



Consultation paper: Guidelines - Clinical Record Keeping for Chiropractors

28 August 2012

Guidelines – Clinical Record Keeping

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 and approve codes and guidelines to provide guidance to practitioners in accordance with section 39 of the National Law.

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

The Chiropractic Board of Australia (the Board) has developed Guidelines - Clinical Record Keeping for Chiropractors to guide and support practitioners in the practice of their profession. The objectives of the National Registration and Accreditation Scheme as set out on s3(2) of the National Law have been fundamental in the development of these guidelines.

1. This draft Consultation Paper is for public consultation. The Board welcomes feedback and peer review of its proposals.
2. Additionally, the Board also seeks views as to whether this guideline should remain as a stand-alone document or be appended to the Code of Conduct for Chiropractors.

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 make comments on this draft paper, please provide written comments in electronic form to chiroboardconsultation@ahpra.gov.au by close of business 26 October 2012

Issued by the Chiropractic Board of Australia under authority by Paul Fisher (Executive Officer) 28 August 2012



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Introduction

These guidelines have been developed by the Chiropractic Board of Australia (the National Board) under section 39 of the Health Practitioner Regulation National Law as in force in each state and territory (the National Law). The National Board also notes the parallel obligations for practitioners in relation to *Health Records* legislation as enacted in each state and territory. Although there is some commonality, these guidelines are not a substitute for, or summary of, these obligations. Practitioners should ensure that they are familiar with legislative requirements in the jurisdictions in which they practice.

Who needs to use these guidelines?

These guidelines show the National Board's expectations on the appropriate standards for clinical record-keeping. The guidelines address how chiropractors should maintain clinical records (including e-health records) related to their practice

They apply to all registered chiropractors, and any personnel working under their supervision. The guidelines will be used as evidence of what constitutes appropriate professional conduct or practice for chiropractors during an investigation or other proceedings against a registered chiropractor.

These guidelines are supplementary to the information provided in section 9.4 of the Code of Conduct for Chiropractors and accordingly this document should be read in conjunction with the Code of Conduct for Chiropractors

Summary

Chiropractors must create and maintain clinical records that serve the best interests of patients and that contribute to the safety and continuity of their care. The keeping of adequate clinical records is fundamental to the safe and effective care of a patient. Good clinical records may also assist in any investigation or dispute resolution.

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 regardless of 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, care or health care services of the chiropractor. In other contexts, the terms 'client' or 'health care consumer' may be used. Also the terms treatment, care and management can be used interchangeably for the purposes of this guideline.

Clinical records held by chiropractors

1. Responsibilities

Chiropractors have both professional and legal responsibilities to:

- a. keep confidential the information they collect and record about patients, and retain, transfer, dispose of, correct and provide access to clinical records in accordance with the requirements of relevant state, territory and commonwealth laws relating to privacy and health records information, and
- b. be familiar with the provisions of relevant state, territory and commonwealth laws relating to privacy and health records information, including but not limited to the *Privacy Act 1988*, *Healthcare Identifiers Act 2010* and the *Healthcare Identifiers Regulations 2010*, *Health Insurance Amendment (Compliance) Act 2011*.

2. General principles to be applied

- a. Clinical records can be kept in either paper or electronic format. Any electronic format should be the equivalent of any paper format and should be able to be printed.
- b. Each patient should have an individual health record containing all the health information held about them.
- c. A chiropractic clinical record must be made at the time of the consultation or as soon thereafter as practicable or as soon as information (such as test results) becomes available. It must be an accurate and contemporary reflection of all consultations or interactions. If the date the record is made is different to the date of the consultation, the date the record is made and the time and date of the consultation must be noted.
- d. Entries on a clinical record must be made in chronological order.
- e. Chiropractic clinical records must be legible and understandable and of such a quality that another chiropractor could read and reasonably understand the terminology and abbreviations used and, from the information provided, be equipped to manage the care of the patient. The *Australian Dictionary of Clinical Abbreviations, Acronyms and Symbols*¹ is a useful resource for practitioners regarding abbreviations. It may be helpful for individual practitioners to maintain a readily accessible glossary of common abbreviations that they use to assist subsequent practitioners.
- f. If documents are scanned to the record, such as external reports, the scanning needs to be undertaken in a way that retained the legibility of the original document.
- g. Chiropractic clinical records must be able to be retrieved promptly when required.
- h. Chiropractic clinical records must be stored securely and safeguarded against loss or damage, including a process for secure transmission and a backup of electronic records.
- i. All comments in the clinical record should be respectful of the patient and be couched in objective, unemotional language.

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

- j. Chiropractors should be familiar with, and adhere to the requirements in the Board's *Code of Conduct for Chiropractors* that relate to record keeping.
- k. Corrections can be made to a clinical record at the time of entry. The correction must be initialled, dated and tracked by the practitioner and the original entry must still be visible or digitally traceable.
- l. A treating chiropractor must not delegate responsibility for the accuracy of information in the chiropractic clinical record to another person.
- m. A treating chiropractor must recognise and facilitate a patient's right to access information contained in their clinical records. If a patient disputes the information then 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.
- n. The transfer of health information must be done promptly and securely when requested by the patient, and patients advised of the location of records upon request.

3. Information to be recorded at an initial or new presentation

The following information forms part of the clinical record and is to be recorded and maintained, at the initial presentation about that consultation:

- a. identifying details of the patient, including name, preferred name, contact details and date of birth
- b. current health history including a relevant medical history, systems review, work history and 'red flags'(current medications/supplements)(allergies)(referrals)
- c. relevant family history
- d. relevant social and lifestyle history including cultural background (where clinically relevant)
- e. contact details of the person the patient wishes to be contacted in an emergency (not necessarily the next of kin)
- f. Presenting Complaint
- g. examination conducted and relevant clinical findings
- h. relevant diagnosis(es)/clinical impressions/ working diagnosis(es), therapeutic trials(s) or management/care plan(s)
- i. details of any informed consent
- j. any contraindications or health alerts
- k. name of the consulting practitioner

4. Information to be recorded at a subsequent consultation or any consultation where care or advice is provided

For each presentation, clear documentation of information relevant to that consultation including the following clinical details:

- a. date of the consultation
- b. any change in consulting practitioner
- c. name of the person providing information if not the patient, e.g. parent, guardian

- d. reason for care/consultation
- e. relevant subjective information including response to any treatment, including that provided by other practitioners
- f. relevant objective information about the examination conducted and relevant clinical findings
- g. the documentation of any offer of a chaperone to patients or when any such request is made by a patient
- h. when there are changes to the informed consent given, i.e. withdrawn, extended, modified, along with notes on the parameters of the change
- i. changes to a documented working diagnosis or therapeutic trial
- j. changes to a documented management/care plan
- k. procedures conducted, techniques used and advice/ instructions given
- l. item prescribed, administered or supplied for the patient
- m. any referrals, letters, correspondence, clinical records, reports, or any relevant communications regarding the patient
- n. any unusual sequelae of treatment or changes in contra-indications or health alerts
- o. any relevant diagnostic data, including accompanying reports
- p. setting and context (e.g. after hours, home visit or at a sporting event)
- q. details of anyone contributing to the chiropractic care and record.

Date of issue: August 2012

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