Record Keeping

The British Dietetic Association (BDA) and Sports and Exercise Register (SENR) proudly represent the dietetic workforce, and accredited professionals within the speciality of sports and exercise nutrition, respectively. Registrants have a professional and legal obligation to keep an accurate record of their interaction with service users or clients.

This record keeping guidance is intended for use by all members of the BDA and SENR, who include registered dietitians, dietetic support workers/assistants, student members and sports nutritionists. These guidelines apply to all roles and settings in which they work.

This guidance document comes at a time when there is huge variability in terms of the use of paper or digital records across the profession. Therefore, it has been written in such a way as to provide members of the BDA and SENR registrants with the principles that underpin good record keeping no matter what format their records are in or where they are employed.

This guidance is necessarily broad and cannot provide definitive answers to every situation a member/registrant may encounter. Nor does it provide a rigid framework for an auditable standard. It does, however, provide the principles that will guide dietitians, the wider dietetic workforce and sports and exercise nutritionists in making, protecting and sharing of clinical records and any other personal data that they hold. These guidelines should be used alongside any record keeping guidelines set out by your employer.

Primary Purpose	Secondary Purpose
Underpin day-to-day service and delivery of care	Assist in audit
Help structure thoughts to aid decision-making	Provide data for service development
Be an accurate account of intervention and care planning	Provide data for research
Communicate between professionals	Provide data for population monitoring
Act to aid memory	Provide evidence for claims complaints, inquests, inquiries, disciplinary hearings and other legal proceedings.

Traditionally, health records have been thought of as having both primary and secondary purposes. As the digital world evolves around us, and service users increasingly expect data from their record to be used (anonymously) for service reporting and clinical research to enhance both the quality and diversity of service provision. The boundary between what is considered a primary and secondary purpose is becoming blurred.

Making the Record

Records are fundamental to safe and effective service provision.

Protecting the Record

All record keeping is governed by the European Union General Data Protection Regulations (GDPR).

Sharing the Record

Your duty to share information in line with GDPR, is as important as your duty to maintain patient confidentiality.

Making the Record

Being able to make and maintain records is a requirement of HCPC and SENR Code of Professional Conduct and all those who provide direct care are required to keep records. You have a duty to communicate fully and effectively with colleagues to ensure that they have all the necessary information to provide safe and effective care.

- You should complete the record as soon as possible after the consultation or event and certainly within timescales stipulated in local policies. This should normally be within the working day.

  Notes not completed in timely fashion case study resulting in missing information & substandard care/ safety risk (fictional)

- You should communicate clearly and concisely in an appropriate style so that your message is understood.

- You must write in a way that the person you are caring for could understand your entry.

- Records should be structured in a way that is conducive to capturing relevant information efficiently and in a way that information is accessible when needed.

  CLICK HERE - RECORD TEMPLATE - *A record template which can guide you to structure your notes and improve them*

- You should embrace information standards, realising that the record is only part of the health and social care jigsaw. You should proactively seek to implement and adopt existing standard templates and terminology that enable consistent recording of quality data across systems and organisational boundaries.

  CLICK HERE - The Professional Records Standards Body (PRSB) - *Develops national standards for the structure and content of health and social care records.*

- Where possible the BDA's SNOMED (Systematized Nomenclature of Medicine) subsets should be incorporated into electronic record templates to promote consistent practice across the profession. (Not applicable to SENR Registrants).

- You should avoid approximations, jargon, meaningless phrases, irrelevant speculation, bias.

- The BDA and SENR does not have a definitive list of abbreviations. Use of abbreviations varies nationally, locally and even within different departments of the same organisation, it is good practice to check if your organisation has a ratified list of acceptable abbreviations or acronyms and adhere to it.

- If you are recording that a decision has been made you should record how those decisions were made; including the information that lead to that the decision, to include who was involved in the decision-making process.

- If your records are hand-written, they must be legible, written in permanent ink and be legible when photocopied or scanned. All hand-written records must be transferred to a secure electronic format for retention (note that this transfer may also include relevant information from email, SMS, WhatsApp, or other channels of communication).

- You should adhere to local policy regarding signing and dating record entries including signing in and out of computers using your own unique ID. You are responsible for your records.

