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GUIDELINES FOR CLIENT RECORD KEEPING

Introduction

This information sets out the essentials for natural health practitioners for documenting and maintaining client records. Designed to apply to client records created in Endeavour Student Clinics, it offers practical guidance with respect to the principles and requirements for all client records from all modalities. Endeavour College students when graduated may work in a variety of health care situations including:

- Private practice
- Integrated health clinics
- Hospital & outpatient clinics

In all of these situations client records must be kept in accordance with many health regulations and medico-legal requirements. These guidelines can be used as a template for Best Practice in Client Record Keeping.

Principles

Medical/client records are central to all client health care activities. Ethically and legally all types of health care professionals have a responsibility to maintain an accurate record of health events for their clients and ensure the privacy of this information is protected.

Good client record keeping is recognised as an important part of any type of quality health care.

All health care professionals are obligated to make records for each of their clients. The primary use of these records is for the treating practitioner and other health care professionals to ascertain the client’s medical history and identify problems or patterns that may help determine the course of health care that should follow.

The client health record is a legal document that records events and decisions which help the practitioner manage client care. It may also provide significant evidence in lawsuits, hearings or inquests when the client care provided by the practitioners is in question.

In addition, good client records can help optimise the use of resources, both financial and human, by reducing duplication of services. Client records may also provide information essential to others for a wide variety of purposes such as:

- Cost of health care
The Importance of Good Record Keeping

*Continuity and Quality in Health Care*

Good clinical records are essential in ensuring high levels of client care and for the protection of the practitioner by minimizing exposure to litigation and facilitating effective health care.

Good clinical documentation facilitates best practice in client care by ensuring that:

- Important clinical information is available to all treating or consulting practitioners; and
- Continuity of care is possible between practitioners over time and between different health services.

The client record should “tell the story” of the client as determined by the practitioner in the circumstances in which they saw the client. The client record is not just a personal memory aid for the individual practitioner who creates it. It should allow other health care providers to read quickly and understand the clients past and current health concerns. While some records may be requested by clients, it is not expected that all clients will be able to read and understand information in their client records. Client records may contain abbreviations and terminology unique to the health care professions.

*Compliance*

Students are required to follow these guidelines as closely as possible and it is suggested that the same guidelines can be used in their own practices after graduation. It should be recognised that the client record is a legal document which records events and decisions that assist practitioners manage client care. Many health care practitioners may work in institutions or facilities that may have their own record keeping requirements.

*Records and External Reviews*

Client records are often fundamental components of regulatory reviews, such as those conducted for quality improvement purposes (e.g. peer assessment programs), College complaint investigations, investigation by relevant State Health Departments, and billing audits.
Client health records may provide significant evidence in lawsuits, hearings, or insurance claims. Regardless of the type of assessment or investigation, a good or bad client record may have a significant positive or negative effect on the outcome of the process.

**Content of Client Records**

*Overview and Organisation of Client Records*

Maintaining a daily diary of patient appointments is required by most health care organisations. While some practitioners use the diary only to list clients seen each day, the daily diary can also contain other useful information, such as the patient file and file number, the patient complaint or health problem, and information related to the complaint or problem.

*General Principles for Contents of Client Records*

A client record is an essential tool in providing continuity of care for all clients, regardless of the nature of the relationship between the health care provider and the client, and/or the frequency of client encounters. A client’s record should tell the story of the client’s health care condition and should allow other health care providers to quickly read and understand the patient’s health concerns or problems.

Each record of a client encounter should include a focused relevant history, appropriate focused physical examination (where indicated), a provisional assessment/diagnosis of condition (where indicated) and a treatment plan.

*Communicating with Patients*

The first step in taking a client’s history is to clarify and verify the client’s reason for the visit. The health care professional should be mindful that nonverbal communication such as tone of voice, mannerisms and ‘body language’ may give important clues as to the client’s underlying problem or concerns.

The College expects all students not to make derogatory or inappropriate comments about clients in the client record.

*Communicating with Other Health Care Providers*

The need for good communication also applies between health professionals. Multidisciplinary health care is now well recognised in Australia’s health care system and the client record serves
as the conduit of information shared between health care providers. Continuity of care can only be preserved if the flow of information remains uninterrupted and intact.

