

Therapists in Private Practice

Guidance Sheets 2

Record Keeping

Foreword

I am so pleased to introduce the second of our well informed, comprehensive Therapists in Private Practice (TIPP) guidance documents to you all.

We are aware how difficult it can be to navigate all that record keeping in therapy encompasses so this document has been produced to help break this down and guide you through all that is needed. Inside you will find the guidance covers each stage of the therapeutic process with regards to record keeping and what you should be covering at each step. It also offers a really clear explanation of GDPR and the importance of complying with these requirements, together with many tips and suggestions throughout.

I feel it has been written in such a way that it is both easy to digest the important information and practical enough to utilise where applicable/appropriate. I really hope that you find this too and can incorporate some of this guidance into your everyday practice whilst remembering to always consider what is legal and ethical.

This is such a complex topic so we are particularly thankful to our Head of Private Practice, Faye, for bringing a number of areas together so clearly and concisely for you all. Many thanks also to our Comms Manager, Elaine, for working her magic again and making it such an easy-to-read document. Please remember that we are always here if you have any queries or concerns.

Take care and best wishes,

Freya Bottomley

Deputy CEO

Introduction

The keeping of a client's personal information is a privileged, yet complex duty. It is an important part of our work to maintain records of the therapeutic process (depending on your modality), but it is not always clear how much, for how long and what data we need to record. Especially since the introduction of General Data Protection Regulation in May 2018 (GDPR), it is more important than ever that we keep a constant eye on our practice of record keeping, as there are legal obligations for us to do so.

GDPR is a set of data protection rules, which enhance how people can access information about themselves and places limits on what organisations can do with personal data they hold. For the purposes of GDPR in our work as hypnotherapists

we are classed as 'Data Controllers' and this means we must adhere to strict rules and principles as keepers of someone else's sensitive information. The European Commission summarises GDPR as 'Privacy by design and privacy by default'. This means that any processing of personal data must be done with data protection and privacy built in at every stage. Once a service has been initiated, the strictest privacy settings must apply by default. Putting it simply, as therapeutic practitioners we could see it this way; it is about treating any information our clients give us, sensitively and respectfully. In many respects we are already used to doing this in our client work; we always hold their personal stories carefully and confidentially and have that at the heart of our practice. We just need to be sure that we replicate this ethos in our record keeping and ensuring it is backed up by good practice.

At the core of GDPR are seven key principles which have been designed to guide how people's data can be handled. GDPR's seven principles are:

- **Lawfulness**
- **Fairness and transparency**
- **Purpose limitation**
- **Data minimisation**
- **Accuracy**
- **Storage limitation**
- **Integrity and confidentiality**
- **Accountability**

Here we will set out the information you need to ensure that all the client details you hold are recorded and stored legally and ethically. However, due to the complex nature of our work in hypnotherapy and the laws in place, this information should only be seen as guidance. Sometimes as practitioners we have to use our own judgment about a particular situation, and this is where the support of supervision is particularly important. It helps to remember that there are always two important points you need to consider if ever you are unsure; is it ethical to keep this information, and is it legal? If asked, would you be able to give a valid reason as to why you may hold certain personal information about a client?

If you have any specific concerns or questions, it might be best, in addition to using supervision, to contact the HS directly, or in specific circumstances, a legal representative.

The Hypnotherapy Society Code of Ethics states under the section 'Confidentiality, Maintenance of Records and Recording of Sessions':

All Practitioners undertake to:

"Ensure that client notes and records be kept secure and confidential and that the use of computer records remains within the terms of the Data Protection Act. N.B. Manual records should be locked away when not in use and those held on computer should be password coded. Client records (paper files, laptops) should be kept in a locked cabinet within a locked office. Avoid transporting client files outside of

your practice premises - if this must be done keep files in a locked container. Should you need to leave client records in a car, they should be in a secure, locked container and locked in the car boot. Recognise that the maintenance of case notes should include personal details, history, diagnosis, a programme of sessions (as agreed between therapist and client), session progress notes and a copy of any contract.”