- The decision to delegate tasks (e.g. completing a client record) and the subsequent countersigning of said record must be a reasoned and individual decision. If there is no local policy, the ultimate responsibility about when and how delegation and countersigning take place lies with the supervising dietitian or sports and exercise nutritionist. All student entries into the record must be countersigned by the supervisor.

- You should check your record for mistakes

- If you need to alter a record you must adhere to local policy and ensure that all changes are clear, non ambiguous and signed and dated (electronically or by hand). Electronic patient recording systems should have a built-in audit trail that meets ISO standard ISO 27789:2013.

- Records should be audited regularly, and action taken to ensure best practice, patient safety and quality of care.

  CLICK HERE - AUDIT TOOLS *The BDA has developed audit tools to help you to audit your own notes*

Protecting the Record

A health or care record is any record of information relating to someone's physical or mental health that has been made by (or on behalf of) a health professional. Such records are extremely personal and sensitive.

A record is comprised of all data relating to an identifiable individual including but not limited to written records, emails, letters, diaries, photos, scans and monitoring charts. From paper to hard drives to the cloud, client data may be stored in a variety of platforms.

All personal data in the UK is governed by the 2018 Data Protection Act and EU General Data Protection Regulations (GDPR) 2018. There are 6 principles of the GDPR which must be adhered to. GDPR goes beyond the health care record and is applicable in all aspects of work where the processing of data that could personally identify an individual occurs.

Therefore, GDPR covers the whole business. For example, application would include but is not limited to personal data held as part of recruitment tasks, employment, running events and marketing services.

Principles of GDPR
1. Processing should be **lawful, fair** and **transparent**
2. Personal data shall be collected for **specified**, **explicit** and **legitimate** purposes
3. Personal data must be **adequate**, **relevant** and **limited to what is necessary**
4. Personal data shall be **accurate** and **kept up to date**
5. Personal data shall be kept for **no longer than is necessary**
6. There must be **appropriate security** in place in respect of the personal data

- You must recognise your duty as a data processor or a data controller and abide by the regulations stipulated in the GDPR.

- Every organisation and sole trader who processes personal data must register with the Information Commissioners Office (ICO). If you work for an organisation (such as an NHS Trust, health board or private company), your organisation must be registered. If you provide patient care as a freelancer you must register yourself via the ICO website.

  CLICK HERE - REGISTER *Via the Information Commissioners Office (ICO) website*

- If you are employed, you must acquaint yourself with local systems and adhere to policies and procedures that safeguard records. This may include possessing a smartcard, using electronic passwords, filing and storing records securely.

- If you are a freelancer you must map the flow of personal data through your business, identify and mitigate risks and have your own policy on how you process personal data. You should create a privacy notice and ensure that clients and prospective clients understand what data you need and how you will process it. Consent for sharing can be obtained via a privacy notice.

- You should only access the records of patients and clients for legitimate purposes and should never access records for yourself, family or friends.

- You should take all reasonable steps to ensure that records are stored securely to prevent unauthorised access or loss.

  Client records not stored securely case study resulting in irretrievable loss of information and breach of the GDPR (fictional)

- You should not hold conversations regarding the content of records in public and should ensure that the content of records in not made visible on trolleys, computer screens, phones, or desks.

- You should report issues of missing/ accessing records to your line manager if you are employed. If you are a private practitioner, you must keep a record of any data protection breaches and follow ICO guidance if they occur. This may involve informing the ICO of the breach.

- Do not keep records for any longer than is necessary. There are legal requirements for how long health records should be kept.

  CLICK HERE - *Department of Health's record retention policy*

  CLICK HERE -*Scottish Government records management: code of practice*

  CLICK HERE - *Welsh Non-Clinical and Clinical Record Schedule*

  CLICK HERE – *Northern Ireland Department of Health, Social Services and Public Safety. Good management, good records - health acute and community*

Sharing the Record

The duty to share information can be as important as the duty to protect client confidentiality. You have a legal duty to disclose confidential information if there is risk of harm to the service user, yourself or others. This may mean sharing information without consent. You should discuss your scenario with your trust's Caldicott guardian if working in the NHS, or Institute Director if employed in the Institutes of Sport.

