Record keeping checklist

Maintaining appropriate and proper clinical records relies on speech pathologists integrating fundamental record keeping practices into their daily routines. Using this checklist will help to evaluate your practice. '**No**' answers are opportunities for improvement.

Actions	Yes	No
I keep a separate record for each client.		
I obtain and record informed consent for all services provide.		
My entries are legible, accurate, and made in chronological order and clearly dated. Any corrections I make to records do not remove the original information.		
I have signed my notes, and initialled any corrections or additions.		
I record sufficient information to allow me or someone else to return to the records at any time and be able to understand what took place and why.		
My entries are made at the time of the session, or as soon thereafter as practicable within 48 hours.		
If I don't have an opportunity to write my notes until the following day, I always enter the date I'm making the additional entry in the client's record.		
If documents are scanned to the record, such as external reports, the scanning is done to a sufficient quality that retains the legibility of the original document.		
I have consistent processes for recording the details of any further interactions with clients that may occur via telephone, text message or other method.		
I only use abbreviations that are widely recognised and accepted in speech pathology or I provide a list of abbreviations in the client's file.		
I don't make subjective or emotive comments; all information is professional. I know that clients have a right to access their records.		
All client care and entries in the record are made with the SPA's Code of Ethics in mind.		
I keep an appropriate, consistent standard of clinical records for all clients, not just those with complex needs.		
While I may ask a suitably qualified assistant to record some health information in the client's record, I always review their entries. I know that I cannot delegate responsibility for the accuracy of health information recorded to another person.		
The date of any funding claim matches the date of therapy in the clinical record.		
The claim item number matches the therapy type and length detailed in the clinical record.		
The provider number recorded for a claim matches the provider number for the speech pathologist that provided the service according to the clinical record.		
My records are stored securely and in a way that ensures they can be promptly retrieved.		
My records are collected, maintained, transferred and disposed of in accordance with privacy laws and state or territory laws.		
I have developed a privacy policy that provides information to clients about the collection, access, disclosure and retention of their health records.		
We have regular training for everyone at our practice about the appropriate collection, storage, access and disposal of records.		