Record keeping requirements.

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

Clinical records and insurance claims

Clinical records can impact insurance claims in two ways:

1. Poor records which lack detail can lead to incorrect clinical decision making and poor clinical outcomes for the patient and therefore patient complaints.
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 patient care

It's not uncommon to hear health practitioners claim 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 Australian Health Practitioner Regulation Agency (Ahpra) regulated practitioners need to be well aware of their many regulatory requirements; good record keeping is one of these. Each profession's Code of Conduct contains information about a practitioner's obligations and requirements regarding record keeping. Several Ahpra National Boards have also created a separate document on guidelines for clinical records which further explains what's required.

It's the responsibility of every registered health professional 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 healthcare and can conduct audits to be sure health practitioners are billing appropriately.

It's not uncommon for a health practitioner to receive a request from a funding provider to produce clinical records to justify their billing practices. This is another example of when a practitioner needs documented evidence of what they've done and why. If the reasons behind treatment, and therefore billing, isn't clear, funding providers can demand repayment.

What to record?

The key question many health practitioners ask when it comes to clinical record keeping is 'how much detail do I need to record?'. Practitioners should refer to their Code of Conduct, as well as the guidelines on record keeping if one exists, to better understand the detail required in a clinical record.

Exactly what to include can vary according to the type of health profession as well as the specifics of the patient's condition and treatment. 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
- Reason for the patient presentation
- All examinations and investigations conducted and their results, even if there is no abnormal finding
- Diagnosis and treatment plan
- Consent to treatment
- Treatment provided and the patient's response
- Any items supplied, or instructions given, to the patient
- Referrals to other health professionals

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

When a practitioner is unsure if they have included enough detail, they should ask themself 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

Clinical records need to always be professional and objective. Negative 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 and your regulator, so always be mindful of the language used. The language used should match the professional language a health practitioner would use when speaking to the patient during a consultation.

Using Artificial Intelligence

As with many other parts of our lives, the use of artificial intelligence (AI) is creeping into record keeping practices more and more all the time. And while there are numerous potential benefits of using AI, there are also risks that health professionals need to understand and manage. The first step in this requires practitioners thoroughly research any AI tool 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; practitioners must be sure they review any AI-generated information to be sure it's detailed and accurate. And when doing this 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 patients are aware of the use of AI. When patient data is being input into an AI tool or if consultations are being recorded, informed consent is a must.

For further information about the use of AI in healthcare, refer to guidance available from Ahpra that can found at **www.ahpra.gov.au/Resources/Artificial-Intelligence-in-healthcare**.

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 patient are kept for 7 years from the last date of entry. For a patient who was under 18 years of age when the last record was made, those records need to be kept until that patient turns 25 year 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.

There's varying legislation across the different states and territories regarding processes to adhere to when disposing of records. It's recommended practitioners make themselves familiar with what's required, if intending to dispose of records, and seek independent legal advice if needed or speak to your professional association.