- You must gain consent and record that you have obtained consent to share data about a patient. If you are employed you must adhere to local policies. If you are a freelancer you should include a privacy statement as part of your data processing policy.
- You should understand how any information you share is going to be used and be able to articulate this to the patient, or client.
- You should check that systems for sharing records are secure such as email, fax, letter.
- You should take care when using social media that information is not shared inadvertently.

The following case studies are tailored to sports and exercise nutrition scenarios to provide SENR members with relevant examples;

Case Study 1 – The Importance of Record Keeping

John, a performance nutritionist, works part time and always has very busy clinics. He previously worked in another industry before retraining as a performance nutritionist and has not been accustomed to keeping detailed notes on clients, although is aware that he ought to do this from his professional training. At the end of each clinic, John barely has time to write up his hand written notes, and doesn't get around to transferring these notes to the electronic record keeping system. A few months into the job, a complaint is made by an athlete about some dietary advice that was given by John. An investigation into this complaint is carried out and the electronic record keeping system is accessed during the investigation to look at Johns' notes. No notes could be found and John had lost the notebook that he had jotted his treatment plan for the athlete. The athlete claimed that the dietary advice had a negative effect of their performance. There was no rationale or reasoning for the advice given by John documented, or notes on how the athlete was followed up. How could John's advice be justified and argued to be reasonable if no notes were available?

How could this have been prevented?

1. If John was struggling to keep up with his record keeping, he could have notified his manager to say he needs more time and perhaps he could be have been paid some extra time to do this.
2. If additional time was not an option, the number of athletes booked into the clinic could have been reduced so he had adequate time to complete his notes.

Failure to maintain adequate records was a Code of Conduct breach and lead to the complaint by the athlete being upheld as no information was available to support the practitioner.

Case Study 2 – The Importance of Timely Record Keeping

Melissa is a performance sports nutritionist who works as part of a high-performance multidisciplinary team within a sports institute. On a Friday, she does her sports nutrition clinic which finishes at 5pm. During the last hour of the day, she usually writes up her notes and completes any letters or handover she requires. One Friday afternoon, she got a call from her colleague and spent a good 40 minutes discussing a particular athletes' case. This meant she only had 20 minutes to get everything done and she wanted to leave at 5pm on the dot to get to her gym class. She decided that on this one occasion, it would be ok to finish the last couple of records on Monday morning.

After a busy weekend, she arrived at the office and found the unfinished notes from Friday. For one of the athletes, a road cyclist, she couldn't remember if she had discussed the use of CBD oil supplementation as a means of improving recovery during a forthcoming three-day stage race at the request of the athlete. She decided she must have done, as she usually does in response to supplementation queries. So, she wrote in the notes she had completed this activity with the athlete.

The athlete competed in the stage race the following weekend and was subsequently informed by WADA of an adverse analytical finding for THC following a routine doping control.

This was preventable if the records were completed in a timely fashion.

What could & would have been different?

1. Melissa could have cut the call short with her colleague explaining she needed to use her time to write up notes, or prioritise clinic notes over letters in the 20 minutes she had, or left a little later for the gym once she had completed her notes.

2. If Melissa had written up her notes that day, she would have remembered that the athlete had arrived late for the consultation and she did not have time to discuss the use of the new supplement that the athlete had purchased.

3. On the athletes' second visit to see Melissa, she would have seen her reminder to discuss the supplement at this session. She would have ensured this was completed as per her previous record keeping informed her. The athlete would have been informed of the risk of THC contamination in the supplement and would have been advised against its' use in the absence of reliable batch testing for the substance.

Failure to comply with timely record keeping led to substandard care, a risk to the athlete's competitive career and the reputation and standards of the institute – all of which would have been preventable if the notes were completed in a timely fashion.

Case Study 3 – The Importance of Secure Record Keeping

Ben is a self-employed, freelance performance sports nutritionist. He conducts consultations with his client base in a wide variety of settings, from home, gym, club, track, and remote online scenarios. Investing in his business, he bought a dedicated laptop for input and storage of client records in these settings. Conscious of security, Ben ensured that the laptop was encrypted and had good insurance cover.

