# Let the record show...

Speech pathologists benefit from discussing professional risks and managing them proactively. Maintaining health records is one of these important risk areas to be managed and understood. Guild Insurance's experience in managing claims suggests many health practitioners would benefit from learning more about record keeping and what's required.

## Health records and insurance claims

Health records can impact insurance claims in two ways:

1. Poor records can contribute to a poor or unexpected outcome from therapy, due to a lack of detail or incorrect information guiding therapy decisions, leading to the client complaining and possibly seeking some form of compensation.
2. Poor records may make a complaint, and therefore an insurance claim, difficult to defend due to the lack of evidence.

## Why keep detailed clinical records?

### 1. Continuity of client care

The primary purpose of clinical records is to ensure the safety and continuity of client care. It's not uncommon for speech pathologists to believe they can remember the details of client consultations. However, Guild sees examples where clinicians haven't remembered key aspects of prior therapy sessions which has led to poor outcomes for the client. It's therefore imperative to have all relevant information recorded, and readily available, to ensure certainty as to how and why you've provided therapy to the client in the past.

It's also important to be sure you refer to the information within the client's record. Clients can suffer harm when recorded information is overlooked or forgotten about and therefore the therapy isn't appropriate.

### 2. Regulatory requirement

Speech Pathology Australia's (SPA) Code of Ethics assists and supports speech pathologists to maintain the high level of professional practice expected of them. Members of SPA commit to upholding the Code of Ethics as part of their annual membership renewal. As stated in the Code of Ethics, speech pathologists are required keep adequate records of the professional services they provide.

It's the responsibility of all speech pathologists to make themselves aware of and adhere to the Code of Ethics; 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 speech pathologist, regardless of how minor or significant the matter may seem, their records are going to be incredibly important. Those records provide evidence of what took place and why.

Without a good record, the clinician 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 clinician'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 conduct audits to be sure health practitioners are billing appropriately and members are claiming appropriately. It's not uncommon for a health practitioner to receive a request from a funding provider to validate a claim made by a health professional or a client.

If the reasons behind treatment, and therefore billing, isn't clear, funding providers can demand repayment.

### What makes a good clinical record?

The key question many health practitioners ask when it comes to record keeping is 'how much detail do I need to record?'. When a speech pathologist is unsure if they have included enough detail, they should ask them self whether another clinician could read the record and understand the full picture of what took place and why, without the treating clinician or client filling in any gaps. If the full story isn't there, there isn't enough detail.

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

- Client identifying details and health history.
- Client and emergency contact information.
- Name and signature of the clinician as well as the date and location of the consultation.
- Who, if anyone, attended the session with the client.
- Reason for the client presentation.
- The client's informed consent to the assessment and the details of that assessment.
- Observations, clinical findings (even if there is no abnormal finding), and any working diagnoses.
- Therapy goals, proposed plan of care, associated risks and alternatives (if any) discussed with the client.
- The client's informed consent to the agreed plan of care and fees.
- All therapy provided and the client's response to the intervention.
- Any advice, instructions or warnings given to the client and a plan for future sessions.

- Details of any exchanges with the client, or their parent/carer, occurring via telephone, email etc.
- Referrals to or correspondence with other health professionals or service providers.
- Any other information you feel is relevant to that client's care.

In some cases, it's worth noting what didn't occur as well as what did. For example, if a client has refused to consent to what would be considered the most ideal or obvious therapy option, the record should reflect that it was discussed and declined. If it is simply left out of the record, it would appear that it wasn't considered or discussed as an option.

It's acceptable to use abbreviations in clinical records, however they need to be understood by others who may access the record.

Therefore, if a speech pathologist uses an abbreviation not widely recognised within the profession, they should ensure there's easily accessible information in the record explaining what that abbreviation means.

### Professional and objective

Health records need to always be professional and objective. Observational comments about the client or client's family can be included, however this must be professional and only when this is relevant to the therapy being provided. This may occur in situations where the client isn't complying with instructions and this is detrimental to their outcomes. However, it's important to remember that health records can be accessed and read by a number of people, including the client, their family, your regulator and insurer, so always be mindful of the language used. The language used should match the professional language a speech pathologist would use when speaking to the client during a consultation and remain within scope of practice for a speech pathologist.

### Timing of entry in a client record

As mentioned earlier, information recorded at the time of the consultation is considered to be the most accurate. However, it's also recognised that completing the clinical record immediately after a consultation isn't always practical and clinicians often add to the records some time after the consultation. It's considered best practice to have the record of a consultation completed within 48 hours after the consultation or contact/event occurred as this allows for the most comprehensive and accurate description of what's being documented.

It's recommended that managers and clinic owners allow their staff time in the day to complete their records. This process shouldn't be rushed as clinicians, especially those in the early stages of their careers, need time to process and record in detail all of what occurred in the therapy session.

### Privacy and health records

All businesses have an obligation to keep confidential information they hold regarding their clients private. This requirement is particularly important in healthcare given the sensitive nature of health information as well as personal and payment information also held by health organisations.

The Privacy Act (1988) regulates how health providers collect, store, use and disclose personal information. The Act requires compliance with the 13 Australian Privacy Principles (**www.oaic.gov.au/privacy/australian-privacy-principles**). There may also be state or territory based legislation relevant to specific locations, which the speech pathologist should be aware of.

All health professionals have an obligation to store health records in a manner which protects the information from unauthorised access or disclosure. There are various methods for the safe storage of health records and which method is used is up to each individual health professional or business. The storage of records in both paper and electronic format is permitted and it's important to remember that all records must adhere to privacy requirements, regardless of their format. It's recommended that health professionals who store their health records electronically seek assistance from technology experts to minimise their risks.

The Notifiable Data Breach (NDB) scheme commenced in February 2018. This scheme requires all businesses covered by the Privacy Act to notify the Office of the Australian Information Commissioner (OAIC) and affected individuals (such as your clients) when a notifiable data breach has occurred. A notifiable data beach is a breach, such as unauthorised access to records, which is considered likely to result in serious harm to individuals that information relates to. Further information about this scheme can be found at **www.oaic.gov.au/privacy/notifiable-data-breaches**.

Further information can be found on the Speech Pathology Australia website (**speechpathologyaustralia.com.au**) under Resources for Speech Pathologists, Professional Resources on a range of topics such as informed consent, Private Health Fund audits and privacy.

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