Guidelines on clinical records

Introduction

These guidelines have been developed by the Osteopathy Board of Australia (the Board) under section 39 of the *Health Practitioner Regulation National Law* as in force in each state and territory (the National Law).

Who needs to use these guidelines?

These guidelines show the Board's expectations of registered osteopaths, or those seeking to become registered in the osteopathy profession, on the appropriate standards for clinical record-keeping. The guidelines apply to all osteopaths and any personnel working under their supervision in the practice of osteopathy, and address how osteopaths should maintain clinical records (including e-health records) related to their practice.

The guidelines will be used as evidence of what constitutes appropriate professional conduct or practice for osteopaths during an investigation or other proceedings against a registered osteopath.

Summary

Osteopaths must create and maintain clinical records that serve the best interests of patients and that contribute to the safety and continuity of their osteopathic care. To facilitate safe and effective care, patient records must be accurate, legible and understandable, and contain sufficient detail so that another practitioner could take over the care of the patient if necessary. These guidelines describe the *minimum* requirements for clinical records, whether they are in paper or electronic form.

Note: for the purpose of these guidelines, the term 'patient' is used to refer to the person receiving the treatment and care of the osteopath. In other contexts, the terms 'client' or 'consumer' may be used.

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Clinical records for osteopaths

1. Responsibilities

Osteopaths have a professional and legal responsibility to:

- keep as confidential the information they collect and record about patients
- retain, transfer, dispose of, correct and provide access to clinical records in accordance with the requirements of the laws of the relevant states, territories and the Commonwealth:
  - Practitioners must be familiar with the requirements of the *Privacy Act 1988* (Cth), as well as their state or territory privacy and health records legislation (in jurisdictions that have health records legislation). This includes the provisions that govern the retention of health records (which require retention for seven years after the last visit) and the retention of records relating to children and youth treated while under 18 years of age until the child turns 25.
  - Useful information regarding privacy and health records legislation can be found at: www.privacy.gov.au.
  - Information regarding privacy in the private healthcare system is contained in information from the Commonwealth Privacy Commissioner at: www.privacy.gov.au/materials/types/guidelines/view/6517#b6.
  - Osteopaths must be familiar with, and comply with, the *Healthcare Identifiers Act 2010* and the *Healthcare Identifiers Regulations 2010* (www.comlaw.gov.au) which specify that the identifiers are to be used for healthcare and related management purposes, with penalties in place for misuse.
  - Third party access to clinical records is subject to the provisions of the relevant privacy and health records legislation. Practitioners must be able to substantiate an amount paid for services by Medicare in the previous two years as per the Health *Insurance Amendment (Compliance) Act* 2011 (www.medicareaustralia.gov.au/provider/business/audits/files/4772-health-insurance-act-0711.pdf).
  - Under tax law, records must be kept for a minimum of five years. The general record keeping provisions contained in section 262A of the *Income Tax Assessment Act 1936* (ITAA 1936) and section 382-5 of Schedule 1 to the *Tax Administration Act 1953* are found in *Taxation Ruling 96/7* (http://law.ato.gov.au/atolaw/view.htm?docid=TXR/TR967/NAT/ATO/00001).

2. General principles to be applied

- Each patient should have an individual health record containing all the health information held by the practice about that patient. Each person who requests it must have a separate billing record from other members of their family or from estranged relatives or partners.
- An osteopathic clinical record must be made at the time of the consultation, as soon thereafter as practicable, or as soon as information (such as results) becomes available, and must be an accurate, complete reflection of the consultation. If the date the record is made is different to the date of the consultation, the date the record is made must be recorded and the time and date of the consultation noted.
- Entries on a clinical record should be made in chronological order.
- Osteopathic clinical records must be legible and understandable, and of such quality that another osteopath or any member of another healthcare profession could read and understand the terminology and abbreviations used. To ensure that other practitioners can understand the terminology and abbreviations in the record, standard Australian osteopathic and clinical abbreviations should be used.[1] From the information provided, other practitioners should be equipped to manage the care of the patient.

1. The following may be useful resources: *Australian Dictionary of Clinical Abbreviations, Acronyms and Symbols,* ISBN 978-1-876443-15-3, published by the Health Information Management Association of Australia Limited; and Fryer G, 'Abbreviations for use in osteopathic case notes', *Journal of Osteopathic Medicine,* 2001;4(1):21-24 http://vuir.vu.edu.au/493/1/Abbreviations_2001.pdf.

