Electronic Health Records (EHR):
Guidance for Community Pharmacists and Pharmacy Technicians

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This guidance has been produced by the Royal Pharmaceutical Society, the Association of Pharmacy Technicians UK and the National Pharmacy Association. It is anticipated that further versions of this document will be developed, as experience in practice increases the evidence base of pharmacist use of electronic health records.

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Professional Overview

Healthcare professionals need to keep records of patient care to ensure the safety, quality, consistency and continuity of care. They also enable the professional to respond to any questions that might arise subsequently about the care a patient has received.

Community pharmacy professionals use electronic health records to access patient information in systems such as the pharmacy patient medication record (PMR) system, a GP or other institutional system, or one of the national unscheduled care record services (the Summary Care Record in England, the Emergency Care Summary in Scotland, or the Individual Health Record in Wales). Some of these systems, such as PMRs, are well-established in pharmacy practice, whereas other systems, such as the national summary record systems, are still being used in a pilot capacity. However, professional requirements concerning the use and management of patient information in pharmacy practice apply for all of these electronic systems.

Pharmacy professionals should ensure that they create, use and maintain electronic health records according to the relevant legal requirements (Data Protection Act), professional standards (General Pharmaceutical Council Professional Standards for Confidentiality and Consent) and governance frameworks (NHS Connecting for Health Information Governance Toolkit).

Pharmacy professionals are advised to:

1) Ensure that electronic health record (EHR) systems used in their pharmacies comply with relevant information governance requirements (and, in England, the NHS Care Record Guarantee http://www.nigb.nhs.uk/guarantee).

2) Store, access and share electronic health record information in full accordance with professional standards for confidentiality and information governance requirements.

3) Take responsibility for the accuracy of patient information stored in electronic records.

4) Obtain overall consent for the collection, storage and use of identifiable patient information relating to pharmacy services, where there is not a legal or contractual requirement to store information.

5) Access national care records services in accordance with the consent model for that service (i.e. permission to view for the England Summary Care Record (SCR), where permission to view needs to be sought for each episode of care).

6) Ensure that patients are able to view their records when appropriate and feasible.

7) Exercise appropriate care and attention when EHR are accessed in the course of a patient consultation.

8) Maintain electronic health records in accordance with relevant records management guidance (guidance is available for Scotland and Wales).
Electronic Health Records - An Introduction

Healthcare professionals should maintain records of the patient care activities that they perform. It is recognised that good record keeping supports patient safety, evidence-based healthcare, continuity of care, and good professional practice. Record keeping also facilitates audit and quality monitoring, which has become of increasing significance in many healthcare economies, and is also important from a medicolegal perspective.

Over the last three decades, the use of PMR systems by pharmacy staff has become universal, and pharmacy professionals are familiar with the use of computerised records to support the dispensing process and provision of advice on medicines in their sphere of practice. However, in both community and hospital pharmacy, new pharmacy services and innovative ways of working are being developed, which require real-time access to electronic health records for clinical decision making. Furthermore, an increasingly multi-disciplinary approach to healthcare demands the use of patient records that are shared between different healthcare professionals. EHR systems enable this to happen.

However, EHRs contain sensitive, personal information about a patient’s medical conditions and treatment, and this information is used to make important treatment decisions. In addition, electronic records have the capacity to be disseminated or accessed from different locations. For these reasons, the security, back-up, support and accessibility of the record are important issues in the development and use of EHR, as is the question of who can or should contribute to the record and how they are identified.

This publication will provide guidance for pharmacists and pharmacy technicians on the use of EHRs in pharmacy practice. It will provide guidance on accessing the EHRs, sharing the EHR, subject (patient) access to records, and scenarios where EHRs may be used to support pharmacy practice. This guidance will encompass the specific use of the England national care records system, the Summary Care Record (SCR), but the principles will be equally applicable to other forms of EHRs used in pharmacy practice within a community pharmacy context. The guidance will be updated to take into account any experience gained with use of the EHR in a pharmacy setting.

