

GP Online Services Guidance

*Checking patient records for safe online access FAQ*

Introduction

Consider writing a practice policy on checking patients’ records to identify evidence of a safeguarding risk and potentially harmful and confidential third-party information in a patient’s record that should be redacted. This becomes relevant when:

* Automatic record access becomes available to patients aged 16 and over in England in 2022 or when patients reach their 16th birthday.
* A new patient registers with the practice.
* A patient applies for online access to their historic records.
* A patient consents to a trusted third-party having proxy access.
* A third-party requests proxy access for a patient who does not have capacity.
* A patient’s relevant circumstances change significantly, especially if a safeguarding risk is suspected.

Depending on the circumstances, the purpose of reviewing the records may be to:

* Find evidence that record access would put the patient at risk of harm, e.g. evidence of a safeguarding risk, serious mental health disorder or impaired intellectual capacity.
* Ensure the clarity, completeness, accuracy, timeliness and safety of the record.
* Identify information in the record which is potentially harmful to the patient or is confidential information relating to a third-party in order to hide the information from online view by the patient. This will not hide the information from clinical care in the practice or who the record is shared for direct care.
* Inform the decision about whether the patient should be allowed online record access or whether it should be blocked or switched off. It may be possible to switch full record access on again in the future if the patient’s circumstances change.

Record checking for online patient safety

There are questions that are frequently asked about checking patients’ records/ for the patient to have safe online access. They form the basis of a practice policy on the process.

1. **What is the purpose of checking the record?** To look for evidence that record access might be harmful, to hide potentially harmful and confidential third-party information from online view, to improve data quality and inform discussions with the patient about whether it is currently safe for them to have record access.
2. **Which parts of the record should be checked?** This depends upon why an individual patient’s record needs checkingIt may be the whole record when a patient requests access to their entire record, especially if they are new to the practice or to look for evidence of a safeguarding risk before the launch of automatic record access. When a patient who has automatic access asks for access to their full record or consents to proxy access for a trusted third-party, it may only be necessary to check their older record up to when they obtained automatic access.
3. **What should be redacted?**  In addition to confidential third-party information, anything that may relate to safeguarding issues should always be redacted. The potential for harm in other information is strongly influenced by the circumstances and views of the patient. The assessment of what should be hidden must be made in the individual patient’s best interests and clinicians must use their professional judgment and knowledge of the individual in making the assessment.

iThere is more information about these problems in the guidance on “[Managing Potentially Harmful Information](https://elearning.rcgp.org.uk/pluginfile.php/179161/mod_book/chapter/762/Managing%20potentially%20harmful%20information.docx)” and “[Data Quality for Record Access](https://elearning.rcgp.org.uk/pluginfile.php/179161/mod_book/chapter/780/Data%20quality%20for%20record%20access.docx)”.

1. **Who should check the record?** The clinician who knows the patient best, is ideally placed to do this. An experienced clinician, or the record access clinical lead or practice Caldicott Guardian may also do so. It can be done by well-trained non-clinical staff with clear guidance escalating decisions about the safety of information or whether to block, refuse or restrict the patient’s online access.
2. **How many records can be checked?** Reviewing records takes time, even with software to screen the record before a manual check. Consider limiting the number of records checked each month. It helps to be able to warn patients how long they may have to wait for a decision when they apply for record access.
3. **When should online record access be refused?** If there is potentially harmful information that cannot be reliably hidden from online view, it may be best to refuse or switch off record access. Consider discussing the decision with an experienced clinician such as the practice record access or safeguarding leads. It may be possible to subsequently allow access after a careful discussion with the patient.
4. **Should the patient be told that data has been redacted?** Yes, whenever possible the patient’s view should be taken into account.
5. **What should be recorded in the notes about online record access?** Discussions with the patient, and decisions made about record access should be entered in the patient’s notes and hidden from view by the patient.