

SERVICE STANDARDS FOR RECORD KEEPING

The committee would be pleased to receive the views of members on the enclosed Standard.

COMMENTS SHOULD BE EMAILED TO DILRUBA@FSRH.ORG

This consultation closes on 24th February 2010



Faculty of Sexual and Reproductive Health Care
of the Royal College of Obstetricians and Gynaecologists

SERVICE STANDARDS
FOR
RECORD KEEPING

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SERVICE STANDARDS FOR RECORD KEEPING

Introduction

All individuals who work for an NHS organisation are responsible for any records which they create or use in the performance of their duties. Furthermore, any record that an individual creates is a public record and may be subject to both legal and professional obligations.

This guidance relates to documentation in patient health records of consultations in sexual and reproductive healthcare. The Appendices should be used in conjunction with the Faculty's Clinical Effectiveness Unit (CEU) method specific guidance and the UK Medical Eligibility Criteria for Contraceptive Use (UKMEC), as this record keeping document is about what to record, not how to choose or use a contraceptive method.

Information should be recorded in a manner that accurately reflects the consultation and shared decision-making between client and clinician. Guidance applies to paper and electronic records. Services may wish to develop local protocols for record keeping to address all standards referred to in this document in ways that will facilitate its implementation.

Guidance about record keeping for various methods of contraception is included as appendices to this document. This list is not exhaustive.

The prescription of Contraceptive Medicines for use outside the terms of their licence - "Off License Use" or "Off label use"

There are many generally accepted off licence usages of contraception. The General Medical Council guidance document "Good Practice in Prescribing Medicines" (2008) states that "when prescribing a medicine for use outside the terms of its licence, you must be satisfied that there is sufficient evidence base and/or experience of using the medicine to demonstrate its safety and efficacy, and make a clear, accurate, legible record of all medicines prescribed and, where you are not following common practice, your reasons for prescribing the medicine. Some medicines are routinely used outside the scope of their licence... Where current practice supports the use of a medicine in this way it may not be necessary to draw attention to the licence when seeking consent....."

The Clinical Standards Committee of the Faculty of Sexual and Reproductive Healthcare and the Clinical Effectiveness Committee have agreed that Clinical Effectiveness Unit Guidance on use of contraceptives is guidance on "common practice" and "current practice" in the use of these medicines and devices. Therefore it is recommended that it may not be necessary for clinicians to document every occasion when a contraceptive preparation is prescribed outside the product licence if such use falls within current guidance issued by the Faculty's Clinical Effectiveness Unit. Similarly, current guidance from the RCOG and NICE should be regarded as common practice.

Records Management

NHS organisations need robust records management procedures to meet the requirements set out under the Public Records Act 1958, the Data Protection Act 1998 and the Freedom of Information Act 2000. Storage, retrieval, disclosure, transfer, archiving and disposal of health records must comply with Records Management: NHS Code of Practice¹

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747. Part 1 was published in April 2006 and Part 2 was published in January 2009. Guidance on retention of health records is summarised in Appendix 7 of this document.

The Department of Health Records Management Roadmap contains a range of practical tools and guidance designed to support organisations in the implementation of an effective records management system in line with the principles contained in the Records Management: NHS Code of Practice¹. The Roadmap contains a model Records Management Policy and a model Records Management Strategy, together with guidance on records management audit. The Roadmap complements guidance in the Information Governance Toolkit. The Roadmap can be accessed at <http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/records>

Guidance on maintaining the confidentiality of health records is available from the NHS Confidentiality Code of Practice¹, Faculty of Sexual and Reproductive Healthcare Service Standards for Sexual Health Services² and Faculty Standards on Confidentiality³

1. Standard Statement on Purpose

Clear record keeping is important for clinical governance and serves the needs of clients.

Good record keeping^{1, 2, 3, 4} ensures that:

- 1.1 Clinicians and other staff can work with maximum efficiency without having to waste time searching for information
- 1.2 There is an "audit trail" which enables any record entry to be traced to a named individual at a given date/time with the secure knowledge that all alterations can be similarly traced
- 1.3 Those making a subsequent entry can determine the reason for, and results of, the consultation and the outcome
- 1.4 Any decisions made can be justified or reconsidered at a later date
- 1.5 Complaints, untoward incidents and medico-legal cases can be handled efficiently

2. Standard Statement on Process

The process of making clinical records should be accurate and show evidence of clinical reasoning.

