Professional Practice Board

Guidelines on the use of Electronic Health Records

October 2011
Introduction

In 2010 the Society’s Professional Practice Board decided to set up a working party to draft Society guidelines on the use of Electronic Health Records*.

The purpose was to provide guidance to members on various aspects of using such records, and a resource to which members could refer, and which they could use for support.

The report would also set out the Society’s position on various aspects of the use of this technology.

The Working Party

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* The Working Party decided consistently to use the term ‘Electronic Health Record’ (EHR) in place of many synonymous phrases.

For further resources for Practitioner Psychologists please visit: www.bps.org.uk/PPB
1. Electronic Health (EHR) or Clinical Records are increasingly being implemented in the NHS and other organisations to record, store and process health-related information. This Report is concerned primarily with EHRs and systems to manage these, and is driven by existing Society guidance.

2. Data in the individual EHR serves multiple purposes: for recording and communicating user demographic and clinical characteristics, care needs and associated service activities; for local service management; commissioning and contracting; for local and national policy information requirements; and for clinical and other research. It is the intention of the Department of Health (England), with the likelihood of similar policies in the other nations that the content of the record will be available to, and be able to be accessed, added to and commented upon by service users themselves, and by staff with appropriate access rights. Also, with informed consent, and as appropriate and needed, information from the EHR will be shared with others involved in care, including non-NHS agencies, such as Social Care services.

3. EHRs already collect and will contain increasing amounts of information about work carried out by Chartered Psychologists from the Registered disciplines.

4. The introduction of such records poses professional and ethical concerns for users and for many clinicians. Central NHS agencies such as the Department of Health in England and the equivalents in the other nations, as well as professional organisations, devote a substantial amount of effort to addressing and resolving these issues. Web addresses to key resources are provided in Appendix 1.

5. This guidance covers the Society’s view of both general issues and those that may be specific to psychologists. It is the formal advice of the Society to its members and is intended to provide assistance on the professional, ethical, and legal responsibilities of members contributing to these records. The policy statements of the Health Professions Council (HPC), the Society’s Code of Ethics and Conduct and the Society’s Generic Professional Practice Guidelines provide general guidance about record keeping. The HPC as the regulator of the profession has a role in monitoring standards of practice.

What information is stored?

6. Essentially, the purpose of an electronic record is to replace with a single virtual file the contents of numerous pages of paper files relating to service user care. It is the working assumption of many of those designing and managing these systems that all information will, therefore, be entered in this record and any associated original paper-based documentation digitised and then destroyed (for paperless systems). Some systems or organisations may permit the storage of some associated paper-based records. Given the amount of space required and the cost of storing and maintaining paper records (to meet the NHS requirements for such retention), some services may also chose to digitise their record archives.
7. It is clear that a great advantage of an electronic record is that information may be shared quickly amongst appropriate professional staff and other agencies. Indeed, numerous national enquiries have referred to the unfortunate consequences of failure to share information between professionals and/or agencies. At the same time this benefit is one of the most challenging to the clinical process because of the reservations and concerns of services users, NHS staff and others about confidentiality, security and the ease of sharing. Whilst the Society commends the general principle of information sharing in the interests of safe clinical care, it recognises that there will be situations, particularly in mental health services, HIV/AIDS services, general hospital work, and in services for sexually transmitted diseases, in which the psychologist may not wish to store certain information electronically. Or otherwise, unless there are appropriate secure arrangements, with access formally and safely controlled; and even with assurances over security and confidentiality, there may be other concerns about entering any service user identifiable data on electronic or other systems.

8. It is neither feasible nor appropriate for the Society to offer an absolute position on such matters as much will depend on specific circumstances. In coming to their own decisions, psychologists must consider, among other things, Trust policy, the advice of Trust Caldicott Guardians, the Society’s Code of Ethics and Conduct, and relevant Health Professions Council standards alongside weighing the risks of sharing or not sharing, storing and not storing, in relation to the wishes, needs and interests of the individual service user. The Society notes that the very implementation of EHRs has transformed the landscape of record keeping from a private arrangement between a patient and a Health Professional to a contribution to databases used for a variety of purposes.

9. The Society recognises that, as one option, the individual applied psychologist practitioner makes their own judgement that it is in the interests of their client not to proceed in accordance with the official positions and protocols. As with any other clinical professional decision made by practitioners, they may be called upon to account for their action. Appendix 2 provides a pro forma for clarifying if and how to store clinical material outside of the EHR.

**Access, Consent, and ‘Sealed Envelopes’**

10. The Society notes that a wide variety of electronic systems is being used by NHS Organisations, and rules and protocols allowing access to records may be variable, as is the deployment of effective audit trails of individuals accessing clinical notes. Substantial guidance concerning standards relating to these may be found on various official websites (see Appendix 1). Briefly, access to records must be restricted to internal staff and other agencies with a legitimate interest in the care of a patient and a clinically-justifiable need to know, and in line with Trust Caldicott guidelines. Informed user and third party consent must be obtained for the recording and sharing of information. Practitioners should consult national guidelines on information governance (see Appendix 1). There should be facilities for ‘sealing’ or blocking access to information: that is, there should be facilities in the record for sections of content to be sealed by the request of the service user, for clinicians to have such facilities, and for some material to be restricted, particularly in paperless systems.
11. In the absence of such safeguards, commonly the current situation, psychologists should be careful about the information they record on electronic systems. There are, of course, a number of examples of situations in which the NHS already chooses not to record information in this way, such as Sexual Health Clinics, so it might not be appropriate for a Trust to insist that psychological data are so stored.

