Consultation paper on:
Guidelines on Clinical Records

Introduction

This consultation paper has been developed under the requirements of the Health Practitioner Regulation National Law Act (the National Law) as in force in each state and territory. The National Law empowers National Boards to develop registration standards for Ministerial Council approval. It also empowers National Boards to develop and approve codes and guidelines to provide guidance to the health practitioners a Board registers and about other matters relevant to the exercise of Boards' functions.

The National Law includes a requirement for National Boards to ensure there is wide ranging consultation on proposed registration standards, codes and guidelines.

The Podiatry Board of Australia (the Board) has developed draft *Guidelines on Clinical Records*. The Board welcomes feedback on the draft guidelines.

If you wish to provide comments on this consultation paper, please lodge a written submission in electronic form, marked 'Attention: Chair, Podiatry Board of Australia' to marie.cassidy@ahpra.gov.au by close of business on **Tuesday, 10 May, 2011**.

Please note that your submission will be placed on the Board's website unless you indicate otherwise.

15 March 2011

Guidelines on Clinical Records

Introduction

These guidelines have been developed by the Podiatry Board of Australia (the Board) under s.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 podiatrists or those seeking to become registered in the podiatry profession. They apply to all podiatrists and any personnel working under their supervision in the practice of podiatry.

These guidelines address how podiatrists should maintain clinical records related to their practice.

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. These guidelines describe the minimum requirements for clinical records whether they are in paper or electronic form.

Clinical records for Podiatrists

1 Behaviours

1.1 Podiatrists have a professional and legal responsibility to:

a) keep as confidential the information they collect and record about patients.

b) 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

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

2 General principles to be applied

2.1 A podiatry clinical record must be made at the time of the consultation or as soon thereafter as practicable and must be an accurate and complete reflection of the consultation.

2.2 Entries on a clinical record must be made in chronological order

2.3 Podiatry clinical records must be legible and understandable readily by third parties (particularly another podiatrist). To ensure that other practitioners can understand the terminology and abbreviations in the record standard Australian medical abbreviations are to be used.

2.4 Practitioners must be familiar with the requirements of the Commonwealth Privacy Act as well as their State or Territory privacy legislation. Useful information regarding privacy legislation can be found at: www.privacy.gov.au. Third party access is subject to the provisions of the relevant privacy legislation.

2.5 Podiatry clinical records must be retrievable promptly when required.

2.6 Podiatry clinical records must be stored securely and safeguarded against loss or damage including a secure backup of electronic records.

2.7 Podiatrists should be familiar with the provisions of legislation in their State or Territory that govern the retention of health records (which usually require retention from 7-10 years), as well as any provisions regarding the retention of records relating to children and youth under 18 years of age.

2.8 All comments in the clinical record must be couched in objective, unemotional language.

2.9 Podiatrists should be familiar with the requirements in the Board's Code of Conduct at 3.16 regarding 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.

2.10 Corrections made to clinical records must not remove the original information.

2.11 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

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

a) identifying details of the patient

b) complete and current medical history including alerts to adverse drug reactions

3.2 Clinical details

a) for each consultation, clear documentation describing:

- the date of the consultation
- the identifying details of the practitioner providing the treatment, including a signature where applicable
- the presenting complaint
- relevant history
- information about the type of examination conducted
- clinical findings and observations
- diagnosis
- treatment plans and alternatives
- appropriate consent

- all procedures conducted
- instrument batch (tracking) control identification, where relevant
- any medicine / drug prescribed, administered or supplied or any other therapeutic agent used (name, quantity, dose, instructions, repeats and details of when started or stopped)
- details of advice provided
- review plan

b) unusual sequelae of treatment

c) radiographs and other relevant diagnostic data; digital radiographs must be readily transferable and available in high definition digital

d) other relevant digital data relating to the patient's care.

e) instructions to and communications with laboratories

3.3 Other details

a) all referrals to and from other practitioners

b) any relevant communication with or about the patient

c) details of anyone contributing to the podiatry care and record

d) estimates or quotations of fees

Note: For the purpose of this guideline, 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' are used.