Health Records

Background

Record keeping is an important component of professional physiotherapy practice. Over the last two decades the need for high standards of documentation for physiotherapy records has increased due to a combination of professional, ethical and legal requirements. Failure to maintain appropriate clinical record would cause considerable difficulties in respect to any legal proceedings, e.g. allegations of negligence. It would also in all probability be a breach of government legislation covering clinical records.

The purpose of clinical record keeping is:

- To provide an accurate and comprehensive account of patient care with clear treatment plans and the relevant interventions by health professionals
- To record the chronology of events, any problems that arise, and the action taken in response to them.
- To assist the continuity of care amongst professionals and provide written evidence that the service has been delivered.
- To meet legal, professional and statutory requirements.
- To provide information for quality assurance, clinical audit, research and evaluation and the investigation of complaints.
- To provide evidence of care before a court of law

Accurate information is essential to the delivery of high quality evidence-based health care and as such good clinical records form the bedrock of physiotherapy practice. They are the basic tools for recording a physiotherapist’s contribution to an individual’s management plan and will demonstrate the success or failure of an intervention.

Record keeping is a professional requirement of all physiotherapists in any situation in which they are providing physiotherapy services – paid or unpaid, contractor or employee, within a practice or on a sporting field, in a residential aged care facility or in a hospital. Appropriate record keeping is an ethical and legal requirement of practising as a registered physiotherapist, however the content and format of these records will vary according to the client, setting, and assessment or intervention.

"With the advent of various electronic media, the Internet, and the consumer’s enhanced role in compiling their health information, the definition of the legal health record has become more complex. Therefore, the definition of the legal health record must be reassessed in light of new technologies, users, and uses."^2

Clinical Records

Studies have also shown that electronic clinical records are advantageous over paper clinical records in that they prompt and facilitate better and more complete patient recording. However physiotherapists’ adoption of electronic clinical records has been limited to date.
In 2009 a survey was conducted regarding electronic clinical records in private physiotherapy practices within Australia. The major benefits identified from this survey for using electronic clinical records were:

- improved access to records
- improved legibility and
- easier storage.

The barriers preventing usage included lack of knowledge about available software packages and increased expense.

Respondents indicated that incentives which were likely to encourage the implementation of electronic clinical records in physiotherapy practices include the provision of software, cash payments and training. The survey also found that 75 per cent of subjects who used paper only systems would consider adopting electronic clinical records indicating that practitioners are willing to embrace the technology.

**Health Records**

Health records are similar in nature to clinical records, but are general in nature and more patient centred. They are defined as:

A record of patient health information generated by an individual's encounter with any care delivery setting. Allows a degree of patient contribution and control and is not solely owned by the provider.

In 2004 the National E-Health Transition Authority (NEHTA) was formed to introduce standards and platforms for E-Health and to facilitate the introduction of a Personally Controlled Electronic Health Records (PCEHR).

A Personally Controlled Electronic Health Record (PCEHR) is a secure, electronic record of your medical history, stored and shared in a network of connected systems. The PCEHR will bring key health information from a number of different systems together and present it in a single view.

NEHTA proposes that the PCEHR should ‘provide a consolidated summarised record of an individual’s health information for consumers to access and for use as a mechanism for improving care coordination between care provider teams.’ It is based on a 16 digit unique number assigned to each individual known as an Individual Healthcare Identifier (IHI). In 2010 the Australian Government committed $466.7 million investment over two years to establish a secure system of personally controlled electronic health records that will provide:

- Summaries of patients’ health information – including medications and immunisations and medical test results;
- Secure access for patients and health care providers to their e-Health records via the internet regardless of their physical location;
- Rigorous governance and oversight to maintain privacy; and
- Health care providers with the national standards, planning and core national infrastructure required to use the national e-Health records system.

**Privacy Issues**

People regard health information as one of the most sensitive types of personal information. For this reason, the Privacy Act provides extra protections around the handling of health information. All organisations that provide a health service are covered by the Privacy Act which controls how these organisations collect and handle personal information, including health information. It also includes provisions that generally allow a person to access information held about them.
There are ten National Privacy Principles that regulate how private sector organisations manage personal information, covering the collection, use and disclosure, and secure management of personal information.¹⁰

**The APA position**

The APA recognises the importance of clinical documentation to facilitate the delivery of high quality care to clients, and also as a legal requirement to practise as a registered physiotherapist. In addition the APA recognises the emergence of new technologies to manage clinical records and endorses the adoption of these within physiotherapy practice.

The position of the Australian Physiotherapy Association is that:

- Legislation that is consistent across jurisdictions must be developed to ensure that client health information will be used in a way that protects patient privacy. Guidelines that are consistent across jurisdictions should be developed to ensure that physiotherapists are aware of these legislative requirements.

- PCEHRs are important to help improve the efficiency of physiotherapy practice. These records should be subject to the same accuracy, security and privacy requirements as paper based records.

- Physiotherapists must be provided with increased government support to update their information and communication technology infrastructure, including access to broadband internet so they have access to accurate and more up-to-date health information contained on PCEHRs.

- Physiotherapists must to the best of their ability accurately document all consultations. Records are to be documented for each attendance and completed as soon as practicable after the treatment session.

- Clinical records should be dated, and if appropriate, include the time of consultation. They must be legible and signed by the treating physiotherapist with the physiotherapist’s name clearly printed. Where service is provided by a physiotherapy student, the records must be countersigned by the supervising physiotherapist.

- Electronic clinical records must be auditable, and access should require authentication and be tracked, capturing and reporting on details of the initialisation, modification, and viewing of records.

- Clinical records should contain sufficient information to allow a physiotherapist of similar skill to continue the treatment of that patient if required.

- All abbreviations, terminology and symbols recorded in the clinical record should be recognisable by physiotherapy peers.

- Physiotherapists must retain clinical records for a minimum period of seven years from the date the last entry was made for consumers 18 years of age or more, and for consumers less than 18 years of age, seven years from the date the consumer turns 18. If a physiotherapist destroys or transfers any records, a register must be kept noting details. If the recommendations in this document conflict with State or Territory guidelines, the statutory requirements of the State or Territory should take precedence. The storage, destruction and transfer of any clinical records must be secure.
References:


