Guidelines on Patient Records

Summary

Naturopaths and Herbalists must create and maintain clinical records that serve the best interests of patients and that contribute to the safety and continuity of their 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.

Where laws exist related to the keeping of patient case records, practitioners must comply with those laws. If there is any inconsistency between this guideline and the provisions of any Act or Regulation, the provisions of the Act or Regulation prevail.

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

Scope of application

These guidelines are developed to provide guidance to registered Naturopaths and Herbalists. They apply to all Naturopaths and Herbalists and students and any personnel working under supervision in the practice of Naturopathy and Herbal Medicine.

The guidelines will be used in an investigation or other proceedings related to registered Naturopaths and Herbalists as evidence of what constitutes appropriate professional conduct or practice.

Requirements

1. Responsibilities

Naturopaths and Herbalists have a professional and legal responsibility to:

- comply with state and territory privacy and health records legislation, including the provisions that govern the retention of health records (which usually require retention from seven to 10 years) and the retention of records relating to children and youth under 18 years of age
- ensure third party access is subject to the provisions of the relevant privacy and health records legislation

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.

A 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 date of the consultation noted. The time of consultation is to be recorded where there is more than one consultation or treatment on the same day.

Entries on a clinical record must be made in chronological order.

Clinical records must be legible and understandable and of such a quality that another practitioner or member of the health care team could read and understand the terminology and abbreviations used and, from the information provided, be equipped to manage the care of the patient. The use of generally accepted abbreviations in patient case records is satisfactory, but the use of obscure codes and abbreviations should be avoided.

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.

Clinical records must be able to be retrieved promptly when required and must be stored securely and safeguarded against unauthorised access and loss or damage.

Naturopathic and herbal medicine clinical records must be stored securely and safeguarded against unauthorised access and loss or damage.

All comments in the clinical record should be respectful of the patient and be couched in objective, unemotional language.

Naturopaths and herbalists 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 provided the correction is signed by the practitioner and the original entry is still visible.

A treating Naturopath or Herbalist cannot delegate responsibility for the accuracy of information in a clinical record to another person.

3. Information to be held with the patient record

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 (and patient's parent or guardian where applicable)

- current health history and relevant past health history, including known allergies and alerts to adverse drug reactions
- relevant family health-related 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 date of the consultation
    - the name of the practitioner who conducted the consultation, including a signature where applicable
    - consent where appropriate
    - the presenting condition
    - relevant history
    - information about the type of examinations conducted
    - relevant clinical findings and observations
    - other treatments/therapies being used (including Naturopathic medicine, herbal, pharmaceutical, manipulative, dietary, psychological, etc.)
    - any medicine prescribed, administered or supplied for the patient or any other therapeutic agent used (including name, strength, quantity, dose, instructions for use, number of repeats and details of when started or stopped); if supplied, the details recorded must comply with the standards of the profession
    - details of advice provided
    - recommended management plan and, where appropriate, expected process of review;
    - other relevant information (e.g. a discussion about possible side effects or alternative forms of treatment)
- details of how the patient was monitored and the outcome (progress notes)
- any unusual sequelae of treatment or adverse events
- relevant diagnostic data, including accompanying reports
- instructions to and communications with other health service providers
- all (relevant) diagnostic laboratory, imaging and other investigations data and reports
- other details:
    - all referrals made or recommended and any letters and reports from other practitioners
    - details of anyone contributing to the naturopathic and herbal medicine care of the patient
    - letters received from hospitals and other clinical correspondence
    - all relevant communication (written or verbal) with or about the patient, including telephone or electronic communications
    - estimates or quotations of fees

4. Progress Notes

The level of detail required in a patient case record may vary according to the nature of the presenting condition and whether it is an initial or subsequent consultation. For example, in the case of subsequent visits for an ongoing condition, information recorded in earlier consultations need not be repeated, unless there are relevant changes. Progress details and treatment must, however, be recorded clearly.

5. Requests for reports or records

Naturopaths and Herbalists have a professional and legal responsibility to, where requested by the patient, provide:

- a report of the patient‘s treatment and progress to another health practitioner
- access to and or copies of records relevant to the patient. A reasonable fee reflecting the time and costs associated with this request may be charged to the patient

5. Accounting records

Naturopaths and Herbalists have a professional and legal responsibility to maintain accurate, legible contemporaneous accounting records of each visit.

As a minimum, each accounting record must be labelled with the patient/clients identifying details and:

- the date of each service;
- itemised fees charged; and
- details of all payments including the date of the payment

An itemised receipt must be issued for each payment, indicating the date of payment, name of the practitioner who provided the service, address where the service was provided with contact telephone number, name of the patient who received the treatment, date of service, all treatment(s) provided and all product(s) supplied with charge(s).

6. Electronic records

Electronically held records must meet the same requirements as non-electronically held records with the following additional considerations:

- Records should be password protected to ensure that only the practitioner and authorised support staff can access the records. Protective passwords should be used and updated on a regular basis including when a staff member ceases employment
- Patient records should not be sent by email unless there is protection, such as encryption, from potential unauthorised access. No individual should be permitted to access or use the practice computer(s) other than the Naturopath or Herbalist and authorised staff members. Patient access to their records held on computer can be provided via a direct print out of the record
- Adequate backup systems to protect patient records are essential and must provide a guarantee of the ability to restore up-to-date information in the event of power loss or system or computer failure

7. Confidentiality

Naturopaths and Herbalists have a legal and ethical responsibility to keep patient information confidential. Obligations are set out in a number of State and Commonwealth laws.
The principles enshrined in these laws should inform Naturopaths’ and Herbalists’ record keeping in terms of collection, use, disclosure, disposal and transfer of information, as well as in relation to the quality and security of the information and the mechanisms by which access to information is given.

Naturopaths and Herbalists must inform themselves regarding relevant laws and standards and ensure compliance.

Naturopaths and Herbalists have the responsibility to ensure that all staff members with access to patient records are properly instructed in maintaining patient record confidentiality. The legislative requirements apply to all individuals who handle patient information.

Review

These guidelines will commence on 21 March, 2013 and be reviewed on 21 March, 2013.