



Consultation Paper: Public Consultation

30 November 2011

Draft Guidelines for Clinical Records

Important information

This consultation paper has been developed under the requirements of the Health Practitioner Regulation National Law Act (the National Law) as in force in each state and territory. The National Law empowers National Boards to develop registration standards for Ministerial Council approval. It also empowers National Boards to develop and approve codes and guidelines to provide guidance to the health practitioners a Board registers and about other matters relevant to the exercise of Boards' functions.

The National Law includes a requirement for National Boards to ensure there is wide ranging consultation on proposed registration standards, codes and guidelines.

The Osteopathy Board of Australia (the Board) developed draft *Guidelines for Clinical Records*.

This draft Consultation Paper is for public consultation. The Board welcomes feedback and peer review of its proposals.

Interested parties are invited to make written submissions on this proposal. Please note that your submission will be placed on the Board's website unless you indicate otherwise.

If you wish to provide comments on this draft paper, please provide written comments in electronic form to osteoboardconsultation@ahpra.gov.au by close of business on Friday 3 February 2012.

Issued by the Osteopathy Board of Australia under the authority of Dr Robert Fendall, Chair, on 30 November 2011.



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 Act* 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.

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), including 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.

- osteopaths must be familiar with and comply with the *Healthcare Identifiers Act 2010* and the *Healthcare Identifiers Regulations 2010* found at 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 is subject to the provisions of the relevant privacy and health records legislation (for further information see point 1 of the *References* section at the end of this document)
- for Medicare, practitioners must be able to substantiate an amount paid for services in the previous two years as per the [Health Insurance Amendment \(Compliance\) Act 2011](#)
- Under tax law, you must keep records 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](#).

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.
- An osteopathy clinical record must be made at the time of the consultation or as soon thereafter as practicable or as soon as information (such as results) becomes available, and must be an accurate and 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 must be made in chronological order.
- Osteopathy clinical records must be legible and understandable and of such a quality that another osteopath or any member of the health care profession could read and understand the terminology and abbreviations used and, from the information provided, be equipped to manage the care of the patient. To ensure that other practitioners can understand the terminology and abbreviations in the record, standard Australian clinical abbreviations are to be used (see point 2 of the *References* section at the end of this document).
- If documents are scanned to the record, such as external reports, the scanning needs to be undertaken in a way that reproduces the legibility of the original document` - or the original documents must be kept.
- Osteopathy clinical records must be able to be retrieved promptly when required.
- Osteopathy clinical records must be stored securely and safeguarded against loss or damage, including a secure backup 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; the correction must be signed by the practitioner and the original entry must still be visible or digitally traceable.
- A treating osteopath must not delegate responsibility for the accuracy of information in the osteopathy clinical record to another person.
- A treating osteopath must recognise and facilitate a patient's right to access information contained in their clinical records.
- The transfer of health information must be done promptly and securely when requested by the patient.

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 and date of birth
- current health history including a relevant musculo-skeletal history, and medical history including a medicines history
- relevant family history
- relevant social history including cultural background where 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 time and date of the consultation
- the name of the practitioner who conducted the consultation, including a signature where applicable or digital notation and print the name of the person making it
- name of the person providing history if not the patient, e.g. parent, guardian
- the presenting complaint
- relevant history
- information about the type of examination conducted

- the offer of a chaperone to patients who are required to undress prior to examination/treatment
- relevant clinical findings and observations
- diagnosis
- recommended treatment plans, techniques and alternatives, and appropriate consent
- all procedures conducted
- any medicine prescribed or dietary supplements, administered or supplied for the patient or any other therapeutic agent used
- therapeutic equipment or instruments provided
- details of advice provided, exercises given
- referral to another practitioner, or further assessment required (e.g. x-rays)
- recommended management plan and, where appropriate, expected process of review; and
- details of how the patient was monitored and the outcome
- unusual sequelae of treatment.
- relevant diagnostic data, including accompanying reports
- instructions to and communications with diagnostic investigation services; and
- 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, and
 - payment management scheme (if appropriate)

References

1. **Privacy and health records legislation:** Useful information regarding privacy and health records legislation can be found at www.privacy.gov.au. Privacy in the private health care system is contained in information from the Commonwealth Privacy Commissioner at: <http://www.privacy.gov.au/materials/types/guidelines/view/6517#b6>

2. *Australian Dictionary of Clinical Abbreviations, Acronyms and Symbols*. ISBN 978-1-876443-15-3.
Published by the Health Information Management Association of Australia Limited.

Date of issue: XX April 2012

Date of review: This guideline will be reviewed at least every three years