DOLAN'S PODIATRY

Record Keeping and Clinical Documentation Policy

Policy owner: Michelle Dolan, HCPC Registered Chiropodist/Podiatrist
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1. Purpose

Accurate, complete and secure clinical records are essential for safe, effective and continuous patient care. Records must provide a clear account of the patient's presentation, assessment, treatment, advice and any follow-up arrangements.

This policy applies to records created during appointments at the main clinic, pop-up clinics, care homes and other locations where podiatry services are provided.

2. Information recorded

Records will contain information relevant to the patient's care, as appropriate, including:

- Patient identification and contact details.
- Presenting complaint and relevant medical history.
- Medication, allergies and relevant risk factors.
- Clinical examination findings, including relevant vascular, neurological, skin and nail assessments.
- Clinical assessment and diagnosis or professional impression.
- Treatment provided, including products or materials used where relevant.
- Advice, aftercare instructions and any agreed treatment plan.
- Consent to assessment and treatment.
- Clinical photographs, where appropriate.
- Referrals, communications with other professionals and follow-up arrangements.
- Relevant incidents, safeguarding concerns or complaints.

Only information that is relevant and necessary for the purpose should be recorded.

3. Standards for entries

Clinical records must be:

- Accurate, clear and factual.
- Relevant to the patient's care.

- Made as soon as reasonably practicable after the appointment or event.
- Dated and attributable to the person making the entry.
- Understandable to another appropriate healthcare professional.
- Stored securely and handled confidentially.

Where appropriate, records should distinguish between information reported by the patient, findings observed during examination and the practitioner's professional opinion.

4. Corrections and amendments

Records must not be altered in a way that hides or misrepresents the original entry.

For paper records, errors should be corrected in a way that leaves the original entry readable, with the correction dated and initialled where appropriate.

Electronic records should be amended using the system's available correction or audit-trail functions wherever possible.

5. Electronic and paper records

Electronic records must be stored in an appropriately secure system. Passwords must not be shared, and patient information must not be stored unnecessarily on personal devices or transmitted through unsecured channels.

Paper records must be kept securely and must not be left unattended in public areas, vehicles or venues where unauthorised people could access them.

Confidential waste must be disposed of securely. Electronic information must be deleted or destroyed securely when retention is no longer required.

6. Clinical photographs

Clinical photographs may be taken where they are useful for assessment, treatment planning, monitoring progress or documenting a clinical finding.

Photographs must be stored securely as part of the clinical record and handled confidentially. Separate, explicit permission must be obtained before using identifiable patient photographs for advertising, social media, teaching, publication or other non-clinical purposes.

7. Confidentiality and sharing information

Patient information will only be accessed or shared where there is an appropriate lawful basis and a genuine professional need.

Information may be shared with relevant healthcare professionals, safeguarding services or other appropriate bodies where necessary for care, required by law, or justified to protect someone from serious harm.

Only relevant and necessary information should be shared, and disclosures should be documented where appropriate.

8. Retention and disposal

Clinical records will be retained in accordance with applicable legal, professional, insurance and practice requirements. Records will not be kept indefinitely without a valid reason.

When records are no longer required, they will be securely destroyed or deleted. Where there is uncertainty about the appropriate retention period, relevant professional or legal advice will be sought before records are disposed of.

9. Loss, unauthorised access or disclosure

Any suspected loss, unauthorised access or disclosure of patient information must be addressed promptly.

I will take steps to contain the incident, assess the potential impact, keep a record of what happened and determine whether notification to affected individuals, the Information Commissioner's Office, an insurer or another relevant body is required.

10. Review

This policy will be reviewed annually or sooner if legislation, professional guidance, technology or practice arrangements change.

Signed: _____

Date: _____