

**CHIROPRACTORS REGISTRATION BOARD OF VICTORIA
STANDARDS OF PRACTICE CODES**

MANAGEMENT OF PATIENT RECORDS

May 2007

1. INTRODUCTION

The following guidelines, relating to the professional, legal and clinical requirements for keeping adequate patient records are provided to assist chiropractors in clinical decision-making.

2. STATUTORY REQUIREMENTS

This document should be read in conjunction with relevant provisions of the Health Records Act (HRA) 2001(Vic), particularly Schedule 1 – The Health Privacy Principles (accessible at: <<http://www.health.vic.gov.au/hsc/act.htm>>)

3. PRINCIPLES

- Standards in this section relate to all chiropractic practices in all settings.
- For professional and legal reasons a chiropractor is required to keep and maintain adequate patient records which clearly reflect the course of patient management.
- Records should be accurate, legible, and comprehensive so that a reviewer of these records can establish the essential relationship between the patient and the practitioner in terms of past, present and future health care.
- Records are usually the only tangible evidence of examinations, findings and care provided.
- Relevant clinical findings, both positive and negative, should be recorded.
- Record keeping styles may vary from practitioner to practitioner.
- The health care record contains confidential information which, as a matter of law, should not be released except on the express consent of the patient or pursuant to a court order or otherwise as compelled by law.
- The taking and recording of informed consent is an increasingly important aspect of record keeping.
- The larger the chart the more you tend to write - use large charts.
- Notes should be taken while patients give their history. Doing it from memory later is less detailed and less accurate.

4. THE IMPORTANCE OF ADEQUATE RECORDS

- Courts usually take the view that if there is nothing in the chart to support a chiropractor's contention that a certain action took place. (E.g. patient informed of certain risks), then that action is deemed not to have taken place at all.
- Legal actions typically take three to four years to be heard in court. Because of the limitations of the human memory, the record provides reliable details of the patient's care.
- Some legal actions may be nuisance claims. Accurate, legible and timely documentation can result in the early dismissal of these claims, thereby reducing the stress of the practitioner.

5. GUIDELINES FOR RECORD-KEEPING

Necessary documentation

- (a) Appointment records - The name of each patient and the date when seen should be recorded in an appointment book or entered in a retrievable, saved computer record.
- (b) Patient file - The first step in the processing of a new patient should be the creation of a patient file to serve as a permanent record. Information should include:
 - Name, age, gender, address, and other demographic data
 - Health insurance, third party payer organisations and other billing information
 - Occupation and employer
 - Referring practitioner (if applicable)
 - Case history
 - Examination
 - Special study findings
 - Imaging and laboratory findings
 - Diagnosis
 - Management plan
 - Other recommendations

Pre-printed history questionnaires that contain the above and other information may be used at the time of initial documentation.

- (c) Patient history - A case history should be kept and should include the following:
 - Patient chief complaint data
 - Relevant past and present health history
 - Family and social history, when indicated

- Systems review (as appropriate)
 - Prior history of therapeutic and diagnostic procedures
- (d) Financial record – The following record should be kept for each patient:
- Date and type of professional service provided (initial visit, subsequent visit, x-ray, examination and any other services provided to the patient)
 - Fee for service(s)
 - Payment received and from which source; and
 - Balance of account to date.
- (e) Record of examination and diagnosis which should include:
- All relevant examination procedures performed, ordered or requisitioned.
 - A working diagnosis of the patient's presenting complaint(s).
 - A plan of management which should include: Therapeutic approach; additional testing or referral to another health care provider when indicated; proposed frequency and duration of patient care visits; and any complicating factors.
 - A tentative prognosis
 - Relevant clinical findings, both positive and negative, should be recorded.
- (f) Consent - Patient consent to chiropractic care should be obtained verbally or preferably in written form. Evidence of this should be included in the patient's records. Extra ordinary cases where the consent of another party may be required include:
- Consent for the care of a minor.
 - Consent for the care of a legally incompetent patient

The best record of any consent is one that is objectively documented and signed by the patient.