Let’s break that down in more detail and look at what you can do to ensure that you comply to all professional and legal standards.

To do this, we will use an example of a typical therapeutic process from beginning to end and follow it through each stage, in relation to record keeping. But first...

What are Client Records?

Whilst you could think that client information consists of just a few contact details and our case notes (also known as ‘process notes’), this is not the truth. Anything we are in possession of that relates to a client, is considered part of their record. This might include any of the following:

- Our appointment diary, with any record of past or future sessions.
- Invoices and receipts.
- Any forms of communication; emails, texts, voicemails etc.
- Contracts.
- Questionnaires and assessments.
- Records of any interventions; worksheets, diaries etc.
- Photographs, artwork.
- Audio or video recordings.

In all cases, remember those two important points that we must consider; is it ethical to keep this information, and is it **legal**?

Initial Contact

Your first communication with someone who may wish to use your services, automatically involves the requirement of obtaining some information about them. If they have contacted you by email, you will then be in possession of their email address. If they have called you on the phone, you may have taken down their name and contact number in order to call them back, and you might also have a voice recording of them on your answerphone. Of course, we may never hear from this individual again if they choose not to go ahead and book any hypnotherapy sessions, but we must still ensure that we don’t keep their contact details anywhere that they will be seen by anyone else (have you scribbled their name and number in haste on the back of an envelope, or in a notepad/diary?) and we must not keep them longer than we need to. In these situations, delete any emails (and then delete them from your ‘Trash’ folder to make the removal permanent and

irreversible), delete any voicemail messages that the enquirer may have left and permanently and effectively destroy any paper record you may have of their name and number by shredding or burning. If desired, you could send any sensitive paperwork to a confidential waste disposal provider. There will be local companies near to you that provide this service, and it is relatively cost effective to do.

An important note to mention here is regarding telephone/email communication where you may use the same phone number, email address or even postal address for both personal and professional contacts.

In the eventuality that any of these contact details are shared across both aspects of your life, then you need to consider who else might access client information accidentally as a result of a set-up like this (more likely if you work from home)? Do you have a family member for example who could accidentally open your post (same initials for example), or answer your phone? Again, you need to ask yourself, should an error such as this occur, would this be considered an unethical and/or an illegal breach?

As such it may be better to use a separate phone and email address for your work in order to keep clear boundaries in place. If you have mail sent to your home by clients, then how can you minimise any risk of it being opened by someone else? Could you use a P.O Box for example, or get your mail sent somewhere else?

Initial Session

It is often our first session with a client which necessitates the collection of most of the information and data (other than case notes) that we will keep about them. Your chosen therapeutic approach, your method of delivering therapy (e.g. in person or remotely), as well as other variables, may dictate which information you want to collect. However, whatever your approach, it is important to know that since the introduction of GDPR it is now considered good practice to keep, within reason, as little information as possible. There is debate (particularly in our profession) about which details you need on record, but you may well keep all the following:

- Full name
- Address
- Contact details e.g. telephone (maybe more than one), email address
- Emergency contact*

Some practitioners also like to take down the following details:

- Name of GP and surgery
- Medication
- Medical History

***NB: for the purposes of a client giving you the contact details of an emergency contact (usually a close friend or family member), in this case the client is**

considered to be the ‘data controller’ and as such it is their responsibility to inform the third party that their contact details have been given to you.

It is possible that you include other pieces of information on your assessment form, but if you haven’t already, maybe now is the time to look at any other data you request and whether it is really necessary to have. Less is considered best practice now (we discuss ‘data minimisation’ later

on) and it is in both your clients and your own best interests, to keep records to a minimum.

It is imperative that GDPR rules are adhered to as they are legally binding. The view of the Society is that it is not good practice to keep no records.

