Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists

SERVICE STANDARDS FOR RECORD KEEPING IN CONTRACEPTION IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Reviewed July 2014
Service Standards for Record Keeping in
Contraception in Sexual and Reproductive Healthcare Services
SERVICE STANDARDS FOR RECORD KEEPING

Introduction

Good record keeping ensures that clinicians and other staff can readily access information to provide efficient and high quality care. It facilitates continuity of care whilst informing and justifying decision making in a manner that it is clear to all. In the event of complaints, untoward incidents and medico-legal cases, accurate and comprehensive documentation supports efficient resolution. In addition, good clinical records support audit, management, planning, policy, commissioning and research.

All individuals contracted to work for the NHS 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 that focus on contraception. Guidance about record keeping for specific methods of contraception is included as appendices to this document (this list is not exhaustive). 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).

Information should be recorded in a manner that accurately reflects the consultation. Guidance applies to paper and electronic records. Services may wish to develop local protocols for record keeping to all standards referred to in this document.

Records Management

All providers of NHS services 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 Practice. 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 Practice. 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 Practice, Faculty of Sexual and Reproductive Healthcare Service Standards for Sexual Health Services and Faculty of Sexual and Reproductive Healthcare Standards on Confidentiality.
1. **Standard Statement on Quality of Record**

| Individuals making paper and electronic records should do so in a consistent manner and be clearly identifiable. |

1.1 Records should be well organised with all sections in chronological order.

1.2 Entries in paper records should be written indelibly in black ink.

1.3 Each entry should have the date noted (and time of day if relevant).

1.4 The healthcare professional making the record should be clearly identifiable. For paper records the individual should sign their name and print their role/job title. Electronic records should include the name of the healthcare professional who will be logged on to the system as a registered user.

1.5 Records should be contemporaneous. If any subsequent corrections or additions are made, the date, time and author should be clearly documented to provide an audit trail.

1.6 Staff should be aware of and restrict their use of abbreviations to those on the approved list compiled by their employing organisation.
2. Standard Statement on Recording Patient Details (Identifiers)

Patient identifiers should be accurate and up to date with unambiguous linkage to all entries in the record relating to that patient.

2.1 Records should include up to date personal data (name, date of birth, address with postcode, telephone number and GP details if registered).

2.2 Records should include the patient’s unique identification number and/or NHS number in accordance with the policies of the service provider.

2.3 Records should indicate the patient’s name and either date of birth or unique identification number on every page/screen.

2.4 Patient alert details (e.g. hypersensitivities, significant contraindications etc.) should be recorded in a timely manner and clearly displayed/documentated.
3. Standard Statement on Content

Records should be comprehensive. They should provide an accurate account of consultations and evidence to support clinical decision making.

3.1 Text should make clear the reason for attendance, any investigations performed, diagnosis (if relevant), outcome and future plan.

3.2 There should be appropriate procedures to action the results of investigations and to record those actions.

3.3 Where a particular method is provided or is already in use, compliance with UKMEC should be evidenced by recording the details recommended in the relevant Appendix to this document (pages 13 to 24). These details should be reviewed and updated at subsequent attendances.

3.4 Consent should be recorded 4,6,7,8,9 (where appropriate e.g. for intimate examinations or invasive procedures).

3.5 If a chaperone is offered the patient’s decision to accept or decline should be documented with the name of the chaperone if used.

3.6 Patient participation in decision making should be recorded if appropriate.

3.7 If others are present during a consultation (e.g. partner, friend, relative, interpreter, or trainee) their name should be recorded and, in the case of interpreters, the language used (and language line number as appropriate).

3.8 Individual services may wish to develop record keeping tools to facilitate the recording of a holistic history.
4. Standard Statement on Communications

All modes of communication should be documented, acceptable to the patient and conform to information governance standards.

4.1 Records should indicate the preferred mode of contact and any restrictions on mode of contact as requested by the patient.

4.2 If standard letters are sent these should be identified in the patient record.

4.3 Copies of letters and referral forms should be kept with a record of all addressees and whether a copy was offered to the patient.

