Consent, Confidentiality, Recording and Reporting of Clinical Activity for Academic Purposes

Guidelines for staff and learners on health programmes leading to a professional registration or accreditation.
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Revised 2011

Background

These guidelines were originally produced in 2002 by a small working group from the Supervisors' Committee for the South West Training Scheme for Clinical Psychology. They were based on consideration of the following: discussion within and feedback from Supervisors' and Programme Committee, discussion within the Exeter User Advisory Group, Department of Health guidelines on informed consent, the Good Practice in Consent Implementation Guide (2001) (available on the DoH website doh.gov.uk/consent), a paper on confidentiality, consent and reports of clinical activity (Sperlinger and Callanan, 2002) and the BPS Code of Conduct (2000). The current revision takes into account the requirements of the Mental Capacity Act (2005), the BPS Code of Ethics and Conduct (2006), the BPS DCP (2008) Record Keeping: Guidance of Good Practice, the Health Professions Council Standards of Conduct, Performance and Ethics (2008), the Data Protection Act 1998 and NMC guidance.

Guidelines

All health professionals must obtain clients' voluntary consent before treating or caring for them. This requires the professional to provide as much information (in a form that the person can understand) about the likely risks and benefits of the care, and about what it is likely to involve, as the client reasonably needs in order to make a decision (Department of Health 2001). Trainees should consult the Department of Health website on consent (see above) for guidance of issues of consent for particular client groups (children, people with learning disabilities, older people, people in prison). The Mental Capacity Act (2005) makes a presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. If the client is found to lack capacity to make their own informed decision about treatment, at the time of referral, then those who know the person best must be consulted to consider whether it is in the client's best interests to be seen by a learner. Everything that is done for or on behalf of a person who lacks capacity must be in that person's best interests. The Act provides a checklist of factors that decision-makers must work through in deciding what is in a person's best interests. Carers and family members have a right to be consulted. The learner must follow any policy and good practice guidelines on consent within the Trust in which they are working. Clients who lack capacity may only be recorded if the following applies

• developing more effective ways of treating a person or managing their condition
• improving the quality of healthcare, social care or other services that they have access to

1. As part of the information given, clients should be told that it is possible that their work may be reported or written up, in a suitably anonymised form, for training purposes, and the precautions to protect clients' interests about this: the alteration of identifying features, the requirement that it be reported in a thoughtful and respectful way, limits on who will see it, and that it will be stored in a secure place. How this information is given will depend on particular circumstances, taking into account different client needs and abilities. Basic information may be given in a standardised form to all potential clients within a Trust or service (eg as part of a standard appointment letter).

2. Clients must be offered a choice as to whether or not to be seen by a learner in training. It should be made clear to clients that their treatment will not be compromised in any way if they decide they do not want to be seen by a learner.

3. When clients are offered the option of seeing a learner information should be provided to them (or to carers and family members where the client lacks capacity to give their own informed consent) about what seeing a learner is likely to involve. This will usually include, for example, that the learner will be regularly supervised, the nature of the learner's training and experience, the length of time that the learner will be available, what may happen when the learner's placement comes to an end, that the work may be written up for academic purposes, and that the client may be asked to comment on the learners performance.

4. With regard to confidentiality of personally identifiable material, the learner must explain to the client the limits to confidentiality with regard to supervision and team work (see below point 6). Various legal frameworks safeguard the interests of citizens in relation to disclosure of information. The Data Protection Act 1998 is the most recent of these. It sets out the conditions that must be met before personal data can be processed fairly and lawfully. It allows for the disclosure of "personal" or "sensitive" information only under certain circumstances, including the circumstance when information is needed to protect the vital interests of the person or another person. It also provides that personal data can be processed, if withholding it would be likely to prejudice the prevention or the detection of crime, or the apprehension or prosecution of offenders. The Crime and Disorder Act 1989 also gives power to disclose information to a relevant authority "for the preventing and detecting of crime". In relation to children, the Children Act 1989 sets out a range of duties in relation to statutory authorities to assist in the collection of information in relation to child protection cases. DfES Circular 10/95 for schools makes clear that in cases of child abuse: "Staff have a professional responsibility to share relevant information about the protection of children with other

professionals, particularly investigative agencies. If a child confides in a member of staff and requests that the information is kept secret, it is important that the member of staff tells the child sensitively that he or she has a responsibility to refer cases of alleged abuse to the appropriate agencies for the child's own sake. Within that context, the child should, however, be assured that the matter will only be disclosed to people who need to know about it. Staff who receives information about children and their families in the course of their work should share that information only within appropriate professional contexts. Child protection records should be kept securely locked."

5. Learners should therefore let clients know that there are potential limits to complete confidentiality, and indicate the sort of circumstances under which breaches might occur. The learner should also say that if the need for a breach of confidentiality arose that they would usually try to discuss it with the client first. This need not be a difficult or lengthy discussion - most clients will be happy to talk about this, and the more open the learner is, the more reassured they are likely to be. In addition, learners should remember that they will be regularly breaching confidentiality when they discuss clients with their supervisor. In some settings they may also discuss clients with team members as a normal part of the assessment process. In most settings they will be writing to the referrer and will often include the client's GP in any communications. A good principle is to make sure that clients know about these sorts of discussions and communications, and the boundaries and safeguards that exist to safeguard the client's interests.

6. Under the Data Protection Act, patients are entitled to see all information relating to their physical or mental health which has been recorded by or on behalf of a health professional in connection with their care. If there is a possibility that the person may be seriously harmed by the record, then the health professional responsible for the record may need to be consulted. Trainees should write reports, letters and notes in the knowledge that they may be seen by clients.

