GUIDELINES FOR INFORMATION MANAGEMENT

1. Purpose

The Guidelines for Information Management have been prepared by the Physiotherapists Board of Queensland (the "Board") to provide guidance to registrants' practice in the area of information management.

The Board's primary function is to register physiotherapists. It also investigates the conduct of registrants when warranted, and instigates disciplinary processes.

Some complaints following investigation by the Board have revealed deficient information management systems, in the areas of:

- patient records maintained by the registrant; and
- confidentiality and access of information.

The medico-legal and litigation process shows that the quality of information management maintained by the practitioner often comes under close scrutiny.

The Guidelines for Information Management offer registrants guidance with respect to legal requirements for health records and administrative issues.

2. Terms of Reference

The terms of reference for Information Guidelines Committee established by the Physiotherapists Board of Queensland, are to assist and advise the Board on the development of guidelines for the profession, as referenced in the Code of Practice on:

a) Record keeping relating to:

   i) Clinical record keeping; and

   ii) Administrative/employer and financial record keeping.

b) Information Management relating to:

   i) Privacy/Confidentiality/disclosure, legal obligation, storage of records; and

   ii) Management of electronic information.

3. Background

The Board's Code of Practice, states:

> *"Physiotherapists must maintain comprehensive client records".*

These Guidelines have been endorsed by the Board to reflect the terms of reference.

The Board expects Physiotherapist registrants to implement and maintain documentation according to relevant legal requirements and acceptable procedures and standards, as outlined below.

4. The Guidelines

4.1 Clinical Record Keeping

Effective clinical records "tell the patient's story" in a manner that will be understood by a person who is reading the record for the first time without knowing the patient. It must create a "picture" of the care provided by the practitioner.

The health record is a legal document which records events and decisions which help the registrant manage patient care. It may provide significant evidence in lawsuits, hearings or inquests when the patient care provided by the practitioner is in question.

The Board encourages and recommends that registrants assess their own health record keeping practices, or have them audited by an independent person who is authorised to have access to the records.

Patient Care

Good clinical records are essential in ensuring high levels of patient care and for the protection of Physiotherapists by minimizing exposure to litigation and facilitating effective physiotherapy practice.

Good clinical documentation facilitates best practice in patient care by ensuring that:

- important clinical information is available to all treating or consulting clinicians; and

- continuity of care is possible between clinicians over time & between different health services.

Administration

Record keeping is an essential component of the day to day administration of a health facility or service. It forms the basis for funding, budgets, resources & future planning. Records also provide useful information for clinical & epidemiological research. Finally, they are a valuable source of information for Quality Assurance & Risk Management.

Medico-Legal purposes

Medical records are a crucial historical record of the care provided to a patient, and are essential for medico-legal purposes.

Medical records may be used as evidence in litigation, including records predating the event (if they show history of a pre-existing condition). The use of records as evidence could also be critical in establishing whether or not there was negligence in patient care. Medical records could provide the greatest defence and as such their accuracy and quality are paramount.

Legal records provide a record of the contribution made to patient management giving Physiotherapists the opportunity to demonstrate the success of treatment to the patient referrers and to outside bodies as a profession.

An allegation against a Physiotherapist is often successfully resisted when there is a relevant contemporaneous record to confirm the Physiotherapist's account of events.

<u>Content of Clinical Records</u>

Clinical records must be clear, legible, precise and document some measure of outcome. Clinical records must meet the following requirements:-

a) Clear. Personal abbreviations should be avoided. It is recommended that practices and departments keep a list of acceptable abbreviations used in their clinical records. Abbreviations and acronyms that are not widely known may impede the communication of information to other staff.

b) Precise. The record must avoid verbosity. The record must show evidence that patient assessment and specific treatment has been provided and consented to.

c) Complete. The record provides data for other health professionals concerned with patient care. Letters to doctors and other health professionals should be kept with the notes.

d) Contemporaneous. To ensure accuracy, notes should be made at the time of consultation or as soon as possible thereafter. An entry should be made for each consultation.