4.4 Communications by telephone, SMS, fax and email should be recorded.

4.5 All communication and information transfer methods should be secure and ensure confidentiality e.g. use of NHS mail.

4.6 Information provided in the form of leaflets/websites should be recorded, with the source and date of publication of written information.
5. Standard Statement on Special Issues

The patient record should contain the appropriate documentation to support potential investigations and liaison with or referral to other agencies.

5.1 Health professionals may wish to use checklists (e.g. Fraser guidelines, child sexual exploitation proforma) to assess competence and risk when providing contraceptive methods or advice to young people.

5.2 Advice sought, actions taken and disclosures made in accordance with Safeguarding Children or Vulnerable Adults policies should be clearly documented.

5.3 Medico-legal, complaints documents or incident forms should not be filed within the case note folder or personal electronic record, but stored or filed separately.
6. Standard Statement on system review and audit

Services should regularly monitor their compliance with local and national guidance.

6.1 Records management policies should be regularly reviewed and updated in accordance with the NHS Code of Practice.

6.2 Compliance with record keeping standards should be audited regularly.
7. Standard Statement on prescribing, supply and administration of medicines.

**Full details of all drugs and devices prescribed, supplied or administered should be clearly documented.**

7.1 The following information about the prescription, supply and/or administration of the medicine(s) should be documented:

- date and time of prescription, supply and/or administration
- details of medicine, such as name, strength, dose, frequency, quantity, route and site (if by injection) of administration (record the batch number and expiry date)
- name and signature (which may be an electronic signature) of the health professional prescribing, supplying or administering the medicine
- relevant information that was provided to the patient or their carer including manufacturer’s patient information leaflet with each medicine.

7.2 In addition, if supplying or administering under a Patient Group Direction (PGD)\(^{14}\)

- a statement should be recorded that supply or administration is by using a PGD
- it should be documented how the patient met the criteria of the PGD

7.3 All PGDs must comply with the NICE Medicines Practice Guidelines (Patient Group Directions) and all those supplying or administering medicines under them must be aware of their responsibilities in using them\(^{14}\)

7.4 When prescribing, supplying or administering a medicine for use outside the terms of its product licence (“off-licence” or “off-label”) the clinician must make a clear and accurate record of the reasons for this and the steps taken to obtain valid consent from the patient when this use falls outside common practice; however the use of contraceptive medicines as recommended in current guidance from the FSRH Clinical Effectiveness is regarded as common practice\(^6,7,10,11,12\) (PGDs can be used to supply and/or administer medicines outside the terms of their SPC, provided that such use is supported by evidence and best clinical practice)\(^15\)

7.5 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 website\(^13\), this should be recorded
References


5. Record keeping Guidance for nurses and midwives 2009


Other sources of information

- RCOG e.g. Patient Record Standard for tubal occlusion procedures in women
- BASHH e.g. UK National guidelines on undertaking consultations requiring sexual history taking 2013 UK National Guideline on the Management of STIs and related conditions in Children and Young People (2010)
- GMC Good Medical Practice
- Nursing & Midwifery Council
- Data Protection Act 1998
- Freedom of Information Act
- NHS Connecting for Health
- Care Quality Commission
- Provider organisation record keeping policy
APPENDICES

Appendix 1  Combined hormonal methods (oral, patch, vaginal ring)
Appendix 2  Progestogen-only Pill (POP)
Appendix 3  Progestogen-only Implants
Appendix 4  Progestogen-only injectable 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.
Appendix 1

Service Standards for Record Keeping for Combined Hormonal Methods

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 or anticipated 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 Lupus antiphospholipid factor positive or unknown
   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
1.7.2 Non-prescribed/complementary

1.8 Allergies

1.9 Family history
1.9.1 Genetic mutations 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 and investigations
2.1 Blood pressure (BP)
2.2 Weight and body mass index (BMI)
2.3 Any other

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

Available at http://www.fsrh.org/pages/clinical_guidance.asp

1. Faculty of Family Planning and Reproductive Healthcare Clinical Effectiveness Unit. Combined Hormonal Contraception 2011 (updated August 2012).
2. The UK Medical Eligibility Criteria for Contraceptive Use 2009
4. Faculty of Sexual and Reproductive Healthcare. Statement on 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 Lupus antiphospholipid factor positive or unknown
   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 and investigations**
   2.1 Weight and body mass index (BMI)
   2.2 Any other

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.