**Chronological and Systematic**

All materials in the clients file should be organised in a chronological and systematic manner. Arrange by date, from earlier to later.

**Timing of Events**

All client-related documentation must be dated. Consultation reports, laboratory reports, diagnostic results should be dated when they are written, reviewed or received. Every client encounter should be documented and dated in the client record. In multi-modality clinics, and more than one practitioner will be making entries in a client record, each practitioner’s entry should be identified by signature, and, if appropriate position or title. In Endeavour Students Clinics, the student must sign and date all entries and have the relevant Clinic Supervisor sign and date all entries.

The College requires that entries be recorded as closely as possible to the time of the encounter, when the details are most fresh in the student’s mind. This allows students to keep records that are detailed, accurate and comprehensive. This practice should be continued in graduated practices.

**Clarity and Legibility**

The College expects that records are legible and can be interpreted by other students and Clinic Supervisors. This should be continued in graduated practice. If there is difficulty with the legibility of the records, an alternative means of note taking should be considered (e.g. electronic methods, voice dictation, handwriting recognition software).

Using conventional medical abbreviations and acronyms is permissible. However, the meaning should be readily available to a health care professional reading the record.

Client records must be clear, legible, precise and document a measure of outcome. Client records should meet the following requirements:

- **Clear** – Personal abbreviations should be avoided. Abbreviations and acronyms that are not widely known may impede communication of information to other students, clinic supervisors and when in practice other staff members.
- **Precise** – The record must avoid wordiness. The record must show evidence that patient assessment and specific treatment has been provided and consented to.
• **Complete** – The record provides data for other health care professionals concerned with patient care. Letters to other health care professionals should be kept in the client record.

• **Contemporaneous** – To ensure the accuracy, notes should be made at the time of the consultation or as soon as possible thereafter. An entry should be made for each consultation.

• **Legible** – documentation is of little value if handwriting cannot be understood by other practitioners.

• **Objective** – Records should record facts alone. Practitioners should realize that the client’s notes might, one day, be read by the client and legal advisers. Notes should not be used to express exasperation, invective, criticism or sarcasm.

• **Unaltered** – Records should not be altered or tampered with retrospectively. If an additional entry is required this should be added later in the record, stated to be retrospective and signed and dated accordingly. Corrections are acceptable as long as the change is clearly identifiable, dated and initialed. In Endeavour Clinics no overwriting and erasing is allowed. The original record needs to remain legible.

• Signed and dated on each entry.

Appendix One has an overview of what should be included in Client Records.

**A Cumulative Client Profile (CCP)**

In most settings, each client’s record should contain a brief summary of essential information about the client. The “cumulative patient profile,” (CCP) which separates pertinent information in the history from the continually updated information on short-term problems, can prevent repetitive history-taking and can make information easily accessible to busy practitioners.

This overview of the client includes critical elements of the client’s health history, allowing the treating practitioner, or any other health care professional using the client record, to quickly get the picture of the client’s overall health.

A CCP is an example of a very effective summary that can be used by all types of health care practitioners. Good use of a CCP will save a practitioner time by reducing the need to rewrite information in the progress notes when the information is already contained in the CCP.

A complete CCP containing current information can assist in preventing errors and duplication of documentation. **An example of a CCP form is included in Appendix 3.** Practitioners are encouraged to customise this form to meet their own needs.

Ideally, the information in a CCP would include:
• Client identification (name, address, phone number, health insurance number if applicable)
• Personal and family data (occupation, life events, habits, family medical history)
• Past medical history (past serious illnesses, operations, accidents, genetic history)
• Risk factors
• Allergies and drug reactions
• Ongoing health conditions (problems, diagnoses, date of onset)
• Health maintenance (annual exams, immunisations, disease surveillance e.g. mammogram, colonoscopy, bone density etc.)
• Other health care providers names
• Long term treatment (current medications, dosage, frequency)
• Major investigations
• Date the CCP was last updated
• Contact person in case of emergencies

Making Your CCP Work in Your Practice

The CCP should be completed during the first or second client encounter, and placed at the front of the client’s record for ease of access and reference. However, there is no reason not to commence keeping a CCP for all clients in an existing practice, even when this has not been done before.