Legal & Professional Framework for EHRs

There are three important concepts in law concerning the generation and subsequent use of records of patient care and professional activity.

They are:

- Confidentiality.
- Consent.
- Liability.

These three concepts underpin the need to record medical observations and patient care interventions and are discussed here from the perspective of EHRs.
Confidentiality

The privacy of patient identifiable data is governed in England, Wales and Scotland by common law, by the Human Rights Act 1998 and the Data Protection Act 1998, and other legislation. Requirements for confidentiality in the NHS are described in the NHS Confidentiality Code of Practice (1), and the Caldicott Principles. Confidentiality is one of the key professional requirements for pharmacists and pharmacy technicians, as with other healthcare professions, and the principle of confidentiality is included in the standards issued by the General Pharmaceutical Council (2).

Patients reasonably expect information collected in confidence in the context of a medical consultation to be stored securely, and treated in a confidential manner (not disclosed in an unauthorised manner). Health professionals therefore are said to have a duty of confidentiality, and are required to ensure that the confidentiality of patient information is safeguarded.

Where there is a need to transfer patient information from one care provider to another, professionals should ensure that the transfer of information takes place as securely as possible, in accordance with current NHS information governance requirements. When deciding whether or not to share patient information, the pharmacy professional's duty of confidence should be weighed against the need for the continuity of effective patient care, and the possible consequences to the patient if the information is not shared, so that a decision is made that is in the patient's best interest.

There are some clearly defined circumstances where a pharmacy professional is required to share patient information with a third party without the patient's consent (2), for example to assist the police in the investigation, detection or prosecution of serious crime.

Consent

In the UK, the Data Protection Act 1998 requires healthcare professionals to obtain a patient's consent to store information about them to support services provided, stating the purpose for which the information is being collected. The principle of consent is established in the General Pharmaceutical Council Professional Standards (3). Pharmacists should therefore seek explicit, informed consent from a patient to store and process their personal information to support any pharmacy services, in situations where there are no other overriding legal requirement to keep patient records. When a medicine is dispensed, pharmacy professionals are contractually obliged to make a record of the supply, and presentation of a prescription by a patient constitutes implied consent to this process. However, for any pharmacy service other than the dispensing of medicines, which requires an activity record containing patient identifiable information, patient consent must be sought to record and store their personal data.
Liability

Records of patient care and treatment have traditionally played a major part in providing evidence of appropriate patient care in situations when allegations of negligence are made. This has not been a major issue for pharmacists in the past, but as pharmacists take on new roles, and provide clinically-focused professional services, they will need to make appropriate documentation of patient care interventions in order to account for their professional decision making.

Some pharmacists may be reluctant to document professional activity in case it is challenged by a patient or relative at a later time. However, pharmacists should bear in mind that there is an equal liability associated with not comprehensively recording details of care provided and a contemporaneous note is often invaluable at a later date in helping to demonstrate that the appropriate standard of care was provided by the practitioner at the time.

The other major liability issue is concerning the use of information from national care records services such as the English Summary Care Records (SCR), Scottish Emergency Care Summary (ECS) and the Welsh Individual Health Record (IHR). If the information is available in a standard record, then it might be argued that the record must be accessed every time that a professional decision needs to be made, in order for the health professional to avoid liability. This a particular issue for pharmacists who are not working in a clinic or office setting, and where access to records is not easy, either for technical or feasibility reasons. For example, this issue has arisen in England with the proposed use of the SCR by community pharmacists who would be working in busy dispensaries.

While specific services (for example, the English SCR) provide guidance for healthcare professionals about liability associated with record use, the current consensus is that healthcare professionals have a number of record sources available to them, and that they should use their professional judgement concerning the best record to access in each instance. For example, if a pharmacist has a query about the supply arrangements for a patient receiving a clinical trial medicine, then it would be professionally justifiable for the pharmacist to seek the information to answer the query from systems other than the SCR. It is accepted professional practice that pharmacists currently complete many routine tasks (such as straightforward over the counter sales or the supply of repeat medication) without referring to additional sources of information, and having access to the summary care record is not expected to radically alter this situation.
Information Governance & Data Sharing

In a healthcare environment where IT is increasingly used to produce a joined-up service across care settings, it is essential that community pharmacists are seen to be handling patient information in a secure way when providing professional services.