- 2.1 Records should include up-to-date personal data (name, date of birth, address, and postcode and telephone number) with an indication of the preferred mode of contact and any restrictions on mode of contact as requested by the client
- 2.2 Records should contain the client's unique identification number and/or NHS number in accordance with local Trust policies
- 2.3 Records should be well organised with all sections in date order. It is essential that paper and electronic records are managed consistently to ensure that a complete health record is available at the point of need
- 2.4 Entries in paper records should be written legibly and indelibly in black or blue ink⁴
- 2.5 Records should indicate the client's name and either date of birth or unique identification number on each page/screen;
- 2.6 Each entry should have the date noted (and time of day if relevant)
- 2.7 Records should be contemporaneous; contemporaneous corrections and later additions should be dated and signed, or on electronic records amended clearly showing user's name
- 2.8 Each entry in paper records should be signed, with name of clinician and role/job title printed; each entry in electronic records should include the name of the clinician (who will be logged on to the system as a registered user) together with the name of any trainees involved in provision of each episode of client care
- 2.9 Clinical alert details (eg hypersensitivities, significant contra-indications etc) should be recorded in a timely manner and clearly displayed /documented
- 2.10 Appropriate mechanisms should be in place for action on the results of investigations and recording of those actions⁴
- 2.11 Abbreviations which are generally (or locally) agreed may be used, but these must be listed and retained for staff reference
- 2.12 Medico-legal, complaints documents or incident forms should not be filed within the case note folder or personal electronic record, but stored/filed separately
- 2.13 Text should make clear:
 - 2.13.1 The reason for attendance;
 - 2.13.2 Where consultation took place;

- 2.13.3 All persons present and relationship to client eg partner, relative, friend, chaperone, trainee;
- 2.13.4 Use of interpreter, with name and language used (and language line number as appropriate);
- 2.13.5 Outcome, future plan, and review date;
- 2.13.6 Investigations;
- 2.14 Communications should be recorded, ie:
 - 2.14.1 Copies of letters sent;
 - 2.14.2 Whether a copy was sent to the client;
 - 2.14.3 If a standard letter was sent it should be identified
 - 2.14.4 Telephone conversations and SMS messages
 - 2.14.5 faxes/emails sent and security measures taken to ensure security of transfer and confidentiality e.g. use of NHS mail³
- 2.15 Record consent where appropriate^{4,5,6,7}
- 2.16 Record if chaperone offered and accepted or declined, name and role of chaperone if present
- 2.17 Record client participation in decision-making where appropriate
- 2.18 For clients aged under 16, Fraser competency assessment should be recorded
- 2.19 Record any advice sought/actions taken/disclosures made in accordance with Safeguarding Children or Safeguarding Vulnerable Adults policies
- 2.20 Record written /website information or audio/video cassettes/CD-ROM/DVD given, identifying source and date of publication, e.g. fpa leaflets
- 2.21 Records management policies should be regularly reviewed and updated in accordance with the NHS Code of Practice¹ and compliance with record-keeping standards should be audited regularly

3. Standard Statement on Prescribing and Issuing

All drugs and devices prescribed, issued or provided should be clearly documented and the identity of the prescriber should be recorded

- 3.1 Record, date and sign all prescriptions. Where drugs or devices are supplied, record batch numbers, expiry date and manufacturer's product patient information leaflet (PIL) given⁸
- 3.2 when prescribing a medicine for use outside the terms of its product licence ("off-licence" or "off-label") the prescriber must make a clear and accurate record of the reasons for prescribing the medicine (and the steps taken to obtain valid consent from the client) when this use falls outside common practice; however, the use of contraceptive medicines as recommended in current guidance from the FSRH Clinical Effectiveness Unit is regarded as common practice^{9,10}
- 3.3 The use/prescription of unlicensed products should be clearly identified, with a record of the client's valid consent^{5,6,8,9,10}
- 3.4 Adverse reactions – where a 'suspected adverse drug reaction' report (including any reactions with 'black triangle' drugs) is sent to the Medicines and Healthcare products Regulatory Authority (MHRA) as a yellow card or via the MHRA website¹¹, this should be recorded
- 3.5 Protocols for patient group directions should include the standards in this record keeping guidance¹²
- 3.6 Those issuing drugs under patient group directions must ensure record keeping is in line with agreed protocols

