

Giving patients the opportunity to access their own records online improves relationships with health professionals and gives patients autonomy

Increasing access to patient records

In this article...

- **Benefits for patients and nurses of increased access to records**
- **Possible drawbacks to increased access**
- **Implications for practice**

Author Jacqui Gladwin is a principal lecturer at Department of Nursing at Manchester Metropolitan University.

Abstract Gladwin J (2013) Increasing access to patient records. *Nursing Times*; 109: 35, 22-24.

By 2015, all patients are expected to be able to order prescriptions and book appointments online, as well as being able to access their own GP-held records. This will undoubtedly hold benefits for patients and health professionals, but is likely to present significant challenges for nurses in terms of managing patient expectation and ensuring fair access.

This article discusses the background to records access and outlines the possible benefits for patients and nurses. It gives a personal perspective of the challenges for nurses and patients in accessing online GP services.

The concept of patients accessing health records has become an established part of the NHS constitution (Department of Health, 2013), which states that patients have the right to access their own health records.

Patients, or those authorised by the patient (including children assessed to be "Gillick competent"), are entitled to access their medical records under legislation provided by the Access to Medical Records Act 1988 and, with certain exemptions, the Data Protection Act 1998. Provisions under the Mental Capacity Act 2005 have also enabled access for those who lack mental capacity. However, records access usually involves making a written application to the organisation holding the record and the applicant will normally have to pay to access the information.

The implementation of electronic health records (EHR) has made it easier for patients to access their records. A small group of GPs has pioneered a system that allows patients easy access to GP-held records. This group includes Amir Hannan who took over many of Harold Shipman's patients and in doing so recognised the great deal of work needed to rebuild the trust between doctors and patients (Hancock, 2006). His response was to set up electronic records access using the Egton Medical Information System (EMIS) for his patients.

As one of Dr Hannan's patients, my immediate response to the concept was shock and I responded as a nurse rather than a patient, asking him the questions I have since heard other professionals ask:

- » What happens if patients see information that is incorrect?
- » How safe is the system?
- » What happens if they see something distressing when the surgery is closed?

It appeared that my concerns with the system were not shared by other patients attending the practice. In fact, I found that other patients responded enthusiastically. At a meeting to discuss the development of records access, several patients in attendance had found errors in their records. However, rather than viewing this negatively they were positive about being able to identify errors and the response they had received when they reported them. Reactions included feeling trusted to own the information, and secure when travelling abroad that they could allow health professionals to access their medical information if needed.

My fear that older patients may not have the skills to access their records was

5 key points

1 The NHS constitution gives patients the right to access their medical records

2 The better patients understand their condition, the more likely they are to be concordant with treatment

3 The EMIS system is currently the most widely used electronic records system in general practice in England

4 Records access improves transparency, which can help to build trust between patients and health professionals

5 Health professionals need to beware of making personal or inaccurate comments in records



Informed patients have better outcomes

also challenged when an 80-year-old woman explained that she had never used a computer before being given the opportunity to access her records. She had decided to buy a laptop and attend a beginner's course at the local library, and now uses the internet regularly and manages many of her health needs online.

Benefits for patients

The Department of Health (2006) suggests that informed patients have better health outcomes; the more they understand about their conditions, the more empowered they are and the more likely they are to be concordant with treatment. Empowerment, according to Kickbusch (2012), is simply about people gaining control and using their initiative to solve problems and make decisions. The better able patients are to manage their long-term health needs, the less likely they are to need crisis intervention, which could reduce the burden on acute services.

Since patients can make their records accessible to any service, they can receive individual support tailored to their needs from all services they come in to contact with. In the future, patients may have a single record, which everyone involved in their care is able to input into. For this to become a reality, we would need fully integrated IT systems that are more effective than the various systems healthcare organisations currently use; this is a significant barrier to achieving effective integration of care (Rosen et al, 2011).

The EMIS system is currently the most widely used electronic records system in general practice in England. It allows patients to view their complete records, order repeat prescriptions and book appointments, as well as providing links to a range of information about medication and health that patients can trust. This gives patients the opportunity to access further information about their needs and treatment, which can act as a basis for discussion at future consultations.

In the past year there have been several reports highlighting failings in care in a number of areas (Francis, 2013; Keogh, 2013; DH, 2012a). While evidence suggests that the public still believe in the philosophy of the NHS, 51% do not trust it to be open and honest (Dahlgreen, 2013). As professionals we must work to reinforce the NHS core values and rebuild trust with patients through greater transparency. Records access can support this by enabling patients to see the information documented about them.

Greater patient access to records will



Avoid abbreviations and jargon when recording information about care

undoubtedly help to identify errors, giving patients a role in ensuring the information held about them is accurate and relevant. Professionals' response when patients report errors will affect the level of trust between patients and professionals. We need to accept that in order to restore trust we have to help patients understand the context of their records and support them if they identify mistakes, which may have impacted on the care and treatment they have received.

Having access to their own records brings wider benefits as patients can decide who to share the records with. Sharing them with family and health professionals can support decision making across services, leading to improvements in care in areas where access to patient information may previously have been limited.