It is important for a practitioner to review the information in the CCP regularly and to revise the information as it becomes outdated. Regular review and revision is particularly important where practitioners are required to send information to third parties such as medical consultants, hospital emergency rooms, insurance companies, rehabilitation providers and lawyers. In these situations, practitioners should ensure they are providing these parties with accurate and current information.

The CCP can be used as a quick and easy way for office staff to access important information such as medications, remedies and immunisations. Practitioners can supply clients with their CCP when they travel or are referred to another health care professional. A comprehensive CCP will be valuable in cases where practitioners are required to produce printed copies of electronic records. The CCP will provide a useful overview that will assist the reader to interpret the sometimes cumbersome or confusing print version of an electronic record.
Progress Notes and SOAP Format

Progress notes are made contemporaneously with a practitioner client encounter. One of the most widely recommended methods for documenting a particular client encounter is the Subjective Objective Assessment Plan (SOAP) format. This format is widely used in medical practices, allied health practices and natural medicine practices and many versions of clinical software uses a SOAP format for documenting client encounters.

There are many advantages including encouraging comprehensive records, reducing unnecessary documentation, assisting in the organisation of the notes, saving time, and facilitating rapid and easy retrieval of information from the record.

Practitioners should consider the following points when documenting their client encounters:

Subjective Data (S)

- Presenting complaint, including the severity and duration of symptoms;
- Whether this is a new concern or an ongoing/recurring problem;
- Changes in the client’s progress or health status since the last visit;
- Past medical history of the client and their family, where relevant to the presenting problem;
- Salient negative responses.

Objective Data (O)

- Relevant vital signs;
- Physical examination appropriate to the presenting complaint;
- Positive physical findings;
- Significant negative physical findings as they relate to the problem.

Assessment (A)

- Patient risk factors, if appropriate;
- Ongoing/recurring health concerns, if appropriate;
- Review of medications, if appropriate;
- Review of laboratory and procedure results, if available;
- Review of consultation reports, if available;
- Diagnosis, differential diagnosis, or problem statement in order of probability and reflective of the presenting complaint.
Plan (P)

- Discussion of treatment options;
- Tests or procedures ordered and explanation of significant complications, if relevant;
- Consultation requests including the reason for the referral, if relevant;
- New medications/remedies/supplements ordered and/or medication repeats including dosage, frequency, duration and an explanation of potentially serious adverse effects;
- Any other patient advice or client education (e.g., diet or exercise instructions, contraceptive advice);
- Follow-up and future considerations;
- Specific concerns regarding the client including client refusal to comply with your suggestions.

Modifying Client Records

Sometimes it may be necessary to modify client records. Where necessary to ensure the accuracy of the client record, it is considered permissible to modify the record. Corrections should be undertaken to ensure that correct information is recorded, (with the additions or changes dated and initialed), and the incorrect information is either removed from the record and stored separately, or maintained in the record but clearly labeled as being incorrect. Where the incorrect information is removed from the record, practitioners should ensure that there is a notation in the record that allows for the incorrect information to be traced. Where incorrect information is maintained in record, practitioners should ensure that the information remains legible.

Where students are uncertain as to how to properly correct information, they should speak with their clinic supervisors for assistance. Where graduated practitioners are uncertain as to how to properly correct information, they should contact relevant authorities – practice managers, state health departments, professional associations, insurance providers etc. Care and consideration must be taken as deliberately altering a client record may be considered professional misconduct.

Removing Portions of the Record

Storage requirements in some practices may necessitate the removal of some materials from a client’s active chart. If investigation results and consultation reports are no longer relevant to the client’s current care, it may be permissible to store them elsewhere. In such cases, practitioners should make a notation indicating the documents have been removed from the
record and the location where the records have been stored. All records in Endeavour Students Clinics must remain in the client record.

Record Keeping for Specific Types of Client Encounters

 Patients with Chronic Conditions

For clients with chronic conditions, such as arthritis, it is often useful to have flow sheets that allow the practitioner to record important clinical information about the client’s management over long periods of time. Flow sheets permit the practitioner to see trends that enhance their ability to identify the appropriate treatment. Flow sheets will, of necessity, deal only with one disease. The CPP and the progress notes will be the principal information used in care and treatment plans.

