HealthCare Records Policy

BRITISH ASSOCIATION FOR PERFORMING ARTS MEDICINE

CARING FOR PERFORMERS' HEALTH

Category	Policy
Summary	This document provides a summary of recommendations for BAPAM staff and clinicians on best practice for producing BAPAM healthcare records.
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Approval date/ via	Medical Committee
Distribution	BAPAM clinicians e-mail & online forum Staff e-mail and meetings Public website
Related documents	*Access to Medical Records Policy* *Audiovisual Recordings Policy* *Clinical Governance Policy* *Data Protection Policy* *Patient Contract*
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Further information	*Standards for clinical structure & Content of Patient Records, July 2013.* Health & Social Care Information Centre, Academy of Medical Royal Colleges.

HEALTHCARE RECORDS POLICY

1. Background and Purpose

BAPAM is responsible for healthcare records created in the course of providing advice and care to performers. BAPAM personnel (staff, clinicians and volunteers) are responsible for the records that they create, and any records created by are subject to both legal and professional obligations.

Whilst BAPAM is not a statutory healthcare provider, the use of healthcare records and access to them is governed by the Data Protection Act 1998 ('the Act') and GDPR 2018. BAPAM's policies and procedures in relation to the Act our outlined in our detailed *Data Protection* policy. As an organisation registered with the Care Quality Commission (CQC), BAPAM's healthcare records are also subject to CQC inspection and we have opted to follow guidance outlined in the Access to Health Records Act 1990 and the NHS Code of Practice: Records management part 1 & 2 2006.

The purpose of this document is to provide a summary of recommendations for BAPAM staff and clinicians on best practice for producing BAPAM healthcare records.

2. Definitions

A ***healthcare record*** for the purposes of the Data Protection Act is one which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection with the care of that individual. (More details are provided in the *Data Protection Policy*).

At BAPAM, a healthcare record is anything that contains information that has been created or gathered when providing advice and care to a performer registered with BAPAM.

It includes the following information which may be produced by a BAPAM Clinician or member of the BAPAM Clinics Team:

- Electronic database record (registration information etc)
- Handwritten or computer produced notes produced by a health professional or member of the BAPAM Team
- Correspondence relating to clinical information, including handwritten or computer produced referral letters
- Imaging, diagrams, audiovisual recordings etc relating to a patient's healthcare

Note that, according to this definition, BAPAM Clinician referral letters are part of the healthcare record. However, they are not considered subject to *Access to Medical Records* requests where they are routinely issued to patients as part of their care at BAPAM – see policy.

3. Recommendations

BAPAM requires that the following must be observed when creating or updating BAPAM patient records:

- All entries must be legible

- All entries must be in blue or black ink
- Each page must include the name of the patient
- All entries must be timed, dated, signed and attributable to the author, including job title/role
- Records must be complete and accurate such that clinical colleagues can make critical judgements with the benefit of all the relevant information.
- Detailed observation of the facts must be recorded precisely and objectively.
- Any amendments to a record must include the name of the BAPAM clinician or Team member responsible and should be dated
- Any errors or anomalies that are identified when using a healthcare record should be brought to the attention of the Director, who will complete an incident form
- Any reports or results must be correctly filed
- A clinical audit will be undertaken every 18 months to assess adherence to these standards

4. BAPAM CLINIC RECORD – Template details

i) FRONT SHEET: created by BAPAM Clinics Team member at registration and prior to patient clinic visit. This is printed from the CRM.
Registration: Patient Demographics

Patient name	Full Name of patient
DOB	Date of birth of patient
Address	Patient usual place of residence
Patient telephone no	Telephone contact details of the person
Patient email address	Email address of patient
Gender	As the patient wishes to portray themselves
Ethnicity	As the patient wishes to portray themselves
Disability	As the patient wishes to portray themselves
Initial Contact Date	Date patient initially made contact with BAPAM
Returning Patient Date	Returning Date if previously seen by BAPAM
Type of Problem	E.g. voice, MSK, performance anxiety
Patient Notes	Brief description of patients problem as reported to BAPAM
NHS GP	Patient seen NHS GP with same problem?
NHS Other	Patient seen other NHS specialist with same problem?
Private Healthcare Practitioner	Patient seen Private practitioner with same problem?
MSHS Eligible	Eligible for HMUK Health Scheme Funding
Special Access requirements	Any adaptions needed for clinic visit

Employment type	Professional / semi-pro / student
Employment status	Freelance etc
GP Name	Name of General practitioner
GP Address	Address of General Practitioner
Branch of performing arts	Eg instrumentalist, actor, circus performer
Type of instrument	e.g. piano

ii) BAPAM CLINIC NOTES created by clinician during consultation in clinic

NB At top of <u>every</u> page of BAPAM clinic note, there must be a record of the clinician's name, patient's name, date of consultation, and clinic location

Consultation Information

Patient Name	The full name of the patient
DOB	Date of Birth of the patient
Clinician Name	Name of clinician - legible
Clinician Speciality	Medical Dr / physio / Osteopath
Time patient seen	Time consultation actually started
Time consultation finished	Time consultation actually finished
Any healthcare professional present	Eg. Student / observer etc
Person accompanying the patient	Eg. No-one / relative / friend / carer

Clinical Content

Presenting complaint (s)	A list and description of health problems and issues experienced by the patient which have resulted in their clinic visit. Including: *- Site of complaint* *- static/improving/deteriorating* *- exacerbating factors* *- relieving factors* *-24 hour cycle*
Performance practice	Patient's branch of performing arts, instrument. Including: *- routine/rehearsal* *- work environment* *- FT/PT/Student*
History of each presenting complaint	Any history directly related to the development and characteristics of each complaint
Impact of complaint on performance	Specific impact of illness on performing arts e.g. practice regime / lifestyle / performance including any modifying steps performer has had to take

Relevant Past Medical History	Patients significant medical, surgical and mental health history
Medications	Current medications taken; name, form, route administered, dose, frequency, reason for being given if known
Drug Allergies	Medication and a description of allergic / adverse reaction experienced by the patient
Other Allergies	
Family History	Relevant family history
Emotional/Psychological State and History:	
Social history and lifestyle:	Including, where relevant: *Household composition* *Activity level/exercise,* *sexual habits,* *recreational drug use,* *Smoking hx* *Alcohol hx* *Travel hx* *Occupational hx* *Educational hx*
Review of Systems	Clinical review of systems – general symptoms pertinent to presenting complaint
Examination	Focused examination relevant to patients underlying complaint – with positive and relevant negative findings
Investigations & Results	Any previous investigations with results (if not already recorded in HPCx)
Diagnosis	Provisional or confirmed diagnosis
Plan/Advice given	Planned investigations (if any) Treatment Patient actions Record of advice given (verbal or written) and notes on patient preferences

Follow -up	Planned follow – up
Safeguarding concerns	Any safeguarding concerns noted, actions taken
Summary/referral letter	Discharge letter written to GP and/or patient
Clinician Signature or Stamp	Notes signed at end by clinician

Version 1.0 = for Medical Committee 21 July 2016 (R Whiticar, D Charnock)
Version 1.1 = 24 October 2016 (D Charnock)
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