**Source of information**

Faculty of Sexual and Reproductive Healthcare. Clinical Effectiveness Unit Guidance on Progestogen-only pills (update in progress)
Appendix 3

Service Standards for Record Keeping for Progestogen only 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 Lupus antiphospholipid factor positive or unknown
      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 Bleeding pattern
   3.6 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 i.e. which arm and where
4.4 Type of Implant inserted, batch number and expiry date
4.5 Implant palpable after insertion by health care professional and patient ideally
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 method of contraception 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

**Source of information**

Faculty of Sexual and Reproductive Healthcare. Clinical Effectiveness Unit Guidance on Progestogen-only Implants February 2014
Appendix 4

Service Standards for Record Keeping for Progestogen-only injectable 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
      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
   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
      1.4.5 Stroke
      1.4.6 Current venous thromboembolism on anticoagulants
      1.4.7 Diabetes, duration of diabetes, presence/absence of nephropathy/retinopathy/neuropathy
      1.4.8 Lupus antiphospholipid factor positive or unknown
      1.4.9 Migraines with aura
      1.4.10 Active viral hepatitis
      1.4.11 Severe cirrhosis, liver tumours
      1.4.12 Current or recent breast cancer
      1.4.13 Eating disorder e.g. anorexia nervosa
      1.4.14 Any other serious medical condition
   1.5 **Medication**
      1.5.1 Prescribed, particularly anticoagulants, oral 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
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 administering**
   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**


1. Faculty of Sexual and Reproductive Healthcare. Clinical Effectiveness Unit Guidance on Progestogen-only Injectable Contraception. (update in progress)
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 Treatment to cervix, including surgery
   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**

Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit Guidance on Intrauterine Contraception 2007 (update in progress)
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 (spontaneous or therapeutic)

1.4 Drug Interaction

1.4.1 Use of interacting medication e.g. enzyme inducers

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 for hormonal emergency contraception

3.1.1 Which products discussed and product selected for use

3.1.2 IUD discussed and fitting offered if appropriate

3.1.3 Mode of action

3.1.4 Risk of failure particularly in view of the time of the cycle when UPSI occurred & time since UPSI

3.1.5 How to take product

3.1.6 Action to take if vomits within 2 or 3 hours

3.1.7 Possibility of irregular bleeding & timing of next bleed

3.1.8 Indications for pregnancy test & follow-up

3.1.9 Product gives no ongoing contraception – option to quick start a regular method to reduce further episodes of risk

3.1.10 Method leaflet given

3.1.11 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 On going 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 Patients’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 patient 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 e.g. off licence use
4.1.3 Copper Intrauterine Device fitted – Refer to Intrauterine contraception record keeping
standard

Sources of information

Available at http://www.fsrh.org/pages/clinical_guidance.asp

1. Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit. Emergency Contraception
Guidance January 2012
2. Faculty of Sexual and Reproductive Healthcare. Clinical Effectiveness Unit. New Product Review.
Ulipristal Acetate. October 2009
3. Faculty of Sexual and Reproductive Healthcare. Clinical Effectiveness Unit Statement. Update on the
use of Ulipristal (ellaOne®) in breastfeeding women. March 2013
4. Faculty of Sexual and Reproductive Healthcare. Clinical Effectiveness Unit Statement. Drug
Interactions between Hormonal Contraception and Ulipristal Products: ellaOne® and Esyma®.
Appendix 7

RetentionPolicy

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


The table below suggests different time periods for the retention of medical records in specific clinical settings. It was written at a time when family planning and genitourinary medicine were separate specialities. The current recommendation is that all records relating to sexual health follow the recommended retention period for genitourinary medicine as in the table below.