References

1. Records Management: NHS Code of Practice. Part 1 2006, Part 2 2009
2. Faculty of Sexual & Reproductive Healthcare. Service Standards for Sexual Health Services. January 2006
3. Faculty of Sexual & Reproductive Healthcare. Service Standards on Confidentiality. January 2009
4. Royal College of Obstetricians and Gynaecologists. Standards for Gynaecology. June 2008
5. Department of Health. Reference Guide to Consent for Examination or Treatment. March 2001 www.dh.gov.uk and Good Practice in Consent Implementation Guide: Consent to Examination or Treatment. November 2001 www.dh.gov.uk.
6. General Medical Council. Seeking patients' consent: The Ethical Considerations. November 1998. www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp
7. Faculty of Sexual & Reproductive Healthcare. Service Standards on Obtaining Valid Consent in Sexual Health Services June 2007
8. EU Directive 2001/83/EC
9. General Medical Council. Good Practice in Prescribing Medicines (2008)
10. Faculty of Sexual & Reproductive Healthcare. Standards for Medicines Management. 2009
11. Medicines and Healthcare Products Regulatory Agency (formerly Medicines Control Agency and Medical Devices Agency). www.mhra.gov.uk
12. Department of Health. Patient Group Directions. HSC 2000/026 (England only).

Other sources of information:

- RCOG eg Patient Record Standard for tubal occlusion procedures in women
- BASHH eg UK National guidelines on undertaking consultations requiring sexual history taking 2006; UK National Guideline on the Management of STIs and related conditions in Children and Young People (2009)
- GMC Good Medical Practice
- Nursing & Midwifery Council
- Data Protection Act 1998
- Freedom of Information Act
- NHS Connecting for Health
- The Healthcare Commission
- Local Trust record-keeping policy

APPENDICES

Appendix 1	Contraceptives containing oestrogen (combined oral contraceptive, combined contraceptive patch, combined contraceptive vaginal ring)
Appendix 2	Progestogen-only pill (POP)
Appendix 3	Subdermal Implants
Appendix 4	Injectable Progestogen-only hormonal contraception
Appendix 5	Intrauterine Contraception (IUD and IUS)
Appendix 6	Emergency Contraception
Appendix 7	Retention of Health Records

Appendices 1 – 6 form part of the generic document on record keeping and should be read in conjunction with it.

Standard Statement

Recording of up to date history and clinical assessment should include information provision, prescription and follow up advice.

- This guidance is about what to record once a particular method has been chosen and should comply with the current UK Medical Eligibility Criteria for Contraceptive Use. It is not prescriptive about how information is recorded, nor about the format of clinical case notes.
- Local services may wish to develop record-keeping tools which can record a holistic History.
- If previous records are not available, women who are already taking a particular contraceptive should have details recorded according to the recommendations below

Appendix 1

Service Standards for Record Keeping for Contraceptives containing Oestrogen

1. Medical history and Clinical assessment

1.1. Personal and lifestyle history

- 1.1.1. Age
- 1.1.2. Current smoking, number per day
- 1.1.3. ex-smoker, number per day and date of cessation
- 1.1.4. Alcohol and substance misuse
- 1.1.5. current/recent immobility

1.2. Contraception

- 1.2.1. Current method
- 1.2.2. Previous contraception used and any problems encountered
- 1.2.3. Awareness and use of emergency contraception

1.3. Gynaecological history

- 1.3.1. Menstrual history including start date of last menstrual period
- 1.3.2. Coital history

1.4. Obstetric history

- 1.4.1. Postpartum < 21 days
- 1.4.2. Current breastfeeding

1.5. Medical history

- 1.5.1. ischaemic heart disease
- 1.5.2. Hypertension
- 1.5.3. Known hyperlipidaemia
- 1.5.4. Other vascular disease
- 1.5.5. complicated valvular and congenital heart disease
- 1.5.6. Stroke
- 1.5.7. Venous thromboembolism
- 1.5.8. Known thrombogenic mutations
- 1.5.9. Raynaud's disease with lupus anticoagulant
- 1.5.10. Diabetes, duration of diabetes, presence/absence of nephropathy/retinopathy/neuropathy
- 1.5.11. Systemic lupus erythematosus
- 1.5.12. Headaches
- 1.5.13. Migraines with/without aura
- 1.5.14. Symptomatic gallbladder disease
- 1.5.15. cholestasis related to past COC use
- 1.5.16. Active viral hepatitis
- 1.5.17. Cirrhosis, liver tumours
- 1.5.18. Current or recent breast cancer
- 1.5.19. Any other serious medical condition