- (g) Progress notes – Records should be made and dated at each patient visit or communication and the notes should reflect:
- The patient's subjective and objective findings
 - Changes in the clinical presentation
 - Specifics of the care given
 - Recommendation(s) made to the patient on self-care, referral or for any other reason.

Relevant information from every reassessment and re-examination should be recorded in the patient file

- (h) External Documentation or Health Records

Relevant documentation to and from external sources becomes part of the patient file, including:

- Correspondence to or from a referring practitioner
- General correspondence from lawyers, third party payers, and others
- Copies of x-ray reports or other relevant clinical data
- Documented results of special studies, when received, should become a component part of the file. If an outside facility is used, there should be a record of the date of the study, and the names of the interpreting practitioner and facility.
- Pertinent copies of health records from previous or concurrent health care providers
- Special consultative reports

(i) Record of discharge

- When the patient is discharged there should be a record made of the reason and the patient's current health status.
- This should include the patient's self-discharge.

(j) .Direct Correspondence - Correspondence in the form of letters or memoranda that leave the office should have information identifying the practitioner and/or clinic, address, and telephone number and be contemporaneously dated. A copy should always be kept on file.

- Introductory letter(s) to or from referring practitioner (chiropractor, general practitioner, osteopath, etc.)
- General correspondence to or from other practitioners
- General correspondence to or from lawyers
- General correspondence to or from patient
- General correspondence to or from various payer groups

What doesn't belong on a patient's chart?

- Criticism of care given by others.
- Communications with your professional indemnity insurance provider.
- Personal comments or notes that could cause embarrassment to the patient or practitioner.

6. CONFIDENTIALITY OF PATIENT RECORDS

- Practitioners should adhere to the provisions of the Patient Health Records Act.
- Patient records are confidential and no part of them should be examined by or released either verbally or in writing to anyone without the written consent of the patient or where legally required.
- Privacy laws relating to patient records should be observed.

7. RETENTION OF RECORDS

A patient's records should be kept in safe custody by the chiropractor to whom they belong for a period of 7 years from the date of the last visit of the patient to the chiropractor, save that in the case of patients under the age of 21 years the records should be so retained until the period of 7 years expires or until the patient is 21 whichever event occurs last.

8. ATTRIBUTES OF RECORDS

Records should be:

- Legible
- Clear and unambiguous
- Concise with an emphasis on essential clinical information
- Chronological
- Recorded at the time of visit
- Recorded in ink or in another permanently retrievable method.

9. USE OF ABBREVIATIONS AND TERMINOLOGY

Recorded abbreviations and terminology should be internally consistent and a key for these abbreviations should be available.

10. AMENDMENT OF RECORDS

Errors in the record should be corrected observing the following:

- When an entry is to be deleted or amended it should be crossed out in such a manner that it can be read if necessary.
- Record date and sign corrected entry.

11. TRANSFER OF RECORDS

Health care records, excluding data and reports from external sources, that are requested by another health professional currently treating a present or former patient should be forwarded promptly, following receipt of patient consent and/or an appropriate request.

12. SUPERVISION OF OFFICE STAFF IN RECORD KEEPING

The practitioner has the responsibility to ensure that staff members involved in record keeping are properly instructed on all relevant guidelines including the confidentiality of patient records.

13. RELEASE OF RECORDS

The patient's written consent is required prior to releasing a copy of or information from their record. Exceptions to this rule include cases involving:

- The practitioner is responding to a court order or subpoena, and/or
- Communication with a professional indemnity insurance provider, after the patient has made a complaint,
- A request from a registration board following a complaint.
- If x-ray films have been provided by a third party, they are generally considered the patient's property and returned.

14. PROCEDURE FOR THE RELEASE OF RECORDS

- Records should be maintained in accordance with the Health Records Act 2001 (Vic) (<<http://www.health.vic.gov.au/hsc/act.htm>>);
- Records should be maintained to show to whom any records or copies of records are released and when.
- If original radiographs should be released, a practitioner should ensure that written notes are recorded on the patient's records.
- A signed release form should be obtained from the patient on file for all documents that are released.