In our first session, we will also be going through our contract/agreement with the client and asking them to sign it. As already noted, this contract also makes up what is considered part of our client records. It will need to include, either within the contract or as a separate document, a ‘Privacy Notice’ or ‘statement’, that gives accurate and up to date information about the data and information we will ask our clients for, why we need to do this, and how long we will keep it for. Under GDPR rules, we need explicit (i.e. written) consent from the client to obtain and keep that information.

What if a client does not give consent?

A client is completely within their rights to refuse consent for any of the above. The purpose of GDPR is about giving legal rights and protection back to individuals regarding the processing of their personal details. If a client declines your request to have this information about them, you have two choices:

- 1. Explain in more detail why some of this data is important for their safeguarding and wellbeing, as well as at times, for the efficacy of therapy. If they still decline, then you may decide that....**
- 2. You are unable to take them on as your client.**

Payments

You will be expecting to be paid by your clients for your services and depending on how you take payment, you may find yourself with their name on your bank statements if they have paid by BACS (bank transfer) and as such you have a duty of confidentiality to protect your client from being identified by your accountant or bookkeeper.

This may mean you have to consider redacting their names from your statements before handing them over; as you can see this is not only a legal consideration in terms of data protection policies, but also an ethical one in relation to client confidentiality. If this is not something you want to consider doing then you will

need to explain in your 'Privacy Policy' for clients, the possibility that their names will be seen by a 3rd party.

You will also have receipts and invoices with client's names on, all of which are considered personal data under GDPR legislation. These will need to be kept for as long as financial records for your business are expected by HMRC (legal obligation). At time of writing, this should be 5 years. If you have concerns about employees at HMRC having access to client names (for example if you are audited), then rest assured they are bound by strict confidentiality rules themselves.

To disclose lawfully required information by an organisation such as HMRC is considered neither an ethical nor a legal (GDPR) breach.

Appointment Diary

Some of us are old-school and our appointment diary continues to be in paper form, for others it could be on your phone, computer calendar or even an online booking system hosted by a third party. In all cases however, it is important we bear in mind how securely we keep this information and how we record it.

Firstly, ensure all paper diaries are kept in a secure, locked place and the room is also secure. All electronic systems containing your diary need to be password protected and if possible encrypted.

It is also good practice to give each client a unique reference number/code which can then be used for scheduling appointments. In this way, even in a worst-case scenario of your diary somehow being found by someone else, then there are no identifiable names to be seen. Simply keep a separate file for yourself which lists each client with their unique reference for your own purposes of identification.

Client Work

The story so far; you have successfully engaged a new client, and each step up to this point has involved a sensitive and diligent respect for any information you have obtained about them. Some of it you may have already deleted/destroyed, the rest is being kept securely in locked files or password protected electronic documents. The therapeutic process now begins and with it comes more data collection in the form of process notes, assessment forms if used, artwork, personal diaries, or even audio recordings. So, let's look again at a phrase used earlier; '**data minimisation**'.

Data Minimisation

The ICO describes data minimisation as, "collecting the minimum amount of personal data that you need to deliver an individual element of your service. It means you cannot collect more data than you need to provide the elements of a service the client actually wants to use."

You shouldn't collect more personal information than you need from a client. "You should identify the minimum amount of personal data you need to fulfil your purpose," the ICO says. "You should hold that much information, but no more."

To illustrate this it gives 3 points to consider for the data you are processing. It needs to be:

- 1. Adequate - sufficient to properly fulfil your stated purpose;**
- 2. Relevant - has a rational link to that purpose; and**
- 3. Limited to what is necessary - you do not hold more than you need for that purpose.**

Yet again, in therapeutic process notes, there would be many differing opinions as to what constitutes, adequate, relevant and limited to what is necessary; depending on each therapeutic approach. One way to think about it is to bear in mind that your client, under GDPR rules, has the right to access any notes you keep about them. As such, consider what you would feel comfortable for your client to see? Furthermore, should your notes be used in a court case for example, or at worst, be accessed by another entirely random external source. What would be appropriate to be available to external parties?