This concern has been at the heart of the debate about community pharmacy access to national summary records, where some medical organisations and civil liberties campaigners have questioned the ability of pharmacists to handle sensitive patient information in what is seen as a “retail” environment. It is essential that community pharmacists fulfil their role as clinical professionals – and take on board the responsibilities that go with that role.

Information governance (IG) refers to the processes by which personal information is collected, managed, transmitted and used in a secure and confidential way in an organisation (4). The NHS Connecting for Health IG toolkit for community pharmacy provides the pharmacy profession with guidance and a compliance framework to enable them to address these information management issues.

All patient identifiable data used by pharmacists, whether accessed from national NHS care records or stored in local or networked systems is subject to relevant NHS IG requirements. These cover many aspects of good practice in information management and security including prevention of accidental disclosure, security of hardware and software, staff training, management of critical incidents and various others.

Information Governance guidance for Wales indicates that information security measures must be in place, which would typically include encrypted data, access controls, secure file sharing software, strong user authentication, regular back up of information, physical security around IT equipment, processes for disposing of confidential waste and IT equipment, and defined procedures for taking information offsite and transporting personal information.

In Scotland, information governance advice is available for information sharing, subject access to records, single sign on and information security for wireless networks, text messaging and social networking.

For England, further information is available at:
http://www.igt.connectingforhealth.nhs.uk

For Wales, further information on IG is available at:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=950&pid=51795
http://www.wales.nhs.uk/sites3/page.cfm?orgid=950&pid=51811

For Scotland, further information on IG is available at:
http://www.ehealth.scot.nhs.uk/?page_id=185

Other EHR Initiatives

In the UK, there have been a number of initiatives that have shaped the information governance agenda. With EHRs in pharmacy, consideration should be given to the principles of the Royal College of General Practitioners’ Shared Record Professional Guidance (5)

These principles cover:

- Obtaining consent to store and share data.
- Clear assignment of clinical responsibility in care records.
- Healthcare professionals using records in a way that is consistent with their legal and professional obligations.
- Procedures for amending errors and offering differences of opinion in records.
- Clear identification of the originator of any record entry.
- Appointment of an IG guardian for the organisation.
EHRs – General Guidance for Pharmacists

Definitions

An Electronic Health Record (EHR) is any information source in electronic form which contains identifiable information concerning a patient’s medical care. The information held on an EHR may include, but is not restricted to:

- Diagnoses.
- Medical History.
- Allergies & Adverse Drug Reaction.
- Results of pathology and other tests.
- Prescribing History.

Pharmacy professionals would include registered pharmacists and pharmacy technicians.

Systems used for EHRs

A variety of systems may be used to store EHRs. In pharmacy practice, these might include:

- Patient Medication Record (PMR) systems for community pharmacy
- GP systems and primary care medical record systems
- A national summary care record service, which may be accessed via a pharmacy PMR systems or by some other application. These would include the Summary Care Record (SCR) in England, the Emergency Care Summary (ECS) in Scotland and the Individual Health Record (IHR) in Wales.
- Other systems used by specific healthcare providers.
- National and local systems for collecting pharmacy service evaluation data.

One or more of these systems may be available within a pharmacy or dispensary. Pharmacy professionals should exercise their professional judgment concerning what information might be available from different systems, and should seek to make professional decisions with as much relevant information as is possible.

It is recognised that, in multidisciplinary environments, the influence of pharmacy staff on the implementation and configuration of EHR systems may be limited. However, where possible, pharmacists should seek assurances from suppliers that the systems they use comply with the principles of the NHS Care Record Guarantee (6) and relevant IG requirements. Pharmacy professionals should also ensure that EHR information is safeguarded from actions of non-pharmacist employers, which might compromise the integrity and confidentiality of the information.

