure of patient records by the GOC or a patient's solicitors will ordinarily be accompanied by a document, signed by the patient, known as a 'Form of Authority'.

Retention periods

In the case of adult patients, the retention period of records, as recommended by the AOP, is 12 years following the patient's last visit. In the case of children, the AOP recommends the records are retained until the patient's 25th birthday. Even where a

patient has died, their records should be kept for 12 years following the death. The GOS Terms of Service require you to keep all records including voucher audit trails for seven years.

Electronic records

Some practices no longer keep hard copy records and are now storing all records electronically. The content of electronic records should be exactly the same as it is for hard copy records. In addition, practices must ensure a back-up of the records is maintained in order that they may be retrieved if the system crashes.

If you keep electronic records you will need to notify the Information Commissioner under the provisions of the Data Protection Act 1998.

Practitioner access

The records are the property of the practice and, as such, locums and employees should agree access to the records in the event of a claim or complaint once they have left a practice.

Summary

The importance of good record keeping cannot be overestimated. It is almost impossible to mount a defence in the absence of proper records.

Optometrists should bear in mind that the extra two minutes spent on record keeping may save hours of stress in the event of a claim or complaint.

Further advice on the issue of patient records can be obtained from any member of the Legal Services Department.

Tips on record keeping

- You should keep full records of the patient's details, clinical details and dispensing details.
- Records must be legible.
- The optometrist responsible for the examination should be identified on the record card.
- If you have not noted down the results of a test, it is assumed you have not carried it out.
- You should either quantify or describe all your findings. It is no longer considered acceptable practice to use tick marks or the abbreviation 'NAD'.
- Don't forget to make a note of all advice given to the patient and any subsequent action, such as referral.
- Whether you record these details on paper or electronically, the information should be the same.
- When you leave the employment of a practice, agree access to the records in the event of a claim or complaint.