1.6. Surgical history

- 1.6.1. Recent major surgery with immobilisation

1.7. Medication

- 1.7.1. Prescribed, particularly drugs which affect liver enzymes and broad spectrum antibiotics

- 1.7.2. Non-prescribed/complementary
- 1.8. Allergies
- 1.9. Family history
 - 1.9.1. Carrier of gene mutation known to be associated with breast cancer
 - 1.9.2. Venous thromboembolism (VTE) in first-degree relative < age 45
 - 1.9.3. Stroke/myocardial infarction (MI) in first-degree relative < age 45
- 2. **Examination**
 - 2.1. Blood pressure (BP)
 - 2.2. Weight and body mass index (BMI)
 - 2.3. Any other examination/tests
- 3. **Information, advice and counselling**
 - 3.1. Contraceptive choices discussed / preparation chosen
 - 3.2. Risks/benefits/uncertainties discussed
 - 3.3. How it works/efficacy
 - 3.4. Side effects
 - 3.5. Teaching about use of method, including when to access emergency contraception
 - 3.6. Information given on symptoms which should prompt urgent medical advice
 - 3.7. Leaflets given – including manufacturer’s PIL
 - 3.8. Advice on practising safer sex
 - 3.9. Follow-up arrangements
- 4. **Prescribing and issuing**
 - 4.1. Record prescription and quantity issued, batch number and expiry date
 - 4.2. Special instructions if any, e.g. additional contraception for 7 days
- 5. **Subsequent attendance**
 - 5.1. Any change in personal or family history, medication or examination findings since the last attendance should be recorded.

Sources of information

- 1. Faculty of Family Planning & Reproductive Healthcare Clinical Effectiveness Unit. FFPRHC Guidance 2006 (updated 2007) First prescription of combined oral contraception. <http://www.fsrh.org/admin/uploads/FirstPrescCombOralContJan06.pdf>
- 2. The UK Medical Eligibility Criteria for Contraceptive Use 2009
- 3. Faculty of Sexual and Reproductive Healthcare. New Product Reviews on Evra (2003), Nuvaring (2009) and Qlaira (2009)

Appendix 2

Service Standards for Record Keeping for Progestogen-only pill (POP)

1. **Medical history and clinical assessment**
 - 1.1. Personal and lifestyle history
 - 1.1.1. Age
 - 1.2. Contraception
 - 1.2.1. Current method
 - 1.2.2. Previous contraception used and any problems encountered
 - 1.2.3. Awareness and use of emergency contraception
 - 1.3. Gynaecological history
 - 1.3.1. Menstrual history including start date of last menstrual period
 - 1.3.2. Coital history
 - 1.3.3. Ovarian cysts
 - 1.4. Obstetric history
 - 1.4.1. Ectopic pregnancy
 - 1.5. Medical history
 - 1.5.1. ischaemic heart disease
 - 1.5.2. Stroke
 - 1.5.3. Venous thromboembolism
 - 1.5.4. Headaches
 - 1.5.5. Migraines with aura
 - 1.5.6. Active viral hepatitis
 - 1.5.7. Severe cirrhosis, liver tumours
 - 1.5.8. Current or recent breast cancer
 - 1.5.9. Any other serious medical condition
 - 1.6. Medication
 - 1.6.1. Prescribed, particularly drugs which affect liver enzymes
 - 1.6.2. Non-prescribed/complementary
 - 1.7. Allergies
2. **Examination**
 - 2.1. Blood pressure (BP)
 - 2.2. Weight and body mass index (BMI)
 - 2.3. Any other examination/tests
3. **Information, advice and counselling**
 - 3.1. Contraceptive choices discussed / preparation chosen
 - 3.2. Risks/benefits/uncertainties discussed
 - 3.3. How it works/efficacy
 - 3.4. Side effects
 - 3.5. Teaching about use of method, including when to access emergency contraception
 - 3.6. Information given on symptoms which should prompt urgent medical advice
 - 3.7. Leaflets given – including manufacturer's PIL
 - 3.8. Advice on practising safer sex
 - 3.9. Follow-up arrangements