e) Legible. Documentation is of little value if handwriting cannot be understood by other clinicians.

f) Objective. Records should record the facts alone. Physiotherapists should realize that the patient's notes might, one day, be read by the patient and their lawyers, and even occasionally, by a Judge. Notes should not be used to express exasperation, invective, criticism or sarcasm.

g) Unaltered. Records should not be altered or tampered with retrospectively. If an additional entry is required this should be added later in the record, stated to be retrospective and signed and dated accordingly. Corrections are acceptable as long as the change is clearly identifiable, dated and initialed (Note: no overwriting and erasing are allowed. The original record needs to remain legible).

h) Signed and dated on each entry.

The Board recommends that Physiotherapists working in Departments and Private Practice develop a policy and procedure manual that establishes a process for clinical record keeping. The Board recommends that registrants include contents of records along the lines of those contained in Appendix 1.

In a medico-legal context, a good rule of thumb for documentation and record keeping can be summarized as:

- Good notes, good defence
- Bad notes, bad defence
- No notes, no defence

4.2 Administrative/Employer and Financial Record Keeping

The Board recommends that Registrants who own a private practice or private business obtain information from the relevant authorities. Appendix 2 has a list of useful web sites and sources where registrants can gain information to meet their legislative requirements in relation to financial and administrative responsibilities for running a business.

4.3 Information Management relating to Privacy/Confidentiality/Disclosure, Legal Obligation, Storage of Records

4.3.1 Privacy

The National Privacy Principles (NPP) cover Health Records. Registrants can find details of the NPP's at:

http://www.privacy.gov.au/publications/npps01.html#a

4.3.2 Confidentiality

A patient's entire record is always confidential and should not be left where other people may view written details of the record. The treating health professionals should be the only people that have access to these documents.

Copying or faxing of the patient's record should only occur with the patient's consent. Physiotherapist registrants must ensure that confidentiality of patient records is upheld at all times.

4.3.3 Disclosure

There are particular circumstances which require the disclosure of clinical records. These include:

- **Freedom of Information**

  Both State and Federal Governments have introduced Freedom of Information legislation which allows patients to have access to their medical records.

- **Privacy Act**

  Under the Privacy Act and National Privacy Principles, patients have access to information contained in their Health Record. Whether records are provided in full (through provision of a photocopy of the record), or a summary of information contained in the Health Record remains a matter for the discretion of the registrant.

- **Subpoena and Search Warrant**

  Medical records can be the subject of subpoena, search warrant or writ of non-party discovery where such are available under legislation and the court process. The records must be:

  - relevant to a matter in question in the proceedings;
  - in the possession or control of the registrant; and
  - able to be produced at trial.

  Registrants are advised to seek legal advice or advice from their insurer if they are not sure about handing over the record.

4.3.4 Storage of Records

There is no strict legal requirement detailing the length of time that records should be kept. It is recommended that patient records are kept for at least seven (7) years after the patient treatment or care ceases in the case of adults and until child patients reach the age of 25. Patient records should be kept as long as it is possible for an action to be brought against the registrant. The destruction of records within 7 years of treatment could be construed as a breach of duty of care or breach of an implied term of the physiotherapist/patient contract.

According to NPP guidelines, appropriate measures should be taken by Physiotherapist registrants to ensure the confidentiality, security and preservation of records and access to information.

4.4 Information Management of Electronic Information

Electronic information includes clinical databases, electronic health records, and transferring of health information by electronic means, including e-mail communication and CD Rom/DVD's. The Board recommends that registrants develop polices and procedures that meet the standard clinical record guidelines. These documents must address confidentially, privacy, consent, security, identification, and storage and retention procedures.

