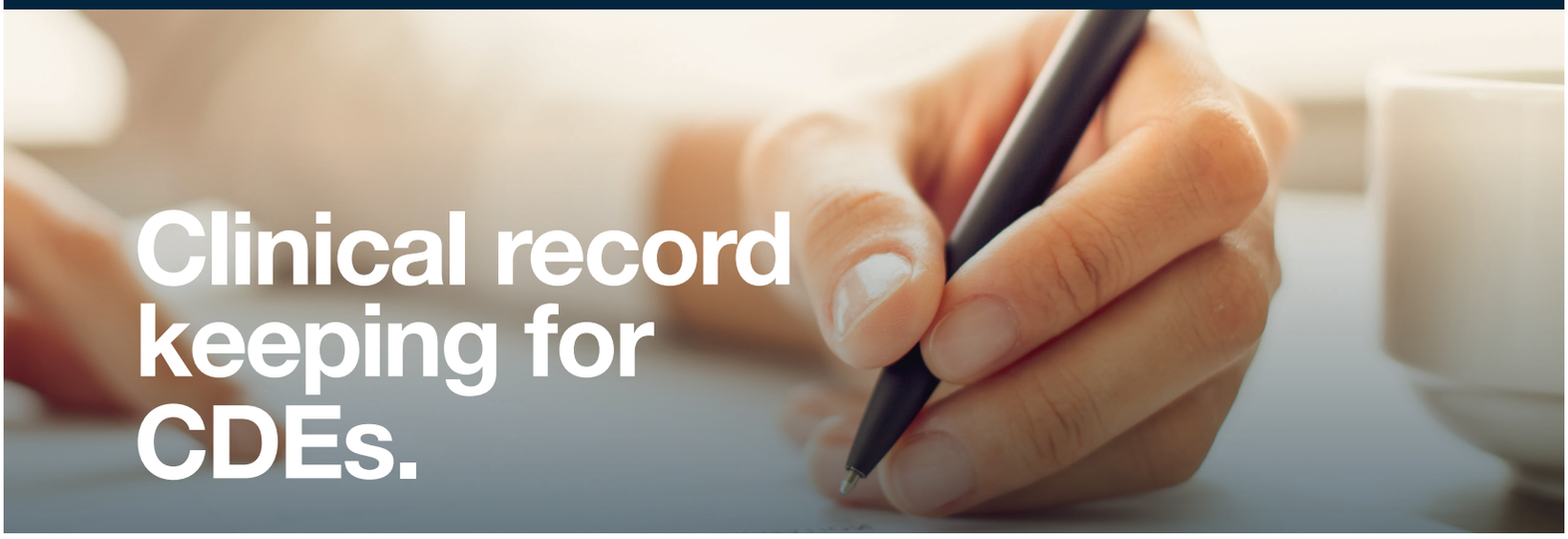

Clinical record keeping for CDEs.

Clinical record keeping is an essential part of providing health care services. Good clinical records are important for providing continuity of care, optimising clinical outcomes for a client, and can also help to protect you in case of a complaint. Guild's experience suggests many health practitioners would benefit from learning more about good record keeping.

While clinical record keeping is a requirement for all health professionals, the following information has been tailored for Credentialled Diabetes Educators (CDEs).

Clinical records and insurance claims

Clinical records can have a negative impact on complaints and insurance claims in two ways:

1. Incomplete or inaccurate records can lead to incorrect clinical advice and decision-making, which can result in compromised clinical outcomes for the client and therefore client complaints.
2. Substandard records may mean that a complaint, and therefore an insurance claim, is difficult to defend due to the lack of detail and evidence.

Why keep detailed clinical records?

1. Continuity of service

It's not uncommon to hear health professionals claim they can remember the details of their professional interactions. However, at Guild, we regularly see examples where health professionals haven't remembered key aspects of advice provided, and this has led to an adverse client outcome. It's therefore imperative to have detailed information recorded to ensure certainty of what's taken place in the past.

It's also important to be sure you refer to the information within the clinical record. People can suffer harm when key information, such as allergy details, is overlooked or forgotten about and therefore not advised or managed accordingly.

2. Professional requirement

It's a requirement for all health professionals to keep detailed clinical records. It's the responsibility of every health professional to be aware of and comply with the various codes, guidelines and policies relevant to them. Not knowing is not an excuse for not complying.

As documented in the ADEA Code of Conduct, ADEA members are expected to keep accurate records that document all care given, and they're expected to store and dispose of records securely.