With these scenarios in mind, it is advisable to ensure your notes do not contain too many details or are too intimate. They should contain no information that makes your client identifiable. It is also recommended that you refrain from recording personal reflection or opinions about your client or their case. Anything that could be open to interpretation by a third party or the client themselves should be avoided. If you do consider it important to take note of your own interpretations of client work, they will need to be clearly labelled as such.

Process Notes

Bearing all the above in mind, we can now better understand the extent to which we can record information about each session we conduct. Essentially, as little as possible. Which begs the question, why keep any such records at all? You might be thinking it sounds complex and daunting, so is it better to keep no records at all?

Remember the quote from the HS that was mentioned earlier?

"Ensure that client notes and records be kept secure and confidential and that the use of computer records remains within the terms of the Data Protection Act. N.B. Manual records should be locked away when not in use and those held on computer should be password coded. Client records (paper files, laptops) should be kept in a locked cabinet within a locked office. Avoid transporting client files outside of your practice premises - if this must be done keep files in a locked container. Should you need to leave client records in a car, they should be in a secure, locked container and locked in the car boot. Recognise that the maintenance of case notes should include personal details, history, diagnosis, a programme of sessions

(as agreed between therapist and client), session progress notes and a copy of any contract.”

Not only do we need to consider the implications of the impact of our clients sensitive information being disclosed outside of the therapeutic environment, whether by necessity or accident, but we also need to think of the impact on ourselves should we be called upon to discuss our work with a client in a legal context. For example, if you were called to represent the client at court, or if a complaint has been made against you. Having no record of the work you have done could potentially expose you to risk in event of complaint or misunderstanding. We need to protect ourselves and we need to be able to exhibit our professionalism; keeping process notes can be evidence on both accounts.

Ideally, case notes will be written as soon as possible after a session has ended. Many of us work to a 50-minute hour, whereby we are with our client for 50 minutes and the final 10 minutes provide an opportunity to write our notes. Some practitioners prefer to write notes from all their sessions at the end of the day. This is all personal choice, but the fresher the client work is in your mind, the more accurate your notes will be. There should be nothing in your notes which could identify the client; no mention of workplace, names of family members etc.

In the eventuality that you need to move any personal data from one place to another, for example from your office to home, or vice versa, then you will need to ensure that this is also done safely. The HS Code of Ethics states:

“Client records (paper files, laptops) should be kept in a locked cabinet within a locked office. Avoid transporting client files outside of your practice premises - if this must be done keep files in a locked container. Should you need to leave client records in a car, they should be in a secure, locked container and locked in the car boot. Records held on computer should be password coded.”

To summarise, keep your notes brief, factual and not open to interpretation. Remember to ask yourself, is what you are writing legal and is it ethical? Who could potentially ask to read it in the future? Keep them locked (if hard copies) or password protected/encrypted if digital. If transporting files, consider carefully how this can be done safely to ensure they are fully protected at all times.

When Mistakes are Made: Ethical Duty of Candour

In our work, we hope and expect that our clients will be as honest and truthful as they can and we know that for the therapeutic relationship to work effectively, this needs to be reciprocated; we all understand ‘authenticity’ and its importance. When we make errors in any aspect of our work, then it is our responsibility to be transparent with our clients about this. The ‘Duty of Candour’ came into being for healthcare settings registered with the Care Quality Commission, and states that service providers have a duty to be open and honest with patients (or ‘service users’), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.

Whilst in a legal sense, we are not bound by the Duty of Candour, it is a principle we can ethically adopt and use to guide us in our work. Therefore, we should be prepared to inform our clients (and if regarding a data breach, the ICO) of any mistakes we've made which could potentially cause harm.

The ICO rules under GDPR state that should a data breach occur it must be reported to them within 72 hours and the individual whose data has been compromised must also be informed. You must then take any action necessary to prevent or minimise any harm and where possible you need to repair any damage caused. Clear apologies need to be made to any individual affected and evidence be given of measures put in place to prove that you have updated your processes accordingly to avoid the mistake being repeated. Finally, as with everything else in our work, you should inform your supervisor and discuss what has happened with them.

