General Chiropractic Council

# The Test of Competence

## Anonymised Patient Records Policy

### Introduction

This policy relates to the anonymised patient records that Test of Competence (TOC) candidates are required to provide to support their answers to Sections 2, 3 and 4 of the Evidence of Practice Questionnaire.

### Purpose of Anonymised Patient Records:

The Evidence of Practice Questionnaire (EPQ) is designed to provide insight into how a candidate practices, in order to inform the assessment process and assist in determining whether they have the knowledge, skills, understanding and attitudes in order to practice in accordance with the standards set out in The Code. The anonymous patient records are an essential component of the EPQ, providing real evidence to support the answers provided, and to demonstrate a candidate's approach to practice across the whole patient journey.

### Source of Anonymised Patient Records

In order to enable assessors to evaluate a candidate's practice, and to be relevant to the assessment process, the anonymised patient records need to demonstrate recent practice that is directly comparable to independent chiropractic practice in the UK. To meet that need:

| The **expected source of patient records** are real notes, written by the candidate, while in independent chiropractic practice, within the previous 24 months. |
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It is recognised that there are some circumstances when this is not always possible. If permission for the release of patient records is the only barrier, the GCC can provide information for overseas educational institutions and employers who hold responsibility for them.

If real patient records written by the candidate (while in independent chiropractic practice within the previous 24 months) cannot be sourced, the following alternative options are available, but an explanation must be provided in the EPQ:

- **Recent graduates** may provide real anonymised patient records taken while under supervision at their training institution as part of their chiropractic education.
- **Chiropractic educationalists** who are not working in independent clinical practice, may provide patient records of clinical cases of chiropractic students that they have supervised, rather than those that they have assessed or cared for directly. Their role and the actions they took in relation to the patient care must be explained in Section 8 of the EPQ.

- Candidates who are working in clinical practice, **but not in the capacity of a registered chiropractor**, may provide real anonymised patient records of patients they have been caring for, providing that the presenting complaints of those patients are similar to those that would present to a chiropractor. The circumstances in which the patients were seen must be explained in Section 8 of the EPQ, together with an explanation of why records were not available while working as a registered chiropractor.
- Candidates who are **unable to source records from real patients** that they have seen while working in practice, may provide anonymised patient records taken while observing another chiropractor. The circumstances in which the patient care were observed must be explained in Section 8 of the EPQ, together with an explanation of why there are no records available from their own independent practice.
- Candidates who are **unable to source records from real patient encounters, or observe a chiropractor**, may, in exceptional circumstances and when all other options have been exhausted, provide hypothertical records based on real cases that they have worked on. An explanation of how the records have been prepared must be given in Section 8 of the EPQ, together with an explanation of why there are no records available from their own independent practice.

If candidates are unable to submit real chiropractic patient records, in order to ensure that the meet the standards outlined in The Code, their interview is likely to be longer and more intense.

**Requirements for Anonymised Patient Records**:

Patient records must be no more than 24 months old, and include everything that is part of the patient record, including details of the initial consultation, all the subsequent treatment notes, any reports, images or letters, as well as any intake or administrative forms that the patient was provided with.

The cases provided must meet the specific clinical requirements of each Section (as detailed on the Evidence of Practice Questionnaire). Sections 2 and 4 stipulate that the case must include a course of treatment involving multiple interactions, demonstrating how candidates have managed the patient over a period of time.

It is important that the anonymised patient records are prepared and organised in the following manner:

- To protect patient confidentiality, references to patient names, dates of birth, and addresses must be redacted (removed), as well as the candidates name and any licence number. However, the patient's gender, age, occupation and appointment dates must remain visible.
- Any handwritten notes must be accompanied by a typed transcript.
- The patient records for each of the relevant Sections must be compiled into a single document, indexed in chronological order, the pages numbered, and the document clearly labelled to show which Section it refers to.

## Data Protection:

Anonymised patient records will be used for the sole purpose of the Test of Competence. The GCC will not use them for any other purpose, nor share them with third parties, and they will be retained in line with the GCC data retention policy.