All health professionals regulated by the Australian Health Practitioner Regulation Agency (Ahpra) have a Code of conduct that contains information about a practitioner's obligations and requirements regarding record keeping. These can be found at **ahpra.gov.au/Resources/Code-of-conduct**.

3. Defence of a complaint

If there's any allegation of wrongdoing made against a health professional, their clinical records will be incredibly important. Those clinical records provide the health professional's perspective of what took place and why. Without this, the health professional will be relying on their memory as a defence. The information recorded at the time of the consultation is going to hold greater weight as a reliable defence than a health professional's memory months after an event. As the saying goes, 'Good records = good defence, poor records = poor defence and no records = no defence'.

4. Funding audit

Funding providers, such as private health insurers, regularly review the rebates they pay for healthcare and may conduct audits to ensure that health professionals are billing appropriately. It's not uncommon for a health professional to receive a request from a funding provider to produce clinical records to justify their billing practices. If the reasons behind services and advice provided, and therefore billing, isn't clear, funding providers can demand repayment.

What to record?

The key question many health professionals ask when it comes to clinical record keeping is 'how much detail do I need to record?'. Exactly what to include will vary according to each

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unique clinical situation, yet it should be comprehensive enough to support continuity of care.

Generally, clinical records should include, but aren't limited to:

- Client identifying details and contact information.
- Name of the consulting health professional and the date of the consultation.
- Reason for the client presentation.
- Presence of any third parties, such as family members, support people, or interpreters.
- Clinical assessment details, including documentation of the client's relevant medical and psychosocial history, lifestyle factors, current symptoms and diabetes management plan. Include details of the assessment of self-care and the client's goals.
- Consultation details – capture all clinical findings, even if in range, and include the diagnosis and any consent obtained.
- Education or management plan.
- Education provided and the client's response.
- Recommendations made to the client.
- Any educational materials or items provided to the client.
- Referrals to, or liaisons with, other health professionals.
- Follow-up arrangements.

In some cases, it's worth noting what didn't occur as well as what did. For example, if a client hasn't agreed to follow what would be considered the most ideal or obvious option for them, the clinical record should reflect that it was discussed and declined. If it's simply left out of the record, it could seem that it wasn't discussed.

When a health practitioner is unsure if they've included enough detail, they should ask themselves whether another health professional could read the clinical record and understand the full picture of what took place and why, without the health professional filling in any gaps. If the full story isn't there, there isn't enough detail.

Professional and objective

Health professionals must use language in the clinical records that's professional and objective. Negative comments about the client can be included; however, they must be professional and recorded only when relevant to the clinical situation. This may occur when the client chooses not to follow your instructions or advice, which can be detrimental to their health. However, it's important to remember that clinical records can be accessed and read by several people, including the client, so always be mindful of the language used. The language should match the professional language a health practitioner would use when speaking to the client during a consultation.

Using artificial intelligence

As with many other parts of our lives, the use of artificial intelligence (AI) is increasingly creeping into record keeping practices. While there are numerous potential benefits of using AI, there are also risks that health professionals need to understand and manage. The first step requires health professionals to thoroughly research any AI tools they intend to use and be sure they understand how they work, particularly in relation to the storage and use of information input into them.

The task of creating appropriate clinical records can't be left to AI; health professionals must review any AI-generated information to be sure it's detailed and accurate. When doing the review, they must keep in mind that AI isn't perfect; it will at times leave out important information and even make things up. It's also important to be sure clients are aware of the use of AI. Before entering client data into an AI tool or recording consultations, you must obtain informed consent.

Further information about the use of AI in healthcare can be found on the Ahpra website at **ahpra.gov.au/Resources/Artificial-Intelligence-in-healthcare** This information will benefit any health professional, whether they're registered with Ahpra or not.

Disposing of records

There's no requirement to dispose of clinical records, and from a risk mitigation perspective, it's advisable to keep them for as long as you can. In New South Wales (NSW), Victoria and the Australian Capital Territory (ACT), it's required that records for an adult client are kept for 7 years from the last date of entry. For persons under 18 years of age when the last record was made, those records need to be kept until they turn 25 years old. Other states and territories don't have specific legislation regarding time frames for keeping health records. However, it's recommended that practitioners in those states and territories adhere to the requirements for NSW, Victoria and ACT and seek legal advice.

Conclusion

In summary, always remember that as a health professional, your clinical records support you to provide appropriate clinical care and serve as a reminder and record of what's taken place. That's why it's vital you keep detailed, accurate and up-to-date records of all clinical interactions. Really, you'd be lost without them.

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