4. **Prescribing and issuing**

4.1 Record prescription and quantity issued, batch number and expiry date

4.2 Special instructions if any, e.g. additional contraception

5. **Subsequent attendance**

5.1 Any change in personal history, examination findings or medication since the last attendance should be recorded.

Sources of information

Faculty of SRH. CEU Guidance on Progestogen-only pills 2009

Appendix 3

Service Standards for Record Keeping for Subdermal Implants

1. **Medical history and clinical assessment**
 - 1.1. Personal and lifestyle history
 - 1.1.1. Age
 - 1.2. Contraception
 - 1.2.1. Current method
 - 1.2.2. Previous contraception used and any problems encountered
 - 1.2.3. Awareness and use of emergency contraception
 - 1.3. Gynaecological history
 - 1.3.1. Menstrual history including start date of last menstrual period
 - 1.3.2. Coital history
 - 1.3.3. Unexplained vaginal bleeding before evaluation
 - 1.4. Medical history
 - 1.4.1. ischaemic heart disease
 - 1.4.2. Stroke
 - 1.4.3. Current venous thromboembolism on anticoagulants
 - 1.4.4. Headaches
 - 1.4.5. Migraines with aura
 - 1.4.6. Active viral hepatitis
 - 1.4.7. Severe cirrhosis, liver tumours
 - 1.4.8. Current or recent breast cancer
 - 1.4.9. Any other serious medical condition
 - 1.5. Medication
 - 1.5.1. Prescribed, particularly drugs which affect liver enzymes
 - 1.5.2. non-prescribed/complementary
 - 1.6. Allergies
2. **Examination**
 - 2.1. Weight and BMI
3. **Information advice and counselling**
 - 3.1. Contraceptive choices discussed
 - 3.2. Risks/benefits/uncertainties discussed
 - 3.3. Mode of action and efficacy of implant
 - 3.4. Duration of use
 - 3.5. Effects on bleeding pattern
 - 3.6. Effects at insertion site
 - 3.7. Explanation of insertion and removal procedure
 - 3.8. Consent obtained
 - 3.9. Leaflets given – including manufacturer’s PIL
 - 3.10. Advice given on practising safer sex
4. **Details of insertion procedure**
 - 4.1. Name of operator and assistant if present
 - 4.2. Local anaesthesia used, batch number and expiry date

- 4.3 Site of insertion ie which arm and where
- 4.4 Type of Implant inserted, batch number and expiry date
- 4.5 Implant palpable after insertion
- 4.6 Problems encountered, if any, and actions taken

- 5. **Post insertion follow up advice**
 - 5.1 After care instructions for insertion site
 - 5.2 Special instructions if any, e.g. additional contraception for 7 days,
 - 5.3 Follow up date if arranged; "see if any problems" acceptable

- 6. **Follow-up**
 - 6.1 Problems encountered, if any, and actions taken
 - 6.2 Implant palpable in sub dermal position
 - 6.3 If removal is planned, alternative contraception discussed and/or other issues discussed

- 7. **Details of removal procedure**
 - 7.1 Reason for removal
 - 7.2 Duration of use
 - 7.3. Alternative contraception method advised/provided if any
 - 7.4. Name of operator and assistant if present
 - 7.5. Local anaesthesia and any instruments used with batch numbers and expiry dates
 - 7.6. Technique of removal used
 - 7 7. Problems encountered, if any, and actions taken
 - 7 8. After care instructions

Sources of information
 FSRH CEU Guidance on Progestogen-only Implants April 2008

Appendix 4

Service Standards for Record Keeping for Injectable Progestogen-only hormonal contraception

1. Medical history and Clinical assessment

1.1. Personal and lifestyle history

- 1.1.1. Age
- 1.1.2. Current smoking, number per day
- 1.1.3. ex-smoker, number per day and date of cessation
- 1.1.4. Alcohol use

1.2. Contraception

- 1.2.1. Current method
- 1.2.2. Previous contraception used and any problems encountered
- 1.2.3. Duration of use of the injectable progestogen-only contraception to date
- 1.2.4. Awareness and use of emergency contraception

1.3. Gynaecological history

- 1.3.1. Menstrual history including start date of last menstrual period
- 1.3.2. Coital history
- 1.3.3. Unexplained vaginal bleeding before evaluation