EHR systems should provide appropriate access security, and should contain a comprehensive metadata set - i.e. time and date stamps for each entry or amendment, and an audit log of users making changes to records. The data fields on the EHR system should be adequate to provide the level of pharmaceutical care provided by the pharmacy.

There should be a Standard Operating Procedure in place for the use of EHRs in the pharmacy.
Creation of EHRs

When a patient presents a prescription at a pharmacy to be dispensed, consent to the process of supply is implied and the pharmacy contract for England and Wales stipulates that a record of the supply must be made (in practice, this record is normally made on the PMR). Consent for the creation of a record relating to the supply of a medicine is also therefore implied.

However, where any other service is provided by the pharmacy which may or may not involve the supply of a medicine, then the patient must give overall informed consent for the recording and storage of identifiable patient data to support that service. Therefore, if the patient presents for, or is recruited to, a pharmacy service such as NMS, MUR, MAS, CMS, smoking cessation, overall explicit consent must be given by the patient for their information to be recorded on the EHR system.

In line with the Data Protection principles, pharmacy staff must ensure that patient information held is relevant but not excessive. Where possible, to ensure completeness of the medication record, pharmacy staff should ensure that details of all medicines, including OTC and herbal medicines, are included in the EHR medication history.

Access to EHR systems by Pharmacy Professionals

Pharmacists and pharmacy technicians may access EHR systems for patient information in order to discharge their professional duties, in a way that is appropriate to their role and remit within an organisation. There will be times when other pharmacy staff will need to access the EHR system, but the registered pharmacy professionals remain responsible for the appropriate use of the EHR system.

Consent for the use of a pharmacy service and EHR information to support it should be sought in accordance with the General Pharmaceutical Council’s standard for patient consent (3), taking into account capacity and Gillick competence.

Pharmacy staff must not access a patient record for any reason other than to enable provision of a pharmacy service. It would be inappropriate and unethical for pharmacy staff to access information from an EHR for purposes unrelated to the pharmacy service being provided.

Often, access to the record is requested by the representative of the patient, rather than the patient themselves. Pharmacy professionals should bear in mind that no-one can give consent on behalf of a competent adult and, depending on the circumstances, pharmacy professionals should consider whether it is necessary to speak to the patient directly to obtain their consent. However, if it is not possible to speak to the patient directly, the pharmacy professional should always act in the best interests of the patient.
Liability for record use

Pharmacy professionals are responsible for the completeness, accuracy and timeliness of information on EHR systems used in the pharmacy setting, if they are able to make entries to the record.

If a pharmacy professional makes a professional decision in good faith based on information in the EHR that is subsequently found to be inaccurate, they are unlikely to be liable for any unintended clinical consequence. However, pharmacy professionals would be expected to be alert to any obvious errors or discrepancies in the record, according to their qualifications and experience.

If a pharmacy professional identifies an error in an existing EHR, and they have write access to the record, they should correct the error and amend the record appropriately, if they have the correct information to do so. If the pharmacy professional does not have write access to the record, as with national care records services at present, they should inform the patient's GP of the error, and record it as an intervention on their pharmacy system.

As mentioned, a pharmacy may have one or more EHR systems available. Pharmacy professionals should use the most appropriate information sources to support their professional decision making. Pharmacy staff should review any information that may be feasibly accessed in order to reach a professional decision, using their professional judgment. It is accepted professional practice that pharmacists currently complete many routine tasks (such as straightforward over the counter sales or the supply of repeat medication) without referring to additional sources of information, and having access to the summary care record is not expected to radically alter this situation. However, pharmacy professionals should bear in mind that if they decide not to view a patient's records stored on the PMR or not to contact a doctor to ask for the medical records to be checked then, were the patient to come to harm or subsequently complain because of an issue that arose as a result, it might be more difficult to defend the case.

What about patient access to the EHR?

Under the Data Protection legislation, the subject of any personal identifiable information has a right of access to that information. A patient's right of access to their medical records is established in the NHS Constitution (7). The Information Commissioner's Office provides guidance about subject access to personal data (8).