Record Keeping for Couples and Family Therapy

When treating individuals together, the records should reflect information about each individual and also about the relationship. Where individuals are treated together, either in couples or family therapy, the personal health information of the individuals is shared and communicated in a group setting. Practitioners should obtain written consents from both parties outlining the sharing of information before engaging in couple’s therapy. This also applies to family therapy if there are children over the age of 16 or mature minors involved in the sessions.

In cases where couples or family therapy is undertaken by a practitioner it is important to consider the inherent risk of inadvertent breaches in confidentiality and referral to other practitioners should be considered.

Patient Non-Compliance or Failure to Attend Appointment

Practitioners should document all instances of a client refusing an examination or treatment. Most practitioners have had an experience where a patient has refused to have an examination or a treatment, or asked to defer the examination to a later date. It is essential that practitioners document all advice, tests or treatments that are refused or deferred by the client to ensure that anyone who reads the client record will receive an accurate depiction of the treatment that the client has received, and will gain an understanding of the treatment decisions the client has made.
Where treatment has been refused or deferred, the client record should also indicate the reason, if any, given by the client for declining the advice and treatment recommendations of the practitioner, as this information may be important for the future care of the client.

The client record should also always note when a scheduled appointment is missed by a client.

**Telephone Conversations and E-Mails**

The majority of telephone calls from clients should be recorded in their client records. All phone calls dealing with matters of significant clinical impact that are made to or received from the client should be documented.

The documentation should include the date and time of the call, significant information and advice provided.

Records of e-mails to and from clients should be treated in the same way as records of telephone calls. Where possible, it is advisable to copy all correspondence for the client record, particularly those dealing with matters of significant clinical impact.

**Ownership of Records**

**Records in Private Practice**

Practitioners in private practice are considered the owners and custodians of all health records for their clients and are responsible for the following:

- Accuracy and propriety of the records
- The actions of staff who access the records
- The retention of the records according to relevant state health authorities

Practitioners must create a client record for each client. Alterations and requests must be clearly managed according to privacy legislation and state health authorities.

Practitioners must maintain security measures that protect the privacy and the confidentiality of patient information in their custody.

In accordance with privacy legislation, each practice must have a designated privacy person/officer who understands client privacy legislation, and is able to develop policies for the practice and if required understand privacy issues during the transition to electric records. The officer should also train relevant staff and assist clients, upon request, understand their right to privacy. In sole practitioner practices, the practitioners must undertake the role of the privacy officer.
Practitioners, as custodians or owners of client information, can only use it to:

- Identify the person who needs or is receiving health care;
- Provide health care to that person;
- With client’s consent, or in accordance with legal requirements, provide requested information to an authorised third party.

When a practitioner-client relationship is terminated, the practitioner must:

- Upon written request, transfer copies or a summary of pertinent client health record information to the new practitioner custodian;
- Retain the original record (paper or electronic).

Costs for records transferred are the responsibility of the client who may opt to have either a summary or the complete record. Practitioners should discuss the relevant costs with a client.

Practitioners may arrange to have their client records handled by an outside or contracted Information Provider Manager but there must be a legal contract that specifies that the practitioner still has full control of the information.

*Records in Group Practice*

When a practitioner enters a group practice/multi modality practice, the details of the information-sharing protocols and the ownership of the client records must be outlined in a formal, written agreement.

Referrals and transfer of care must be documented even if in a group arrangement.

The use of an integrated record is common and an acceptable record, however, each entry in the integrated record must be attributable and the unified record must not compromise the ability to provide clients access to their information.

*Storage and Security*

Client records should be stored in a safe and secure environment to safeguard their physical integrity and confidentiality. Practitioners should take all reasonable steps to ensure that records are protected from theft, loss and unauthorised use or disclosure, including photocopying, modification or disposal.

