Record keeping for natural therapists.

Patient record keeping is unfortunately one of those dreaded risk management topics. Guild Insurance understands that it isn't the most interesting of topics for natural therapists to spend time thinking and talking about. However, it's incredibly important, and Guild's experience suggests many practitioners would benefit from learning more about good record keeping.

Patient records and insurance claims

Patient records can impact insurance claims in two ways:

1. Poor records may make a complaint, and therefore an insurance claim, difficult to defend due to the lack of evidence.
2. And surprisingly to some, poor records can contribute to a poor or unexpected outcome following treatment, leading to the patient complaining and possibly seeking some form of compensation.

All natural therapists would want to avoid poor patient outcomes as the wellbeing of their patients is paramount. However, they would also want to avoid complaints, which can lead to insurance claims, as these can be very challenging and confronting experiences. Therefore, understanding how to improve the standard of patient records really should be a focus.

Why keep detailed patient records?

1. Continuity of patient care

It's not uncommon to hear practitioners believe they can remember the details of patient consultations. However, at Guild we regularly see examples where practitioners haven't remembered key aspects of prior consultations and treatment, and this has led to a poor outcome for the patient. It's therefore imperative to have this information recorded to ensure certainty as to how and why you've treated a patient in the past.

It's also important to be sure you refer to the information within the patient's record. Patients can suffer harm when information, such as allergy details, is overlooked or forgotten about and therefore the patient isn't treated accordingly.

2. Regulatory requirement

All professionals need to be aware of the various expectations placed on them, which are there to assist people to carry out their work appropriately. And it's a common expectation that practitioners keep detailed records of patient interaction. This is no different for natural therapists.

In the Australian Natural Therapists Association (ANTA) Code of Professional Ethics, it states that practitioners are to 'Maintain accurate, complete and up-to-date clinical records'.

The Code of Conduct for the Australian Health Practitioner Regulation Agency (Ahpra) states that 'Maintaining clear and accurate health records is essential for the continuing good care of patients'.

It's the responsibility of every practitioner to make themselves aware of and comply with the various codes, guidelines and policies relevant to them. Not knowing is not an excuse for not complying.

3. Defence of a complaint

If there's any allegation of wrong doing made against a practitioner, their records are going to be incredibly important. Those records provide evidence of what took place and why. Without this, the practitioner will be relying on their memory as a defence. Information recorded at the time of the consultation is going to hold greater weight as a reliable defence than a practitioner'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 treatment and can conduct audits to be sure practitioners are billing appropriately. It's not uncommon for a practitioner to receive a request from a funding provider to produce patient records to justify their billing practices. If the reasons behind treatment, and therefore billing, isn't clear, funding providers can demand repayment.

What to record?

The key question many practitioners ask when it comes to patient record keeping is 'how much detail do I need to record?'. Natural therapists should refer to ANTA's Guide to Clinical Record Keeping to better understand the detail required in a patient record.

Exactly what to include can vary according to the specifics of the patient's condition and therapy provided. However, generally records should include, but aren't limited to:

- Patient identifying details and contact information as well as health history
- Name of the consulting practitioner and the date of the consultation
- Presenting conditions and symptoms
- All examinations and investigations conducted and their results
- Informed consent to treatment
- Treatment provided and the patient's response
- Any items supplied, or instructions given, to the patient
- Referrals to other health professionals.

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

Professional and objective

Patient records need to always be professional and objective. Constructive critical comments about the patient can be included, however this must be professional and only when this is relevant to the treatment being provided. This may occur in situations where the patient isn't complying with instructions and this is detrimental to their health. However, it's important to remember that clinical records can be accessed and read by a number of people, including the patient, so always be mindful of the language used. The language used should match the professional language a practitioner would use when speaking to the patient during a consultation.