Specialist Material

12. Some psychological activities involve the use of material which should not be in the public domain and which requires specialist interpretation skills, for instance un-used or completed psychological test forms. Completed forms might be scanned and paper copies destroyed; the Society advises in this case that such scanned copies are not accessible to general clinical or other staff. A useful principle is that such material be restricted to those with a need to know and the competence to interpret whereas reports containing the interpreted information and conclusions may be stored with the other clinical documentation. Again, this is customary practice in a variety of clinical departments.

Process Notes

13. Some psychologists and psychology services, and indeed other staff, have a tradition of keeping notes which are not stored in the primary clinical record (commonly the paper case notes), although they may well have been stored elsewhere, such as in separate, secure psychology files. Such material might include, for example, a service user’s own often highly sensitive personal comments, written observations, completed test forms, drawings and charts, etc.

14. The Society advises that it is not appropriate to have a separate ‘process’ file maintained on a long term basis and that any such material should be kept for specific reasons and for a finite time period and then either destroyed or scanned into the electronic file. This is partly because of clinical risk consequences and also because of potential legal issues. However, not every piece of writing about the service user will necessarily be stored: the decision to do so, or not, is up to the individual clinician, having regard to the relevant specific circumstances and the attendant risks.

15. If there is a facility for service users to request the sealing of sections of their electronic process notes (for instance, because they contain sensitive material), where the client has been informed of the potential risks of closing off access, and the treating psychologist agrees that sealing is appropriate, given their assessment of the risk of doing so, then the issue of requiring a separate paper record need not arise. However, it is not clear at this point in time which systems, if any, have adequate ‘sealing’ facilities accompanied by clear Trust protocols relating to ‘sealing’.

Validation of Notes

16. It is the Society’s position that psychologists (such as Trainees or Assistants) with a first degree are not required to have all their entries into paper or electronic records validated by a fully qualified practitioner. The position of a graduate psychologist is similar to that of a medical trainee who is expected to make records of their activities
within their competence, whilst a Consultant or Supervisor has overall charge of the case. At the same time it is incumbent on Supervisors to ensure that Trainees and Assistants have their notes audited from time to time to ensure that they are adhering to good practices in reporting clinical and related activities. Where countersignature is official policy, the issue should be discussed with the Trust Caldicott Guardian.

**Diagnosis**

17. EHRs unsurprisingly tend to contain or expect information about psychiatric or other medical diagnosis, this being a vital part of many clinical/medical records. In fields such as mental health, the making and use of psychiatric diagnosis by psychologists is controversial and there are qualified practitioners who abjure its use on a number of grounds, stemming from the conceptualisations of such diagnoses, their lack of relevance to psychology practices and ultimately, the competence of non-medical practitioners to make such diagnoses. There are also qualified practitioner psychologists who accept the making of psychiatric diagnosis as a valid and necessary clinical activity, and proceed to do so.

18. It is the Society’s advice that it might well be quite proper for Applied Psychologists to decline to make a psychiatric diagnosis using criteria such as DSM or ICD because they do not deem themselves to be competent to do so. Indeed, doing so might well make a Psychologist vulnerable to legal or disciplinary action.

19. At the same time, the Society recognises that to refuse to use such categories on grounds of theory or principle would be fraught with difficulties in some situations (for instance, an employer may say this is a requirement of the post; such categories may have financial implications, etc.), whilst being justifiable in others, such as being asked to comment on diagnosis as an expert witness. The Society recommends that Applied Psychologists finding themselves in a dilemma of this nature seek advice and/or support from psychologist colleagues, or their Applied Division, on a case by case basis.

20. The issue of entering psychiatric diagnosis in a record is sometimes dealt with by ‘workarounds’, such as requiring the non-psychiatrist to enter an ‘interim’ or otherwise tentative diagnosis. It is the view of the Society that while such workarounds may satisfy Trust requirements, they do not avoid the issue of competence to make such diagnoses and are counterproductive because they constitute a ‘solution’ that is illusory. In some mental health services registered psychologists provide provisional diagnosis based on relevant ICD-10 coding. Provisional diagnoses record patterns of symptoms and do not replace the client-centred assessment required to formulate a treatment plan.

21. The Society recognises that in part the problem is that in mental health information systems, there may not be provision for alternative conceptualisations and that, in any event, there are no alternative, generally accepted, structured datasets to capture psychological perspectives for EHRs.

22. Consequently, the Society recommends that the Practitioner Psychologist Divisions actively pursue the development of datasets relevant to their practice and that such
developments are co-ordinated through the Society in order to provide structured specific and generic datasets for potential inclusion in NHS and Social Care electronic records. Whilst there is no mechanism currently, the Society encourages the development of such in order to ensure that psychological perspectives on the needs of service users, the activities of psychologists and the outcomes of the services they provide, can be instanced in EHRs.

