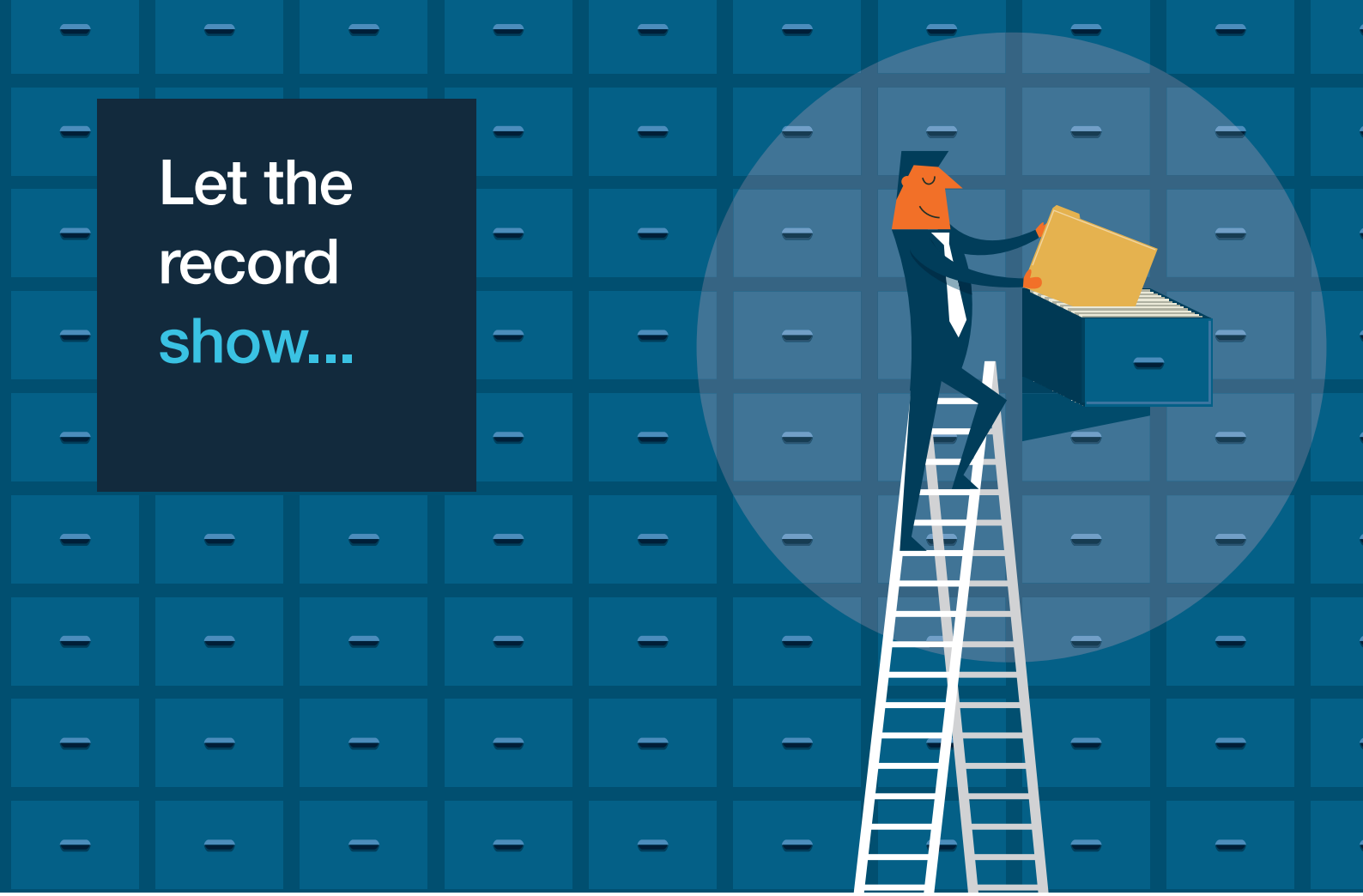
# Let the record show...



Clinical record keeping is unfortunately one of those dreaded risk management topics. Guild Insurance understands that it isn't the most interesting of topics for health practitioners to spend time thinking and talking about. However, it is 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 can contribute to a poor or unexpected outcome following treatment, leading to the patient 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.

All health practitioners would want to avoid poor clinical 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 clinical records really should be a focus.

## Why keep detailed clinical records?

### 1. Continuity of patient care

It's not uncommon to hear health 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 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. All National Boards within AHPRA have produced a Code of Conduct for the relevant profession. Within this code is information about a practitioner's obligations and requirements regarding record keeping. A number of National Boards have also created a separate document on guidelines for clinical records which further explains what is required.

It is 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 is 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 Board's 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 is 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 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

Clinical records need to always be professional and objective. Criticisms of 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.