Evidence from the medical profession suggests that access to EHRs by patients has benefits in patient care, and does not lead to increased litigation (9). So-called triadic consulting where both the clinician and the patient view the EHR on the computer screen during the course of the consultation is common in many areas of medicine (10).

The presence of a consulting room/area in pharmacies to conduct MURs and other pharmacy services, with a workstation in the consulting room enables pharmacists to discuss medicines with a patient, with the EHR available to view for both parties, if appropriate monitor hardware is installed. However, it should be remembered that there may be occasions where the pharmacist will need to view the patient's record prior to a consultation, without the patient being present.

If the patient identifies an error in their record when viewing the EHR, then the pharmacy professional should use their professional judgment to take appropriate steps to correct the record, validating any new information from the patient, and liaising with the patient's GP as necessary.

Viewing the EHR

The availability of the EHR on a workstation in the consulting room makes it easy for the pharmacist and the patient to view a patient's record during the course of the patient's consultation.

However, pharmacy professionals must ensure that a patient's record is only on screen for the duration of the consultation and that systems are in place to ensure that the workstation cannot be accessed in an unauthorised manner when the consultation room is not in use.
Sharing of data

There may be occasions when data on a patient from an EHR system used by pharmacists may need to be shared with another healthcare professional to provide the most appropriate care for the patients.

When sharing patient data with other healthcare professionals, pharmacy staff should ensure that appropriate confidentiality, consent and data security measures are in place, in accordance with IG requirements. The need for absolute patient confidentiality should be balanced with the need for the continuity of effective care, and the consequences to the patient if the information is not shared.

Under the NHS CfH IG requirements for pharmacy, pharmacy organisations should make patients aware of what data are collected and stored about them at the pharmacy (or available to the pharmacy), and with whom this data might be shared. This process would be via an information sheet that is available at the pharmacy, and given to new patients coming to the pharmacy, and to patients who receive a pharmacy service. This information might form part of the practice leaflet required by the pharmacy contract.

Pharmacy professionals should be aware that there are some statutory situations where a patient’s data may be disclosed to a third party without the patient’s consent, for example, cooperation with the police to assist in a criminal investigation. Full details of these are in the General Pharmaceutical Council’s Standard of Patient Confidentiality (1).

Use of data for purposes other than that for which it was collected

Patient data on EHR systems should be used only for the provision of pharmacy services, for clinical and service audit and for identification of individuals eligible for pharmacy services under the supervision of a pharmacist. Patient data on EHR systems must not be used inappropriately or in an unprofessional manner.

The use of EHRs in the pharmacy must be in line with the commitments made in the NHS Care Record Guarantee (6) and the requirements of the Data Protection Act. Data from EHRs must not be used for commercial purposes, other than the provision of pharmacy services. Furthermore, EHR data should not be used for research purposes without the appropriate patient consent and ethics approvals being secured from the appropriate authority.

Business Continuity

Pharmacy professionals using EHRs routinely for patient care should satisfy themselves that system suppliers and other IT support services have appropriate business continuity arrangements in place to ensure that, if systems fail, there is an appropriate level of EHR access to ensure the safety and quality of patient care.

There is a requirement for business continuity in the IG requirements for pharmacy, for which more detailed guidance is currently being prepared.

Archiving and Destruction of Records

EHRs must be retained by organisations in accordance with local and national NHS records management policies. Current NHS England Records Management Guidance indicates that electronic health records should be retained indefinitely (11). Records management policies are in place for Wales and Scotland (12,13).
In what scenarios might EHR information be used by a pharmacy professional?

Information stored on EHR systems – either local systems such as PMR systems or organisational record systems, or national care record services – may be used in the following practice scenarios in community pharmacy. Checking patient information using the records should not be regarded as a pre-requisite for delivering pharmacy services as professional judgement can be used to consult with patients to obtain the necessary information.

