UKREMT

UK Register of Emergency Medical Teams

UKREMT Clinical Record Keeping

2026 guidance for safe, clear and defensible pre-hospital clinical records

Managed Voluntary Register

Hosted and supported by GWAS Ambulance Charity CIO

Registration and public register checking remain free

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1. Purpose

Good clinical records are part of patient care. They support continuity, handover, clinical reasoning, safeguarding, audit, learning and accountability. This guidance applies to paper and electronic records made by UKREMT registrants.

2. Core standard

If you assess, advise, treat, refer, discharge, safety-net or hand over a patient, make a record that allows another competent professional to understand what happened, why decisions were made and what happened next.

3. Minimum content

- Patient identifiers appropriate to the setting, date, location and incident/event reference.
- Presenting complaint, mechanism or reason for contact and relevant history.
- Relevant observations, examination findings, clinical assessments and trends, including abnormal findings and meaningful negatives.
- Working impression or differential where appropriate to the registrant's role.
- Treatment, medicines, interventions and response, including dose, route and time where relevant.
- Capacity and consent where material; refusal of assessment or treatment and the information given.
- Clinical decisions and rationale, particularly non-conveyance, discharge, referral, escalation or deviation from usual guidance.
- Safeguarding concerns, action and information shared where relevant.
- Advice and safety-netting, including what deterioration should trigger further help and how or where to obtain it.
- Handover or referral destination, receiving person/service where known and time of transfer.
- Registrant identity, UKREMT PIN where appropriate, role/grade, date and time of entry.

4. Timeliness and chronology

Complete records during care where practical or as soon as possible afterwards. Entries should be chronological. A later entry must be identified as retrospective or late, with the actual time of writing.

5. Accuracy, language and corrections

Record facts, observations and professional judgement clearly. Distinguish what you saw from what you were told. Avoid vague wording, unnecessary abbreviations and speculation. Never falsify, back-date, erase or obscure a record. Corrections must preserve an audit trail.

6. Clinical reasoning, refusal and non-conveyance

Higher-risk decisions need better documentation. Record assessment, capacity, options discussed, material risks, advice sought, patient preference, agreed plan and safety-netting. A signature alone does not prove informed refusal.

7. Medicines and controlled drugs

Record medicine name, dose, route, time, indication and response, plus relevant allergy and contraindication checks. Controlled-drug records must also comply with law and provider governance.

8. Handover and shared care

Document material information passed to another clinician or service and any transfer of responsibility. Where care is shared, make clear who did what and who held responsibility for subsequent action.

9. Confidentiality and information sharing

Clinical records are confidential. Access, use and disclose information only for legitimate purposes and on a lawful, necessary and proportionate basis. Take particular care with photographs, messaging apps, screenshots, personal devices and remote working.

10. Digital records

Use approved systems and individual user accounts. Lock devices and protect records from loss, damage and inappropriate access. Do not store identifiable patient information in personal photo libraries, consumer cloud storage or unapproved messaging systems.

11. Retention and access

Follow the retention schedule and information-governance policy of the organisation that is the data controller for the clinical record. UKREMT does not prescribe one retention period for every service because requirements differ by provider, patient group and record type.

12. Audit and learning

Registrants should expect records to be audited. Audit should consider completeness, clinical reasoning, medicines, consent and capacity, safeguarding, referral, safety-netting, handover and data security. Serious or persistent failures may require governance or Fitness to Practise action.

13. Quick self-check

- Could another clinician understand the presentation and my assessment?
- Have I recorded material observations and treatment accurately?
- Is my decision and rationale clear?
- Have I documented consent, capacity or refusal where relevant?
- Is the referral, handover or safety-netting clear?
- Is the record attributable, timed and secure?

About UKREMT

UKREMT is the UK Register of Emergency Medical Teams, a managed voluntary register hosted and supported by GWAS Ambulance Charity CIO. Registration and public register checking remain free. This guidance supports professional practice but does not replace employer/provider policy, statutory professional requirements or applicable law.

References and standards

- HCPC Standards of conduct, performance and ethics: full, clear, accurate, prompt and secure records.
- HCPC Standards of proficiency for paramedics: appropriate records, information management and digital record keeping.
- HCPC guidance on confidentiality and keeping information safe.
- Applicable data protection law, provider information-governance policy and current clinical guidance.

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