**Training and Psychology Service Implications**

23. At this time of change involving the introduction of novel systems and the emergence of issues associated with the increasing use of EHRs, it is the Society's view that practitioner training programmes, through their formal teaching and placement supervision, should ensure that trainees are familiar not only with the use of the new technologies, but are proficient with the use of electronic records and especially the proper management of information from these records, including the development of competences to deal knowledgeably, considerately, appropriately and effectively with client consent, security, user access rights, confidentiality and information sharing issues that might arise in the course of their clinical work.

24. Psychology Departments and services should likewise ensure that staff have proper training in the use of electronic records as well as an understanding of the associated issues (confidentiality, cross-agency sharing, client access rights, etc.), and that there are clear protocols covering key areas such as those highlighted in this statement. Where protocols are being developed by Psychology Services, it is important for the service to engage with the Trust Caldicott Guardian from the outset especially as the Psychology position may not always be in agreement with that of management.

25. Principles and practices relating to the electronic record and healthcare information should be part of service’s provision for continuing professional development.

**Research Use of EHRs**

26. Unless there are special grounds not to do so, it is normal practice to use anonymised or pseudonymised EHR data in research. It is assumed that all NHS Trusts will adhere to local and national protocols for access to EHR data for research and audit, and that Practitioner Psychologists as well as Trainees adhere to such guidance as well as guidance regarding research issued by the Society. As with all data, whether in electronic or paper form, it is important that quality checks are undertaken before use: existence in an electronic record is no guarantee of accuracy.
Appendix 1

In relation to informed consent for recording and sharing information, reference to the Mental Capacity Act (2005) and subsequent guidance might be required for service users with impaired capacity.

**Generic Professional Practice Guidelines**

**Code of Ethics and Conduct**
www.bps.org.uk/the-society/code-of-conduct/code-of-conduct_home.cfm

**Health Professions Council Standard of Conduct and Ethics**
www.hpcuk.org/aboutregistration/standards/standardsofconductperformanceandethics/index.asp

**National Guidance on Information Governance (England)**
www.connectingforhealth.nhs.uk/systemsandservices/infogov

See other resources on Home page.
Appendix 2

Managing Confidentiality within Electronic Health Records

The following questions should help clarify local arrangements; they should be worked through with local management with the advice of others in Information Governance and if necessary the Caldicott Guardian.

1. Does the local service have an overarching policy about this reflecting the nature of the service and clinical risk issue (as might be the case in a forensic setting)?

2. If there is no such a policy, what material may be stored outside of open access, with a summary contained in the main record?
   ○ Detailed process notes from psychological therapy
   ○ Trainee process notes
   ○ Psychometric test material
   ○ Sensitive material
   ○ Where client requests this

3. Who does the psychologist check with locally about this if this requires clarification?

4. What are the options for storing such material outside of the main record?
   ○ Password protect
   ○ Sealed envelopes
   ○ Paper record
   ○ Other

5. If paper records are kept, where are they stored and who has the access details in case the clinician is not available?

6. If documents are password protected who has a record of the password and is able to access the document if the clinician is not available?
Appendix 3 – Definitions

● **Service user** – the individual subject of a health or social care record.

● **Electronic Health Record (EHRs)** – a record relating to an individual service user commonly detailing NHS number, other demographic information and information about the clinical features, activities and outcomes relating to that individual held on a local secondary or tertiary care NHS Trust or special service (e.g. Special Hospital) information system. Trusts may implement systems aimed at paperless records or may allow some associated records to be retained on paper.

● **Primary Care Record (PCRs)** – details of the service user’s care held by their General Practitioner. These details may be either held electronically or on paper or both.

● **Primary Care Psychological Care Records (e.g. IAPT)** – newer records such as IAPTUS which may or may not reside in Primary Care.

● **Summary Care Record (SCRs)** – contains selected data from the Primary Care Record intended for controlled access beyond the primary care practice in special circumstances, for instance to provide emergency care clinicians with information about service user clinical needs and circumstances immediately relevant to their emergency care.

● **Electronic Health Records** – collective term encompassing EHRs, PCRs, and SCRs.

● **Electronic Health Record (Software) Systems** – computer systems designed to capture, store and process individual service user health-related data. These can capture data from a variety of devices including desktop, portable, and handheld computers of various types and mobile phones.

● **Digitised Records** – these may be either scanned-in copies of the clinical notes relating to a service user or documents such as letters, reports, drawings, completed psychological or other test forms, associated with the EHR. Digitised records are commonly stored as images whose contents, unlike those of the EHR, may therefore be more difficult to search and process.

● **Process Notes** – a detailed, sometimes speculative, record of clinical sessions.

● **Anonymised** data about an individual are data from which the identity of the individual cannot be determined.

● **Pseudonymised** data are where the normal personal identifiers have been replaced by artificially-created identifiers, thereby concealing the identity of the individual and where the links between the artificial and normal identifiers are stored separately and securely.