<table>
<thead>
<tr>
<th>Health Record</th>
<th>Minimum Retention Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion – Certificate A (Form HSA1) and Certificate B (Emergency Abortion)</td>
<td>3 years</td>
</tr>
<tr>
<td>Audit Trails (Electronic Health Records)</td>
<td>NHS organisations are advised to retain all audit trails until further notice.</td>
</tr>
<tr>
<td>Cervical screening slides</td>
<td>10 years</td>
</tr>
<tr>
<td>Children and young people (all types of records relating to children and young people)</td>
<td>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</td>
</tr>
<tr>
<td>Clinical audit records</td>
<td>5 years</td>
</tr>
<tr>
<td>Clinical Protocol (GP, in-house)</td>
<td>25 years</td>
</tr>
<tr>
<td>Clinical psychology</td>
<td>20 years</td>
</tr>
<tr>
<td>Counselling records</td>
<td>20 years or 8 years after the patient’s death if patient died while in the care of the organisation</td>
</tr>
</tbody>
</table>

Guidance for best practice: the employment of counsellors and psychotherapists in the NHS, British Association for Counselling and Psychotherapy (BACP) 2004
NB “Those (counsellors) working within the NHS may be obliged to make counselling entries onto the patient’s medical records or in a case-file…” These records are subject to the retention periods in this schedule.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DNA (health records for patients who did not attend for appointments as outpatients)</td>
<td>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.</td>
</tr>
<tr>
<td>Contraception and Sexual Health records (including where a scan is undertaken prior to termination of pregnancy but the patient goes elsewhere for the procedure)</td>
<td>8 years (in adults) or until 25th birthday in a child (age 26 if entry made when young person was 17), or 8 years after death. See also Guidance on the Retention and Disposal of Hospital Notes, British Association for Sexual Health and HIV (BASHH) <a href="http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf">http://www.bashh.org/committees/cgc/servicespec/guidance_retention_disposal_notes_0606.pdf</a>.</td>
</tr>
<tr>
<td>Genito Urinary Medicine (GUM) Includes sexual health records</td>
<td>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</td>
</tr>
<tr>
<td>Service/Category</td>
<td>Retention Period</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Immunisation and vaccination records</td>
<td>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.</td>
</tr>
<tr>
<td>Learning difficulties and Learning disabilities</td>
<td>Retain for the period of time appropriate to the patient/specialty, e.g., 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 the patient died whilst in the care of the organisation.</td>
</tr>
<tr>
<td>Operating Theatre Lists (paper)</td>
<td>4 years (for those lists that only exist in paper format and are the sole record); 48 hours (for prints taken from computer records).</td>
</tr>
<tr>
<td>Operating theatre registers</td>
<td>8 years after the year to which they relate.</td>
</tr>
<tr>
<td>Outpatient lists (where they exist in paper format)</td>
<td>2 years after the year to which they relate.</td>
</tr>
<tr>
<td>Referral letters (for patients who are treated by the organisation to which they were referred)</td>
<td>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, e.g., 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 the patient died whilst in the care of the organisation.</td>
</tr>
<tr>
<td>Referral letters for clients referred to health or care services but not accepted.</td>
<td>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, e.g. 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.</td>
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<tr>
<td>Referral letters where the results are sent back to GPs</td>
<td>2 years</td>
</tr>
<tr>
<td>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)</td>
<td>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, e.g. 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.</td>
</tr>
<tr>
<td>Service Standards for Record Keeping in</td>
<td>Contraception in Sexual and Reproductive Healthcare Services</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Scanned records relating to patient care</td>
<td>Retain for the period of time appropriate to the patient/specialty, e.g. 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.</td>
</tr>
<tr>
<td>Standard Operating Procedures (current and old)</td>
<td>30 years</td>
</tr>
<tr>
<td>Ultrasound records (e.g. vascular, obstetric)</td>
<td>Retain for the period of time appropriate to the patient/specialty, e.g. 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</td>
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