7. Audio or tape recordings may be made for a variety of purposes for learners in training. These may include:

    - provision of opportunity for the learner to review and self-evaluate and to receive feedback on their performance, so as to improve the service received by the service user/carer
    - provision of opportunity for the learner to review and self-evaluate, and receive feedback on their performance, so as to improve the learner's skills and competence
    - highlighting positive areas of practice
    - assessment of learner's skills and competence
    - ensuring adherence to therapeutic protocols (e.g. CBT, family therapy)

If tape or audio recordings are made, the same consent and confidentiality standards should be followed as described above. The patients' clinical record should be used to evidence that consent has been sought and that the recording will be held by the university in accordance with the relevant policies and procedures. The recording must be made available to the service user to see/hear and at all times the service user must retain the right to withdraw their consent. All recordings must be anonymous and transferred from Trust premises to University in secure circumstances. The recording should be transferred securely using the secure methods (cryptex or NHSnet where the recipient address is on the approved list) or an NHS issued encrypted USB stick.

When recordings are made for academic purposes, the University will be considered as the data holder. University standards are as follows:

- **Consent**: a consent form (appended) should be used to evidence that consent has been given by the service user. This form should be stored in the client's clinical records. The supervisor should sign a separate form (appended) indicating that they have seen the consent form, and this (anonymous) form will be kept with the stored data at the University. In addition, the recording should begin with a verbal statement by the learner as to how consent was sought and given. The recording must be made available to the service user to see/hear and at all times the service user must retain the right to withdraw their consent. If the client is found to lack capacity to make their own informed decision about recording, then those who know the person best must be consulted to consider whether they consider it to be in the client's best interests to have their work with the learner recorded. Carers and family members have a right to be consulted. The Mental Capacity Act Code of Practice section 11.14 refers to balancing the "benefit and burden of research", and the same may apply to recording clinical practice for learning purposes. The code notes that potential benefits of having their care recorded, for a person who lacks capacity to make the decision, could include:
    - "developing more effective ways of treating a person or managing their condition"

    And/or
    - "improving the quality of healthcare, social care or other services..." (through improving practice through improving the training of the health care professionals.)

  The learner must follow any policy and good practice guidelines on consent within the Trust in which they are working.

- **Retention**: Recorded data for student assessment purposes will be retained no longer than 6 months after the degree award for the learner, or 6 months after the learners' withdrawal from the programme.

- **Disposal**: all copies of the recording must be erased no later than the times specified above, following University Guidelines on Encryption and Shredding of Electronic Data (2009).

- **Information security:** Electronic data must be stored on password-protected computers and laptops. Individual files and/or discs must be encrypted. Memory sticks should be avoided as these are easily lost.

8. With regard to case notes, learners must follow the requirements of the relevant Governing Body including, the Health Professions Council (HPC), NMC, BPS DCP (2009) Record Keeping: Guidance on Good Practice - Clinical Psychology and Case Notes: Guidance on Good Practice (2000) and must follow policy and good practice guidelines from the Trust within which they are working.

9. Health care programmes of study will be expected to prepare learners for obtaining client consent through preparatory workshops during academic teaching blocks; in addition, supervisors and learners should discuss together the best forms of words to use within particular service contexts.

10. Once the client has given general permission to be seen by the learner, the learner, in consultation with the supervisor, must decide whether (and if so, how) further specific permission should be sought for writing up or reporting particular anonymised pieces or aspects of the work. It would normally be expected that learners gain explicit consent for anonymised work to be written up and submitted as course work.

11. The learner must seek consent from other professionals before their anoymised correspondence is included as an appendix for submitted coursework.

12. The learner must report, on the front sheet of all work submitted for academic purposes, how the process of consent was addressed.

13. Learners must ensure that client and carer confidentiality is protected in all work submitted for university requirements. All identifying features such as names, addresses, hospital numbers and any other recognisable details must be changed or deleted. Learners must not use the client's own initials when referring to him or her.

14. Learners must ensure that they consider and respect clients' dignity in all written and spoken communications about their clinical work. A good rule of thumb is to consider what would be the answer to the question; "Would I feel respected if I or my family were written or spoken about in this way?"

15. The question arises as to whether clients should have the right to read anonymised material that is written up about their work and submitted as

part of training requirements. There is no clear consensus on this, either between professionals (see Sperlinger and Callanan 2002) or between clients themselves (as discussed within the Exeter Service User Advisory Group). Whenever a piece of work is written up, supervisors and learners should consider carefully whether the client should be given the opportunity to read the report. If clients do request to see material that has been written about them, then they have the right to do so, under the Data Protection Act, unless it is considered that by doing so they would be seriously harmed. In such a case the learner and supervisor should consider carefully the ethical, therapeutic and practical implications of the decision. The learner may decide not to share the critical review or reflective section(s) of the work in which they record their own response to the work undertaken. Where the client does read the report (or parts of it), his or her comments on it may form part of the content of the report itself.

16. Opinion and guidance about good practice in ethical matters develops over time. The Department of Health is currently developing a new strategic framework for information management in the NHS which aims to bring together all the requirements, limits and best practice that apply to the processing of confidential patient information about individuals and integrating these within a unified framework. Therefore these guidelines will be subject to review, taking into account Department of Health strategic developments, Health Professions Council requirements, and BPS recommendations, through discussion and consultation under the Supervisors' Committee.

References

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