**Essential services:**

- When dispensing prescriptions, to check the previous medication history or for decision support on interactions, contraindications and allergy status. Further experience is required to determine what additional value a national care records service will provide over and above the local system for routine dispensing.

- Supporting self care for public health services and promoting healthy lifestyles – knowing what (other) medication a patient is taking.

**Advanced services:**

- During a medicines use review (MUR) to verify and compare medications currently being prescribed for the patient and their allergy status. Pharmacy PMR systems often provide electronic templates for MURs.

- For provision of the New Medicine Service (NMS).

- During Chronic Medication Service consultations to gain information on adherence, and to support clinical decision making for pharmaceutical care issues (Scotland).

- During minor ailments consultations (eMAS) to confirm suitability of Over The Counter medicines with regular medicines.

**Enhanced services:**

- When supplying medication under an enhanced service to record the medication supplied and for decision support on interactions, contraindications and allergy status.

- Supply of medicines on NHS Patient Group Directions (PGD).

**Non- NHS patient care:**

- When supplying over the counter medication, potential interactions should be checked and ideally a record made of OTC medicine supplied, although this is rarely feasible in a busy pharmacy.

- When dispensing private prescriptions, to record the medicine supplied and to provide decision support on interactions etc.

- When dispensing an emergency supply (at the request of the patient) or out-of-hours supply to verify the name, form, strength and dose of medication previously had by the patient. (NB in Scotland, out of hours supply is an NHS service).

- Supply of medicines on private PGDs.
Information Transfer between National Care Records Services and Local Systems

Transfer of information from national care record services onto local IT systems may be beneficial to patients. However, there are issues to consider:

• Once pasted into another document, the information then becomes a point in time snapshot and is subject to the IG controls that apply to that system and setting.

• Permission informally ends as a result of the patient leaving that pharmacy

• National record systems and PMR data systems will obviously not be linked so if changes are made to national record content, there is no automatic mechanism for making sure that PMR data is updated. Once the information is in the system, it is to support that episode of care and not as an up to date version.

• Community pharmacies would have to ensure that information obtained from a national care record service is securely held in line with the commitments made in the NHS Care Record Guarantee (6) in England and other information governance required.

National care records services will not replace existing sources of data in community pharmacy, but it will supplement them. Pharmacists should exercise their professional judgement concerning what information can be obtained from each system. An example of where it might be helpful to look at a national service in addition to the local system are when there are inconsistencies between the local system and the patient’s recollection.
Existing electronic record systems

The Summary Care Record (SCR) (England)

The Summary Care Record (SCR) has been introduced in a number of PCTs across England, with plans for increased rollout across the country at a later date. The SCR has been created using information held by a patient’s GP and contains the following information:

- Patient allergies.
- Current prescriptions.
- Adverse reactions.

The SCR may also contain additional information such as significant medical history. The SCR offers particular benefits for unscheduled care - for example Accident and Emergency departments will be able to view a patient’s record to assist with the emergency treatment of that patient, for whom they may have no information. The SCR has been shown to be of considerable value for medicines reconciliation by pharmacy staff when patients are admitted to hospital, and has been used for this at the Bolton Hospitals. It is now being piloted to assess its benefits in community pharmacy.

The SCR is a form of EHR and the general principles described above apply to its use in a pharmacy setting. However, the SCR has specific rules and concepts and so NHS Connecting for Health (NHS CfH) and the Department of Health have developed frequently asked questions (FAQ) to support those community pharmacy professionals viewing the Summary Care Record as part of the pilot. The following areas are covered:

- Permission to View.
- Creation of a Legitimate Relationship.
- Situations of use.
- Accuracy of the record.
- Guidance around liability.

A related publication has been prepared by NHS CfH in partnership with the Medical Protection Society (14).

The SCR has a permission to view consent model. The patient’s permission must be sought to view that patient’s SCR and this process is based on six principles:

1) The explanation to a patient, as part of seeking permission to view, should be simple, straightforward, honest and appropriately communicated.

2) A patient’s permission should be sought by the care setting wishing to view their Summary Care Record.