Benefits for nurses

According to Pagliari et al (2012), the potential benefits of increased records access include an increase in shared decision making between professionals and patients, and increased patient satisfaction with services. While this was a small-scale study, the results reflect the increase in patient satisfaction often reported following developments that offer a more personal service.

Patients who are involved in their care and concordant with treatment potentially need less nurse time, leaving nurses more time to devote to those needing more input. It is also likely that nurses will gain greater job satisfaction from seeing patients managing their own health needs and achieving better health outcomes as a result.

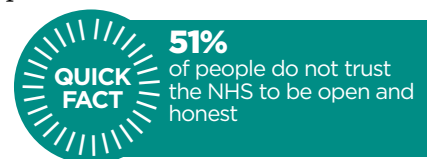
In my experience as an A&E nurse, there have been many occasions where patient safety has been compromised because we had limited information on their medical history. This system gives potential for health professionals to access patients' records from a password on a

medical alert bracelet, their trusted relative or even from a USB stick carried with them. This could help to make care safer and reduce the risk of errors.

Challenges

The DH (2012b) has outlined its strategy for implementing electronic records access for all by 2015, but there are significant challenges to achieving this. Although many GP practices already use the EMIS system, many have not activated the online functions that facilitate records access. Helping all practices to do this will require the support and involvement of clinical commissioning groups, education providers and health professionals across a range of care providers.

Managing "empowered" patients may be challenging for some health professionals who view their role as being the "knowledgeable adviser", and we must also respect the fact that many patients do not wish to become more independent in managing their health. Nurses will need to be able to adapt their approach depending on the level of engagement individual patients want to have with their care.



In order for all patients to understand their care and feel involved in it, as recommended by the Royal College of General Practitioners (2012), there must be trust between the professional and the patient. This can be difficult in a healthcare system under significant pressure in some areas, and where lack of time is the main hindrance to many interventions. Many nurses may see records access as just the "latest fad" and my experience of talking to nurses about it suggests a lack of interest or support for it in many areas. However, it needs health professional support in order to move healthcare forward and to support patients to improve their own health.

There is a significant challenge in ensuring access is available for everyone who wants it. Nurses will need to advocate for patients under their responsibility to the Nursing and Midwifery Council (2008). This is particularly important for those who do not speak English as their first language, as language barriers may exclude them from being able to understand the record. However, while fair access is an important principle, it should not become an argument against developing records access, as any service development would

BOX 1. RESOURCES

- **Access to Medical Reports Act 1988**
tinyurl.com/Gov-MedicalRecordsAccess
- **Data Protection Act 1998**
tinyurl.com/Gov-DataProtection1988
- **Mental Capacity Act 2005**
tinyurl.com/Gov-MCA

be restricted if it needed to be accessible to all from the beginning.

Many factors will influence patients' access to their records including capacity to consent, the type of information available and protecting or restricting access to third-party data. The challenge for clinical commissioning groups and practices will be to have appropriate systems in place and suitable governance processes to ensure safe and effective use. To develop safe and effective records access, investments in terms of time and money are essential. However, the evidence appears to suggest that these investments hold long-term benefits for patients and staff.

Some health professionals have voiced concerns that having access to their records may cause patients harm by increasing anxiety or causing confusion. Evidence from a variety of contexts suggests these concerns are unfounded (Ross and Lin, 2003); however, patients may be at a risk of harm from inappropriate opinion being recorded in their records. A study by Bloch et al (1994) into psychiatric notes found the majority of records they looked at contained significant entries that could be seen as offensive or inappropriate. Although a dated study, this highlights an important challenge in giving patients full access to their records – health professionals will need to make sure everything they document relates to their interaction with the patient. However, this may lead to greater transparency and a more honest approach as professionals will

know their patients are able to access the documentation.

Seeing information that is not an accurate record of a consultation or personal comments that may indicate a health professional has dismissed symptoms or holds subjective views can affect the relationship between patients and health professionals. My experience has made me more aware of the need to clearly, accurately and succinctly document information, avoiding jargon and abbreviations patients may find difficult to understand. This awareness can help nurses to keep their records accurate and safe and reduces the risk of errors. It is good practice to check your entries with your patient before you save them so you both agree on the context of the discussion.

Conclusion and implications for practice

For most patients the records held by their GP are their most complete health record and therefore likely to be the most useful in terms of supporting care. Access to these records will enable patients to be more involved in decision making and clinicians to have a more trusting partnership with patients who wish to take up the opportunity.

It is unlikely that allowing patients access to their electronic health records will revolutionise healthcare in the UK or increase the number of patients taking responsibility for their own health needs overnight. Many will take up the opportunity to access their records out of curiosity, choosing to access them as and when they access primary care services. However, the ability to order prescriptions and make appointments online is much more likely to benefit many more patients.

There are many challenges to implementing records access, not least gaining the resources required to facilitate access and establishing effective governance arrangements to oversee the process. However, we should find a way to support this and to enable patients to reap the benefits

of being able to access their records.

Nurses should not fear greater patient independence but should support patients to gain the most from the opportunities it presents, in particular the potential this gives for a more integrated health service. **NT**

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