1.4. Medical history

- 1.4.1. ischaemic heart disease
- 1.4.2. Hypertension
- 1.4.3. Known hyperlipidaemia
- 1.4.4. Other vascular disease
- 1.4.6. Stroke
- 1.4.7. Current venous thromboembolism on anticoagulants
- 1.4.8. Diabetes, duration of diabetes, presence/absence of nephropathy/retinopathy/neuropathy
- 1.4.9. Headaches
- 1.4.10. Migraines with aura
- 1.4.11. Active viral hepatitis
- 1.4.12. Severe cirrhosis, liver tumours
- 1.4.13. Current or recent breast cancer
- 1.4.14. Eating disorder eg anorexia nervosa
- 1.4.15. Any other serious medical condition

1.5. Medication

- 1.5.1. Prescribed, particularly anticoagulants, corticosteroids
- 1.5.2. Non-prescribed/complementary

1.6. Allergies

1.7. Family history

- 1.7.1. Stroke/myocardial infarction (MI) in first-degree relative < age 45
- 1.7.2. Osteoporosis

2. Examination

- 2.1. Blood pressure (BP)
- 2.2. Weight and body mass index (BMI)
- 2.3. Any other examination/tests

3. Information, advice and counselling

- 3.1 Contraceptive choices discussed
- 3.2 Risks/benefits/uncertainties discussed
- 3.3 How it works/efficacy
- 3.4 Side effects
- 3.5 Explanation of injection procedure
- 3.6 Leaflets given – including manufacturer’s PIL
- 3.7 Advice given on practising safer sex
- 3.8 Follow-up arrangements

4. Prescribing and issuing

- 4.1 Record prescription with batch number and expiry date
- 4.2 Site of injection
- 4.3 Special instructions if any, e.g. additional contraception for 7 days

5. Subsequent attendance

- 5.1 Any change in history or medication since last attendance should be recorded
- 5.2 Date of last injection or number of weeks since last injection
- 5.3 Contraceptive choices discussed

Sources of information

FSRH CEU Guidance on Progestogen-only Injectable Contraception. 2009

Appendix 5

Service Standards for Record Keeping for Intrauterine Contraception (IUD and IUS)

1. Medical history and Clinical assessment

1.1. Personal and lifestyle history

1.1.1. Age

1.2. Contraception

1.2.1. Current method

1.2.2. Previous contraception used and any problems encountered, including difficulty in IUD/IUS insertion

1.2.3. Awareness and use of emergency contraception

1.3. Gynaecological and sexual history

1.3.1. Menstrual history including start date of last menstrual period

1.3.2. Coital history and sexual history to identify risk of sexually transmitted infection

1.3.3. Unexplained vaginal bleeding

1.3.4. Cervical surgery, including treatment to cervix

1.3.5. Current cervical, endometrial or ovarian cancer

1.3.6. History of sexually transmitted infections (STI) and pelvic inflammatory disease (PID)

1.3.7. Immediate post septic abortion

1.3.8. Uterine fibroids with distortion of uterine cavity

1.3.9. Uterine anatomical abnormality including cervical stenosis

1.3.10. Recent gestational trophoblastic neoplasia with abnormal HCG

1.4. Obstetric history

1.4.1. Caesarean Section(s)

1.4.2. Ectopic pregnancy

1.4.3. Postpartum 48 hrs to < 4 weeks

1.4.4. Puerperal sepsis

1.4.5. Current breastfeeding

1.5. Medical history

1.5.1. Current venous thromboembolism

1.5.2. Migraines with aura

1.5.3. Active viral hepatitis

1.5.4. Severe cirrhosis, liver tumours

1.5.5. Current or recent breast cancer

1.5.6. Pelvic tuberculosis

1.5.7. Any other serious medical condition

1.6. Medication

1.6.1. Prescribed

1.6.2. Non-prescribed/complementary

1.7. Allergies

2. Information advice and counselling

2.1. Contraceptive choices discussed

2.2. Risks/benefits/uncertainties discussed

2.3. Mode of action and efficacy of IUDs

- 2.4 Choice of devices and duration of use
- 2.5 Effects on bleeding pattern
- 2.6 Risk of spontaneous expulsion and perforation and advisability of thread check and teaching
- 2.7 Risk of post-insertion pelvic infection and record of any swabs taken if applicable
- 2.8 Explanation of insertion procedure
- 2.9 Consent obtained
- 2.10 Leaflets given – including manufacturer’s PIL
- 2.11 Advice given on practising safer sex