What is reasonable depends on the threats, risks and vulnerabilities to which the information is exposed, the sensitivity of the information, and the extent to which it can be linked to an
identifiable individual. Consideration should be given to each of the following aspects of record protection:

- Physical security (for example, locked file cabinets, restricted office access, alarm systems)
- Technological security (for example, passwords, encryption and firewalls)
- Administrative controls (for example, security clearances, access restrictions, staff training, and confidentiality agreement).

Client records should be kept in restricted access areas or locked filing cabinets, and organisational measures should be in place to ensure that only those who need access to the records for a legitimate purpose are able to use them. Practitioners need to consider that non-healthcare staff, such as maintenance staff, may have access to records, and should ensure that steps are taken to ensure that access to the records is limited or that those who have access to the records are bound by an appropriate confidentiality agreement.

**How Long to Keep Records**

There are requirements in many areas for the storage of client’s records. Client records in public health facilities are governed by a number of State Acts that require client records to be stored securely for anywhere between 7-15 years after the last time a client has been seen by a practitioner. The College has regulatory requirements for the safe storage and disposal of Student Clinic client records.

Natural medicine practitioners in private practice are advised that client records should be kept at least seven (7) years after the client treatment or care ceases in the case of adults and until a child client reaches the age of 25. Client records should be kept as long as it is possible for an action to be brought against a practitioner. The destruction of client records before seven years after cessation of treatment could be construed as a breach of duty of care or a breach of an implied term of the practitioner/client contract.

Under National Privacy Principles guidelines, appropriate measures must be undertaken by the health practitioner to ensure the confidentiality, security and preservation of records and access to information.

**Privacy and Confidentiality**

The National Privacy Principles cover Client Health Records of all types. A client’s entire record is always confidential and should not be left anywhere other people may view written details of the client record. The treating health care professional/s should be the only people that have access to these documents.
Copying, faxing or emailing of the client’s record should only occur with the client’s consent. All practitioners must ensure that confidentiality of client records is upheld at all times. This is particularly important with electronic records as breaches of confidentiality can easily occur.

**Disclosure**

There are particular circumstances that require the disclosure of client records. These include:

- **Freedom of Information (FOI)** – Both State and Federal Governments have introduced Freedom of Information legislation, which allows patients/clients to have access to their client/medical records.
- **Privacy Act** – Under the Privacy Act and National Privacy Principles, clients/patients have access to information contained in the health records. Whether records are provided in full (through provision of a photocopy of the record), or a summary of information contained in the client record remains a matter for the discretion of the practitioner.

Client records can be the subject of medico-legal actions and be requested through a subpoena, search warrant or writ of non-party discovery where such are available under legislation and the court process. The records must be:

- Relevant to a matter in question in the proceedings;
- In the possession of control of the practitioner; and
- Able to be produced at trial.

Practitioners should always seek legal advice or advice from their insurer about supplying client records in these situations.

In a medico-legal context, a good rule of thumb for documentation and record keeping can be summarized as:

- Good notes, good defence
- Bad notes, bad defence
- No notes, no defence

**Withdrawal of Consent and Conditional Consent**

Practitioners should be aware that clients are entitled to withdraw their consent to the disclosure of their personal health information. While this withdrawal will not affect disclosures made prior to the withdrawal, it will apply to any disclosures made after the withdrawal. Practitioners need to exercise care and caution when disclosing personal health information, once the client has withdrawn consent regarding disclosure.
There may be some situations in which clients will give their consent to the collection, use or disclosure of their personal health information (such as in research trials), but will impose conditions or restrictions on the manner in which their information is used or disclosed. Where clients wish to give conditional consent, a practitioner should ask patients to set out any and all restrictions in writing. No restriction or condition imposed by a client shall prevent practitioner from recording information that is required by law, or by standards of professional practice.

The practitioner disclosing the record should indicate on the record that clinically relevant information is missing from it.

**Patient Access to Records**

Generally speaking, all information contained in the record must be released to clients upon request, including letters from other health care practitioners, even when such letters are stamped or indicated as confidential documents. In rare circumstances, where the practitioner believes that disclosure of certain information is likely to cause substantial harm to the physical or mental well-being of the client or to a third party, they may withhold the information. If the practitioner refuses to disclose all or part of the client report, a client may take legal action to obtain the information. As such, the practitioner must be able to justify the withholding of client information.