3) Care settings should be explicit about the scope of permission being sought ie who is being given permission, for how long and in what context.

4) The scope of permission obtained must be recorded.

5) Before setting the “not to be asked in future” consent status for a patient, the user must be sure of the patient’s wishes in terms of scope of this permission.

6) Permission to view does not apply where the patient is unable to give permission to view, and the clinician acts in the patient’s best interests.

In order to have permission to view, the pharmacy professional must have a legitimate relationship (LR) of care with the patient, ie they are the professional who has been assigned to, or who the patient has selected, to be responsible for their care. The SCR has several forms of legitimate relationship, but the one that seems most appropriate for the community pharmacy setting is the clinician self-claimed LR where the pharmacist takes the initiative to claim the LR with the patient, and this will be tested with pharmacy access to the SCR.
Permission to view may be given for more than one branch of a pharmacy, although this will need to be made clear to the patient when asking for consent. Permission to view is given for an episode of care, which may be defined by activity or time. Since community pharmacy professionals may undertake various different activities for the same patient, a time-based episode of care is probably most relevant for community pharmacy, although this needs to be tested with pharmacy access to the SCR. Thus permission to view would be granted to a community pharmacy professional for a period of time.

NHS CfH pilot work will assess the workability of the proposed approaches for use of the SCR and guidance may therefore be amended over time in accordance with learnings from the pilot work.

The SCR is simply one of a number of tools and methods which community pharmacies can utilise to support the care of their patients (for example, use of the PMRs, discussion with patients or communications with the patient’s GP); its purpose is not to replace these, but rather to be an additional choice to be used where the community pharmacist considers it to be appropriate, in accordance with their professional judgement.

Further information on SCR use and procedures may be found at: http://www.connectingforhealth.nhs.uk/systemsandservices/scr

The Individual Health Record (IHR) (Wales)

In Wales, the Individual Health Record will be created from the GP summary, and is available to doctors and nurses routinely in out of hours services, and is being used by pharmacists at the Medical Admissions Unit at the Royal Gwent Hospital.

The Individual Health Record contains the following details:

- Name, address and contact details.
- Details of current GP practice.
- Record of current and recent medication.
- Medical problems from GP consultations.
- Recorded allergies.
- Results of any recent tests - for example, blood tests and x-rays.

Only the last two years of medication history and one year of test results will be shown.

As with the English SCR, patients need to give consent to allow a health professional to access their record, and there is an opt-out system for patients who do not want to have an IHR.

For further information, see: http://www.wales.nhs.uk/sites3/home.cfm?orgid=858

Wales-specific resources:

- Your information, your rights (Welsh equivalent of the Care Record Guarantee) http://www.nhsdirect.wales.nhs.uk/lifestylewellbeing/yourinfoyourrights

NB The NHS Constitution does not apply in Wales
The Emergency Care Summary (ECS) (Scotland)

The Scotland Emergency Care Summary contains the following information:

- Name.
- Date of Birth.
- CHI Number (NHS Scotland identifier).
- GP Surgery details.
- Allergies & ADRs.
- Prescribing History.

The ECS is viewable by staff at out of hours centres, A&E departments, some wards and also by NHS 24 staff. Community pharmacists in Scotland cannot access the Emergency Care Summary directly but have been able to gain access to ECS information through direct contact on a professional line to NHS 24. ECS is used as part of the medicines reconciliation process by some hospitals. The Scottish Government has committed to have an accurate electronic medication summary available to the appropriate healthcare workers involved in a patient’s journey by 2014.

The ECS is extracted from the GP record and, as with other national health records in Great Britain, patient consent is required every time the record is accessed. Patients may opt out of the scheme by contacting their GP surgery.

Further information is available at:


Scotland-specific resources:

NHS Code of Confidentiality Scotland

References & Resources


14) NHS Connecting for Health/Medical Protection Society Summary Care Record – Frequently Asked Questions http://www.connectingforhealth.nhs.uk/systemsandservices/scr/staff/faqs/mpsfaqs