Clinical records procedure

SOP TEMPLATE

Check this template against your local regulations and your own policies before you use it.

SOP no.		Version		Effective date	
Owner		Approver		Review date	

Purpose

To make sure every patient's record is accurate, complete, written on time and kept secure.

Scope

Every clinical record made by any clinician at the practice, on paper or electronically.

Responsibilities

Role	Responsibility
Clinicians	Write complete notes for every consultation on the day.
Practice manager	Manages access, requests and retention, and audits notes.

Procedure

1. **Record the assessment**

   Record the history, findings, diagnosis, goals, plan and the consent given.

2. **Record every treatment**

   Record the date, what was done, the patient's response, any advice or exercises, and the plan.

3. **Write on the day**

   Write notes during or straight after each session, and always the same day.

4. **Correct, don't delete**

   Add a dated correction rather than changing or deleting an earlier entry.

5. **Keep records secure**

   Use your own login, lock screens, and never take records off-site unsecured.

6. **Handle requests**

   Give patients access to their records and transfer them to other providers as the privacy law allows, with written consent.

   > **Caution:** Check the requester's identity before releasing any record.

7. **Keep and dispose**

   Keep records for as long as your local rules require, then destroy them securely.

Records

- The clinical record for each patient.

- The register of access and transfer requests.

Related documents

- Patient consent procedure

Revision history

Version	Date	What changed	Approved by