Ending Therapy

Our clients have the right to access session notes at any time during or after their therapy. Should they do so, you have the right to ask for some time to obtain their file and prepare it for viewing, but this does not mean you have permission to redact or rewrite any notes for the purpose of the client seeing them. Therefore it is imperative that anything you write during the therapeutic process, should always be written with the understanding that it could be viewed at any time.

How long should we keep a client's data?

There continues to be some debate as to how long we should keep a client's case notes after therapy has ended and as such it remains unclear exactly what is right. Insurance companies, membership bodies and the ICO often have different advice. The general guideline, subjective as it is, is that you can destroy any data/records when it is no longer useful/necessary in relation to the reason you originally collected it. It is probably fair to say that if you can give a reasonable legal and ethical explanation regarding the keeping of, or deleting of a client's record, then you should be ok. Should any legal cases or complaints arise, it is worth knowing that a civil claim can be made up to 6 years after therapy, or 6 years after their 18th birthday for any minor you have worked with.

However, although notes would be helpful should a legal case arise, they are not necessary. It is considered to be good practice that anytime between 6 months and 2 years after therapy has ended, a short summary of the process and outcomes can be recorded, along with dates and number of sessions attended. This can then be stored for as long as necessary and all other files relating to the client can be disposed of.

Other Considerations

Requests for information from Police or other agencies / third parties.

It is natural to feel obligated to comply with requests from external agencies that could be seen as having more authority than ourselves, but in reality except in very rare and specific circumstances, releasing our process notes requires a client's explicit consent. As such you should not feel pressured into giving this information to any authority, even the police, without permission from the individual concerned. You have every right to refuse passing on this sensitive information until you have spoken with your client. If in any doubt, contact your supervisor or the Society.

Therapeutic Will

The safe disposal of records on your illness or death is an important and necessary consideration for your practice.

As part of your therapeutic will, ensure that you have nominated at least one and if at all possible two, trusted people who will ensure that all of your clients information will be properly handled should anything happen to you. You will need to leave instructions which include details of where you keep all records (paper and digital), where any keys for filing cabinets are etc. as well as passwords for all electronic devices and software.

Summary - Good Housekeeping

- Only collect personal data you need for your specified purposes.
- Ensure you have sufficient personal data to properly fulfil those purposes.
- Periodically review the data you hold and delete anything you don't need.
- Keep up to date with your admin. Consider setting time aside, perhaps once a week, for going through all your client records (digital and paper) and removing any that you no longer need.
- Hitting delete on an email or document, isn't enough. Email 'Trash' folders, need to be emptied, as does your 'Recycling Bin' for any other digital documents you may hold.
- Keep any case notes separate to personal identifying information about your client.
- If you use a mobile phone to communicate with clients, it's important to ensure their identity and contact details cannot be compromised. Make sure your phone has adequate security to prevent access by anyone other than yourself.
- Data minimisation: only record what is adequate, relevant, limited to what is necessary. Who might ask to see your notes? Keep only a factual record of your session and do not include anything that might disclose a clients identity; home, workplace, family etc.

- Full disclosure: be sure that (usually through your Privacy Policy and/or Contract) your clients are fully aware of all the data you will collect and retain about them, why, how and for how long.
- It is your legal duty, under GDPR, to get a client's explicit permission (i.e. written consent) to hold that data.
- Should any breach occur, it is your legal duty to inform your client and the ICO within 72 hours.
- Ensure you have systems in place to safely dispose of any records in the event of you becoming incapacitated or your death.

We hope this guidance has been helpful for you and that you can, if you aren't already, build some of these practices into your daily routine. Do remember however, that due to the nature of the work we do, some personal judgement or further guidance from other sources may be needed. If you are ever in doubt, take it into supervision, check with your insurance company, or of course get in touch with us here at the Society.

Connect with us today!

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