3. **Details of insertion procedure**

- 3.1 Name of operator and assistant
- 3.2 Any tests undertaken
- 3.3 Bimanual examination and speculum findings
- 3.4 Analgesia/local anaesthesia if used
- 3.5 Tenaculum/Allis forceps application
- 3.6 Uterine sounding/Uterocervical length
- 3.7 Type of device, batch number, expiry date
- 3.8 Use of no touch technique
- 3.9 Problems encountered, if any, and actions taken

4. **Post-insertion follow up advice**

- 4.1 Other treatment if any e.g. antibiotics
- 4.2 Special instructions if any e.g. post-coital IUD
- 4.3 Follow up if any problems or cannot feel thread

5. **Details of removal**

- 5.1 Reason for removal
- 5.2 Coital history (since LMP) to identify risk of pregnancy
- 5.3 Alternative contraception method advised/provided if any
- 5.4 Technique of removal used
- 5.5 Problems encountered, if any, and actions taken

Sources of information

FSRH CEU Guidance on Intrauterine Contraception 2007

Appendix 6

Service Standards for record keeping for Emergency Contraception

1. Medical History and Clinical Assessment

1.1. Reason for request for emergency contraception (EC)

- 1.1.1. Unprotected sexual intercourse (UPSI)
- 1.1.2. Contraceptive method problem
- 1.1.3. Advance provision

1.2. Unprotected sexual intercourse (UPSI)

- 1.2.1. Number of hours since most recent UPSI
- 1.2.2. Day of cycle when this occurred
- 1.2.3. Consensual or non-consensual
- 1.2.4. First episode of unprotected sex in cycle
- 1.2.5. Previous use of emergency contraception in cycle
- 1.2.6. Date(s) when this was used
- 1.2.7. Method problem, e.g. Missed pills, late depo

1.3. Bleeding / Menstrual / Obstetric History

- 1.3.1. Last normal menstrual period
- 1.3.2. Shortest / usual cycle length
- 1.3.3. In case of recent pregnancy – date of delivery, abortion or miscarriage

1.4. Drug Interaction

- 1.4.1. Use of interacting medication e.g. enzyme inducers or products that increase gastric pH

2. Sexually transmitted infection (STI) risk

- 2.1. STI risk assessment
- 2.2. Information re timing & access to STI screening
- 2.3. Ongoing safer sex information

3. Counselling, information and advice

3.1. Counselling hormonal emergency contraception

- 3.1.1. Which products discussed and product selected for use
- 3.1.1. IUD discussed and fitting offered if appropriate
- 3.1.2. Mode of action
- 3.1.3. Risk of failure particularly in view of the time of the cycle when UPSI occurred & time since UPSI
- 3.1.4. How to take product
- 3.1.5. Action to take if vomits within 2 or 3 hours
- 3.1.6. Possibility of irregular bleeding & timing of next menses
- 3.1.7. Indications for pregnancy test & follow-up
- 3.1.8. Product gives no ongoing contraception
- 3.1.9. Method leaflet given
- 3.1.10. Off-licence use

3.2. Counselling re copper Intrauterine Device (see also Appendix 5)

- 3.2.1. Mode of action
- 3.2.2. Efficacy
- 3.2.3. Risks/benefits/side effects

- 3.2.4. Ongoing contraception offered by method
- 3.2.5. Infection risk discussed and antibiotic cover offered if indicated
- 3.2.6. Method leaflet given

3.3 Counselling re Future Contraception

- 3.3.1. Client's chosen method issued after appropriate assessment or clear pathway to accessibility, counselling and teaching of the method
- 3.3.2. Advice about action where client continuing with current method
- 3.3.3. Advice on practising safer sex

4. **Prescribing and Issuing**

- 4.1. Levonorgestrel or ulipristal acetate emergency contraception
 - 4.1.1. Record prescription with batch number and expiry date
 - 4.1.2. Special instructions if any eg off licence use
- 4.2. Copper Intrauterine Device fitted – Refer to Intrauterine contraception record keeping standard

Sources of information

Faculty of Family Planning and Reproductive Healthcare Clinical Effectiveness Unit. FFPRHC Guidance (April 2006) Emergency contraception. J Fam Plann Reprod Health Care 2006; 32 (2): www.fsrh.org

Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit. New Product Review. Ulipristal acetate. October 2009

Appendix 7

Retention of Health Records

Table extracted from Records Management: NHS Code of Practice Part 2 Annex D1 – this table should be read in conjunction with Annex D. For guidance on retention of business and corporate (non-health) records and retention of electronic records/audit trails please refer to Annex D 2 and Annex D3

Down load from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131747

Health Record	Minimum Retention Period
Abortion – Certificate A (Form HSA1) and Certificate B (Emergency Abortion)	3 years
Audit Trails (Electronic Health Records)	NHS organisations are advised to retain all audit trails until further notice.
Cervical screening slides	10 years
Children and young people (all types of records relating to children and young people)	Retain until the patient's 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period
Clinical audit records	5 years
Clinical Protocol (GP, in-house)	25 years
Clinical psychology	20 years
Counselling records	20 years or 8 years after the patient's death if patient died while in the care of the organisation
DNA (health records for patients who did not attend for appointments as outpatients)	Where there is a letter or correspondence informing the healthcare professional/organisation that has referred the client/patient/service user that the patient did not attend and that no further appointment has been given, so this information is also held elsewhere. Retain for 2 years after the decision is made. Where there is no letter or correspondence informing the healthcare professional/organisation that has

	referred the client/patient/service user that the patient did not attend and that no further appointment has been given. Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation.
Family planning records	For records of adults – retain for 10 years after last entry For clients under 18 – retain until 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years) Records of deceased persons should be retained for 8 years after death
Genito Urinary Medicine (GUM) Includes sexual health records	For records of adults -retain for 10 years after last entry. For clients under 18 -retain until 25th birthday or for 10 years after last entry, whichever is the longer i.e. records for clients aged 16-17 should be retained for 10 years and records for clients under 16 should be retained until age 25 (i.e. still retained for at least 10 years) Records of deceased persons should be retained for 8 years after death. See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH) http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf .
Immunisation and vaccination records	For children and young people – retain until the patient's 25th birthday or 26th if the young person was 17 at conclusion of treatment All others retain for 10 years after conclusion of treatment
Learning difficulties and Learning disabilities	Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the

	retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died whilst in the care of the organisation
Operating Theatre Lists (paper)	4 years (for those lists that only exist in paper format and are the sole record)48 hours (for prints taken from computer records)
Operating theatre registers	8 years after the year to which they relate
Outpatient lists (where they exist in paper format)	2 years after the year to which they relate
Referral letters (for patients who are treated by the organisation to which they were referred)	Referral letters should be filed in the patient/client service user's health record, which contains the record of treatment and/or care received for the condition for which the referral was made. This will ensure that the patient record is a complete record. These records should then be retained for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation
Referral letters for clients referred to health or care services but not accepted.	Where there is a letter or correspondence detailing the reasons for non-acceptance that goes to the organisation that has referred the client, so the information is also held elsewhere. Retain for 2 years after the decision is made. Where there is no letter or correspondence detailing the reasons for non-acceptance that goes to the organisation that has referred the client. Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation.

<p>Referral letters (to PCT clinical service e.g. ECG) where the results are sent back to GP's</p> <p>Referral letters – where the appointment was cancelled by the patient before the referral letter was included in the patient record (i.e. before the clinic preparation process)</p>	<p>2 years</p> <p>Where a letter is sent to the referring clinician detailing the reason(s) why the patient/client cancelled the appointment retain for 2 years after the date the appointment was cancelled. Where there is no letter or correspondence detailing the reasons for the patient not attending for their appointment that goes to the clinician that referred the patient/client. Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation.</p>
<p>Scanned records relating to patient care</p>	<p>Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation. NB Providing the scanning process and procedures are compliant with BSI's BIP:0008 – Code of Practice for Legal Admissibility and Evidential Weight of Information Stored Electronically once the casenotes have been scanned the paper records can be destroyed under confidential conditions.</p>
<p>Standard Operating Procedures (current and old)</p>	<p>30 years</p>
<p>Ultrasound records (e.g. vascular, obstetric)</p>	<p>Retain for the period of time appropriate to the patient/specialty, eg children's records should be retained as per the retention period for the records of children and young people; mentally disordered persons (within the meaning of the Mental Health Act 1983) 20 years after the last entry in the record or 8 years after the patient's death if patient died while in the care of the organisation</p>