Ben is a successful practitioner with a large client base. Over a twelve-month period, extensive client records were saved to the laptop's hard drive. Unfortunately, after a weekend away visiting family, Ben returned to his rental accommodation to find evidence of a break-in. A number of electronic items were missing, including his business laptop. Ben reported the break-in to the police and his insurance company. Whilst he received some monetary compensation from his insurance policy, none of the items were recovered.

Ben had entrusted storage of his client records to the laptop's hard drive, exclusively. He had neglected to back-up the records to an external or secure cloud-based source of data storage, at any point. The loss of the laptop meant a complete loss of information crucial to the effective management and support of his client base, and a serious compromise to client confidentially and data protection.

This was preventable if the records were stored securely.

What could & would have been different?

1. Ben should have installed and used secure cloud-based storage on his device for the purpose of record keeping.

2. Utilisation of such storage facilities would have meant that loss, or damage to hardware, would not compromise the security of invaluable and confidential records.

Failure to comply with secure record keeping led to irreparable damage to Ben's work and reputation as a freelance practitioner and a serious breach of client confidentiality and the GDPR. This could have been avoided if Ben had given adequate consideration to secure record keeping.

Example: Audit Tool

1. Month of Audit:

2. Performance Nutrition Team:

3. Audited Sports Nutritionist:

5. Type of Record Audited:

Athlete Medical & Nutritional History ☐

Athlete Medical & Nutritional Electronic Record ☐

Athlete Medical & Nutritional Paper Notes ☐

Other (please state):

6. For all sports nutrition entries, have the following been documented for each entry:

	Yes	No	N/A
Athlete/Client name at the top of page	☐	☐	☐
Entry dated	☐	☐	☐
Entry timed	☐	☐	☐
Errors have a single line through, signed and dated	☐	☐	☐
Has correction fluid been used	☐	☐	☐

Spaces before the sports nutrition entry have been scored through	☐	☐	☐
Are all abbreviations recognised in policy	☐	☐	☐
Name of sports nutritionist printed on first entry	☐	☐	☐

	Yes	No	N/A
Signature of sports nutritionist	☐	☐	☐
Designation of sports nutritionist	☐	☐	☐
Student / junior grades have been countersigned	☐	☐	☐
Bleep/contact number has been given	☐	☐	☐
Athlete/clients records are contemporaneous	☐	☐	☐

7. Please indicate level of legibility:

Electronic record	☐
Legible (all words clear)	☐
Less than 5 illegible words	☐
Some words illegible (less than 50%)	☐
Most words illegible (more than 50%)	☐
Illegible (most or all words impossible to identify)	☐

8. In the assessment; is there clear evidence of:

	Yes	No	N/A
Referral reason	☐	☐	☐
Referral source	☐	☐	☐
Presenting requirement / complaint	☐	☐	☐
Past medical history	☐	☐	☐
Current medical treatment	☐	☐	☐
Contradictions / precautions / allergies	☐	☐	☐
Relevant investigations	☐	☐	☐
Biochemistry / clinical observations	☐	☐	☐
Clinical diagnosis	☐	☐	☐
Assessment	☐	☐	☐
Nutrition and dietetic diagnosis	☐	☐	☐
Strategy	☐	☐	☐
Implementing	☐	☐	☐
Review date	☐	☐	☐

9. Have goals or outcomes of nutritional support been clearly stated? E.g. meet energy requirements / meet protein requirements / increase lean body mass

Yes ☐ No ☐

10. Is there clear evidence of a strategy delivered for this support? E.g. to help attain recommended daily energy intake, examples of foods, portion sizes, and frequency of intake were provided / educated on protein content of foods and provided serving size recommendations with suggestions for timing of intake

Yes ☐ No ☐

a. Has the strategy been agreed with the athlete/client and is there evidence of their involvement with the strategy:

Yes ☐ No ☐ Plan given in best interest ☐

12. Is there clear evidence of the sharing of information for this support? E.g. consultation with coaching / physio / strength and conditioning teams

Yes ☐ No ☐ Not required ☐

13. Is there any evidence of written information (e.g. email support, diet sheet, leaflet, booklets) given to the athlete/client about their nutritional intake, at any point throughout the period of support?

Yes ☐ No ☐ Not required ☐

14. Has a review plan been documented?

Yes ☐ No ☐