Practitioners cannot refuse to grant a patient access to their records for the purpose of avoiding a legal proceeding.

**Disclosure to a Person Other Than the Client**

Information concerning the condition of the client should only be revealed to another person with the consent of the client or the client’s authorized representative (such as a solicitor).

Determining who is an authorized representative may be difficult (e.g. the client is deceased, or the client is a minor whose parents are separated). A practitioner should seek legal advice for clarification in this situation.

**Third Party Reports**

Practitioner’s who are asked to prepare a report for a third parties (eg. insurance companies, Workers’ Compensation Board) must take concise and accurate case notes.

Clients should be informed of the purpose of any examination or treatment and the way it will be conducted. The client must be advised in advance that the prepared report will be disclosed to the third party requesting the report as well as to the client if so requested by the client.
A practitioner who discovers, during the third party examination, a significant medical condition requiring treatment is responsible for ensuring that this is disclosed to the client, with a recommendation to seek treatment.

In terms of client access to clinic records, reports prepared or records relating to examinations conducted at the request of a third party are considered the same as any other client records.

The practitioner must allow the client access to these reports if requested, subject to the same conditions applicable to other client records.

**Refusal to Disclose**

Practitioners may refuse a request for access to information from a third party where:

- The information is protected by solicitor-client privilege;
- It is reasonable to expect that granting access would threaten the life or security of another individual;
- The information was collected in relation to a breach of an agreement or a contravention of federal or provincial laws; or
- The information was generated in relation to a formal dispute resolution process.

Practitioners may refuse a request for access to information from a third party when they have reasonable grounds to believe it would not be in the best interest of the client to make available that information, or where the information is protected by solicitor-client privilege.

**Patient Requests Transfer**

When clients request that their health care practitioners (of any modality) transfer their records to another practitioner, the transfer should take place in a timely fashion. Practitioners may charge the client a reasonable fee to reflect the cost of the materials used, the time required to prepare the material and the direct cost of sending the material to the requesting practitioner.

Client health and safety should not be put at risk because of a delay in transferring client records. Inability to pay for the costs of copying should not prevent client access to records. Practitioners should be flexible in this regard.

In some circumstances, it will be better for the transferring practitioner to prepare a summary of the records rather than to provide a copy of the whole record. This needs to be acceptable to the receiving practitioner and the client. The original practitioner is still obligated to retain the original record, in its entirety, for the time period required by regulation.
Practitioner Relocates

Practitioners relocating their practice may opt to take the client records with them, or leave the records with a designated practitioner for access by clients or other practitioners who may then be undertaking client treatments. Where the practitioner elects to relocate and keep the records, or transfers the files to another practitioner, the original practitioner should notify affected clients as soon as possible of all actions concerning their files after the relocation or transfer has occurred.

Practitioner Ceases Practice

There are many ways in which practices end. A practitioner closing their practice or those responsible for closing it, act in the client’s best interests by ensuring that client’s have access to their records.

When practitioner’s cease to practice their therapy (either because they are no longer licensed in the case of Victorian Acupuncturists, have retired, deceased, or have been suspended from practice) two options are available with respect to client records. The client records may be transferred to another practitioner or they may be retained (either personally or through the use of a commercial record storage company).

Before patient records are transferred to a practitioner’s successor, the practitioner or the practitioner’s representative should make a reasonable effort to give notice to clients, or where this is not reasonably possible, the practitioner or the practitioner’s representative should notify clients as soon as possible after the transfer has occurred.

Where a practitioner is not transferring records to another practitioner, the practitioner or the practitioner’s representative should inform clients that records can be transferred to another practitioner of their choice or copies can be collected in person (within a reasonable time), or the means by which copies can be retrieved from storage at a later date.

Notification of patients may take place by way of a notice in a newspaper, direct communication with each client, or in some other way that ensures that clients will receive notice.

