Guidelines on Clinical Records

Introduction

These guidelines have been developed by the Podiatry Board of Australia (the Board) under section 39 of the *Health Practitioner Regulation National Law Act* as in force in each state and territory (the National Law).

Who needs to use these guidelines?

These guidelines are developed to provide guidance to registered podiatrists or those seeking to become registered in the podiatry profession as to appropriate standards for clinical record-keeping for podiatrists. They apply to all podiatrists and any personnel working under their supervision in the practice of podiatry and address how podiatrists should maintain clinical records related to their practice.

The guidelines will be used in an investigation or other proceedings against a registered podiatrist as evidence of what constitutes appropriate professional conduct or practice for podiatrists.

Summary

Podiatrists must create and maintain clinical records that serve the best interests of patients and that contribute to the safety and continuity of their podiatric care. To facilitate safe and effective care, patient records must be accurate, legible and understandable and contain sufficient detail so that another practitioner could take over the care of the patient if necessary. These guidelines describe the minimum requirements for clinical records whether they are in paper or electronic form.

Note: For the purpose of these guidelines, the term *patient* is used to refer to the person receiving the treatment and care of the podiatrist. In other contexts, the terms *client* or *consumer* may be used.

Clinical records for podiatrists

1. Responsibilities

Podiatrists have a professional and legal responsibility to:

- keep as confidential the information they collect and record about patients
- retain, transfer, dispose of, correct and provide access to clinical records in accordance with the requirements of the laws of the relevant states, territories and the Commonwealth
    - practitioners must be familiar with the requirements of the *Privacy Act 1988* (Cth) as well as their state or territory privacy and health records legislation, including the provisions that govern the retention of health records (which usually require retention from seven to 10 years) and the retention of records relating to children and youth under 18 years of age
    - third party access is subject to the provisions of the relevant privacy and health records legislation (for further information see point 1 of the *References* section at the end of this document) and

- assist patients to make well-informed decisions about treatment procedures and not impose treatment on patients.

2. General principles to be applied

- Each patient should have an individual health record containing all the health information held by the practice about that patient.
- A podiatry clinical record must be made at the time of the consultation or as soon thereafter as practicable or as soon as information (such as results) becomes available and must be an accurate and complete reflection of the consultation. If the date the record is made is different to the date of the consultation, the date the record is made must be recorded and the date of the consultation noted.
- Entries on a clinical record must be made in chronological order.
- Podiatry clinical records must be legible and understandable and of such a quality that another podiatrist or member of the health care team could read and understand the terminology and abbreviations used and, from the information provided, be equipped to manage the care of the patient. To ensure that other practitioners can understand the terminology and abbreviations in the record, standard Australian medical abbreviations are to be used (see point 2 of the *References* section at the end of this document).
- If documents are scanned to the record, such as external reports, the scanning needs to be undertaken in a way that reproduces the legibility of the original document.
- Podiatry clinical records must be able to be retrieved promptly when required.
- Podiatry clinical records must be stored securely and safeguarded against loss or damage, including a secure backup of electronic records.
- All comments in the clinical record should be respectful of the patient and be couched in objective, unemotional language.
- Podiatrists should be familiar with the requirements in the Board's *Code of conduct for registered health practitioners*, *Section 3.16: Closing a practice*. The Code requires the transfer or appropriate management of all patient records in accordance with the legislation governing health records in the state or territory in which the person is treated.
- Corrections can be made to a clinical record at the time of entry; the correction must be signed by the practitioner and the original entry must still be visible.
- A treating podiatrist must not delegate responsibility for the accuracy of information in the podiatry clinical record to another person.

3. Information to be recorded

The following information forms part of the clinical record and is to be recorded and maintained, where relevant:

- identifying details of the patient, including name and date of birth
- current health history and relevant past health history, including known allergies and alerts to adverse drug reactions
- relevant family history
- relevant social history including cultural background where clinically relevant
- contact details of the person the patient wishes to be contacted in an emergency (not necessarily the next of kin)
- clinical details:

  for each consultation, clear documentation of information relevant to that consultation including the following:

  - the date of the consultation
  - the name of the practitioner who conducted the consultation, including a signature where applicable
  - the presenting complaint
  - relevant history
  - information about the type of examination conducted
  - relevant clinical findings and observations
  - diagnosis
  - recommended treatment plans and alternatives
  - appropriate consent
  - all procedures conducted
  - instrument batch (tracking) control identification, where relevant
  - any medicine prescribed, administered or supplied for the patient or any other therapeutic agent used (including name, strength, quantity, dose, instructions for use, number of repeats and details of when started or stopped); if supplied, the details recorded must comply with the requirements of the relevant drugs and poisons legislation in the jurisdiction
  - details of advice provided

  - recommended management plan and, where appropriate, expected process of review; and
  - details of how the patient was monitored and the outcome
- unusual sequelae of treatment.
- relevant diagnostic data, including accompanying reports
- instructions to and communications with laboratories; and
- other details:
  - all referrals to and from other practitioners and letters and reports from other practitioners
  - letters received from hospitals and other clinical correspondence
  - any relevant communication (written or verbal) with or about the patient, including telephone or electronic communications
  - details of anyone contributing to the podiatry care and record and
  - estimates or quotations of fees.

Note: Information to be recorded for patients who are to be assessed for lower limb biomechanical conditions and prescribed foot orthoses, as with all other podiatric consultations, are to follow these guidelines.

References

1. **Privacy and health records legislation**: Useful information regarding privacy and health records legislation can be found at www.privacy.gov.au. Third party access is subject to the provisions of the relevant privacy and health records legislation.
2. *Australian Dictionary of Clinical Abbreviations, Acronyms and Symbols*. ISBN 978-1-876443-15-3. Published by the Health Information Management Association of Australia Limited.

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Date of review: This guideline will be reviewed at least every three years