Registrants are referred to the following checklist/action guide that is useful for practitioners who are considering the use of information technology as an adjunct to their practice. Registrants should consider the risks and complexity of using information technology within physiotherapy.

www.medicareaustralia.gov.au/resources/other_programs/ma_1597_BFH_general_practice_interactive_incentive_claim_form.pdf

Registrants can also access Health eSignature Authority (HeSA). HeSA is a registration authority for managing Medicare Australia's Public Key Infrastructure (PKI) to promote the secure transmission of electronic messages within the health sector in accordance with the requirements of the Australian Government's Gatekeeper accreditation regime. For further information, registrants should visit the following websites: -

www.medicareaustralia.gov.au/providers/online_initiatives/pki_security.shtml (for PKI)

www.hesa.com.au/. (for HeSA)

5. References

APA Quality Endorsement Program Manual, Australian Physiotherapy Association.

Clinical Documentation Information Booklet, Queensland Improvement and Enhancement Program 1999-2004; Queensland Government, Queensland Health.

History Taking Booklet – Medical Indemnity Protection Society Limited, 1986.

CCH – Australian Health and Medical Law Reporter.

McFarlane, Queensland Health Law Handbook.

Contents of Health Records

Cumulative Patient Profile – to prevent duplication, errors

Patient identification (name address, phone number etc.)
Personal and family data
Medical history
Allergies
On-going health conditions
Health maintenance
Consultations/Referrals out
Long terms treatment (e.g. medications)
Major health investigation

Progress Notes: (Treatment Episodes)

Each visit and communication (home visits) is recorded/dated
Consider the following records:

Subjective:
Patient presenting complaint, severity, frequency, duration
Whether the concern is new or ongoing
Changes in progress since last visit
Family history, patients past history
Negative responses of patient

Objective:
Relevant signs
Physical examination - focus on current complaint
Positive physical findings
Negative findings related to the current problems

Assessment:
Risk factors
Ongoing health concerns

Plan:
Discussions of treatment options
Diagnostic tests requested
Consultations requests/referrals
Patient advice/education
Follow-up

Warnings given to patients:

Any problems with treatment
Any extraordinary consent

Non-compliance

Document instances of patient refusing examination/treatment
Document reasons of patient's non-compliance, course of actions recommended

Home Visits/Telephone Conversations

It is strongly recommended that all home visits and phone conversations are documented in patient's record.

Transferring Health Records

Transfer the copy only of the health record, keep the original.
When the patient requests transfer:

Ask for written request
A reasonable fee may be charged for administration such as time to prepare the material, copying, costs of sending
Obligation to pay the account will rest with the patient or the third party who requested the information.

Appendix 2

Web sites and sources for financial and administrative responsibilities

1. Starting Business - Publications, Contacts, Websites

Smart Small Business Guide: A step-by-step guide to starting a Business

http://www.smartsmallbusiness.qld.gov.au

Commerce Queensland – Phone 3842 2244 or www.commerceqld.com.au

www.workchoices.com.au

Dept. of Industrial Relations website www.dir.qld.gov.au

Wageline – provides information about awards, pay rates, employee entitlements, employee hiring and termination Phone: 1300 369 945 www.wageline.qld.gov.au

Workplace Health and Safety Phone: 1300 369 915

WorkCover Phone: 1300 362 128

Electrical Safety Office Phone: 3237 0281

2. Business License and Regulatory Information

Registration of an Australian Company **–** *Australian Securities & Investment Commission* (ASIC) http://www.asic.gov.au/asic/asic.nsf

Australian Taxation Office (ATO) for Australian Business Number (ABN), GST Registration, Fringe Benefit Tax, Superannuation Guarantee, PAYG

http://www.ato.gov.au/

Business Name Registration **–** *Office of Fair Trading (OFT)* Phone: 1300 658 030

http://www.fairtrading.qld.gov.au/oft/oftweb.nsf

3. Financial

For Business Name Extract contact SmartLicence http://www.sd.qld.gov.au

For Company Name Extract contact http://www.asic.gov.au/asic/asic.nsf

Prior to obtaining extract seek advice from your financial institution.

4. Promotion

Professional Website: Domain Name**:** AusRegistry Pty Ltd www.ausregistry.com.au

Australian Physiotherapy Association (APA) web site http://apa.advsol.com.au/

APA Private Practitioners Group. http://apa.advsol.com.au/