- If documents are scanned to the record, for example external reports, the scanning should reproduce the legibility of the original document. If this is not possible, the original documents must be retained.
- Osteopathic clinical records must be able to be retrieved promptly when required.
- Osteopathic clinical records must be stored securely and safeguarded against loss or damage. This includes secure transmission and back-up of electronic records.
- All comments in the clinical record should be respectful of the patient and be couched in objective, unemotional language.
- Osteopaths should be familiar with the requirements in the Board's *Code of Conduct for registered health practitioners*, *Section 3.16: Closing a practice*. The Code requires the transfer or appropriate management of all patient records in accordance with the legislation governing health records in the state or territory in which the person is treated.
- Corrections can be made to a clinical record at the time of entry. All corrections must be signed by the practitioner and the original entry should still be visible or digitally traceable.
- A treating osteopath must not delegate responsibility for the accuracy of information in the osteopathic clinical record to another person.
- A treating osteopath must recognise and facilitate a patient's right to access information contained in their clinical records. If a patient disputes the recorded information, it should be removed, unless the practitioner disagrees. In the latter situation, the record should be maintained, with a note stating the patient's beliefs about the accuracy of the record.
- The transfer of health information must be done promptly and securely when requested by the patient, and the location of records advised to patients upon request.
- Two useful resources for practitioners regarding the management of health records are:
  - Royal Australian College of General Practitioners, *Handbook for the Management of Health Information in Private Medical Practice* (www.racgp.org.au/privacy/handbook)
  - *HB 174—2003 Information Security Management – Implementation Guide for the Health Sector* available online from SAI GLOBAL.

3. Information to be recorded

The following information forms part of the clinical record and is to be recorded and maintained, where relevant:

- Identifying details of the patient, including name, preferred name and date of birth.
- Current health history including all relevant musculoskeletal and medical history. This should include an accurate medicines history.
- Relevant family history.
- Relevant social history, including cultural background if clinically relevant.
- Contact details of the person the patient wishes to be contacted in an emergency (not necessarily the next of kin).
- Clinical details: for each consultation, clear documentation of information relevant to that consultation including the following:
  - The date of the consultation.
  - The name of the practitioner who conducted the consultation, including a signature or digital notation where applicable. The name of the person should also be printed to ensure legibility.
  - The name of the person providing the details of the clinical history if not the patient, e.g. parent, guardian.
  - The presenting complaint.

  - Relevant history including response to previous treatment. This should include responses to treatment provided by other practitioners.
  - Information about the type of examination conducted.
  - The documentation of any offer of a chaperone to minors, vulnerable patients or those who are required to undress prior to intimate examination/ treatment.
  - Any patient request for a chaperone.
  - Relevant clinical findings and observations, including treatment outcomes. A useful resource for measuring clinical outcomes can be found at: Transport Accident Commission of Victoria (www.tac.vic.gov.au/jsp/content/NavigationController.do?areaID=22&tierID=2&navID=F0065BDA7F000001018056DF70ECF3D5&navLink=null&pageID=1675).
  - Diagnosis.
  - Recommended treatment plans, techniques used and record of appropriate informed consent (see the Board's *Code of Conduct for registered health practitioners*, *Section 3.5 'Informed consent'*).
  - All procedures conducted.
  - Details of any medicine, dietary supplements or any other therapeutic agent used, prescribed or supplied, including details of dose, strength, quantity and instructions for use.
  - Therapeutic equipment or instruments used or provided.
  - Details of advice provided.
  - Details of exercises given.
  - Recommended management plan and, where appropriate, expected process of review.
  - Details of how the patient was monitored and the outcome.
- Unusual sequelae of treatment.
- Relevant contraindications or health alerts.
- Relevant diagnostic data, including accompanying reports.
- Instructions to, and communications with, diagnostic investigation services.
- Setting and context:
  - whether a trainee/student/observer/chaperone was present
  - if it was a home visit
  - any education/information materials given to/supplied for patients
  - advice given to the patient regarding the risks associated with the proposed examination(s) and/or treatment(s), and
  - record of informed consent.
- Other details:
  - all referrals to and from other practitioners, and letters and reports from other practitioners
  - letters received from hospitals and other clinical correspondence
  - any relevant communication (written or verbal) with or about the patient, client or consumer, including telephone or electronic communications regarding the patient's care
  - details of anyone contributing to the osteopathy care and record, including history and permissions, and
  - payment management scheme (if appropriate).