While the obligation to retain records when the practitioner ceases practice continues for ten years, it is recommended that, where possible, every effort should be made to ensure all client records are transferred or that copies remain available to clients until they find another practitioner.
Deceased Clients

Ideally, a practitioner should disclose personal health information about a deceased patient only with the consent of the personal representative or trustee for the client’s estate or the person designated by a court of law who has assumed that responsibility if the estate does not have a personal representative or trustee. Practitioners are permitted to disclose information about a deceased client for the purpose of identifying the individual; informing anyone it is reasonable to inform of the client’s death and, where appropriate, the circumstances of the client’s death; and to the client’s spouse, partner, sibling or child, if they reasonably require the information to make decisions about their own health care or about the health care of their children.

Many circumstances involving deceased patients are too complex for simple advice. When confronted with a difficult situation a practitioner should contact their professional association or legal adviser for clarification.

Under Age or Minor Clients

There is a point at which children become responsible for decisions about disclosure of their own records. There is no legal minimum age for consent to the disclosure of personal health information in regard to natural medicine practice. However, it is generally recognized that when minor patients become mature enough to make decisions about their own health care and disclosure of records, and understand the consequences of such decisions, then parents and other third parties can no longer access records without consent.

Minor Clients of Separated Parents

Unless practitioners fully understand the family situation, the legal rights of both parents and all affected children or mature minors are of priority. Practitioners should seek advice from their professional association or legal advisors before providing information to either parent.

Destroying Medical Records

When the obligation to store client records comes to an end, the records should be destroyed in a way that is in keeping with the obligation of maintaining confidentiality. It is recommended that paper client records are shredded (there are confidential shredding services available for large quantities of records).
Electronic records should be permanently deleted from all hard drives, as well as other storage mechanisms. It may not be possible to permanently delete records from a computer’s hard drive. In most cases, it is be preferable to destroy the hard drive altogether.

Practitioners should not dispose of a record of personal health information unless their obligation to retain the record has come to an end.

**Client Record Self Evaluation**

Practitioners should use a self-evaluation check list to identify strengths and weaknesses in record-keeping practices and documentation. A basic self-evaluation list is included in Appendix 2.

**Electronic Records**

Electronic information in health care includes databases, electronic health records and transferring health information by electronic means, including email communication and CD Rom/DVD’s. All health care practitioners should develop policies and procedures that meet standard client record guidelines. Electronic records must also address confidentiality, privacy, consent, security, identification, and storage and retention procedures. You may keep records electronically, but only if capable of being printed on paper.

There are two types of electronic records broadly defined as *Electronic Medical Records (EMR)* or *Electronic Client Records (ECR)* and *Electronic Health Records (EHR)* that multiple health care professionals may be involved with.

**Electronic Medical/Client Records**

EMR’s/ECR’s are electronic versions of traditional medical/client records. EMR’s/ECR’s are ‘provider-centric’. The records focus on medical or practitioner specific information and are configured to reflect the needs of individual practitioners or groups of practitioners responsible for the direct care of a client.

**Electronic Health Records**

An EHR is ‘client-centric’, containing information from a broad range of health care providers. It generally contains a subset of sharable information including culminative client profiles with current prescriptions, supplements, herbal formulas, homoeopathic remedies, physical therapies, allergies and immunisation history. It will have integrated information related to in-client and out-client encounters with the health care system. Information in the EHR is not
always accessed with each client encounter, but is used when additional information is required during a client visit.

Laboratory, diagnostic imaging results, and other reports are also found in the EHR’s but are not necessarily delivered to a specific practitioner for review; i.e. information is reviewed via a “pull” decision on the part of the provider at the time the information is required.

If a clinic is changing from paper records to an EMR/ECR, it should be ensured that client care is not interrupted.

**Special Note**

Best practices in the area of client records especially in the area of EMR’s/ECR’s are continuing to evolve. All health care professionals are advised to keep abreast of client record reporting and Privacy Information legislation.

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**A Brief Overview of Medical-Legal Considerations for Electronic Records**

During the transition from paper to electronic client records practitioners must consider their security of information responsibilities as a top priority. Management of client information must be heightened to ensure integrity and security. Potential threats can include:

- Breakdown of service as a result of viruses, power failures
- Loss of data due to corruption of computer hardware
- Theft of data due to intrusion

**Electronic Record Storage and Security**

Practitioners need to ensure that the privacy of clients records will be adequately protected whether the information is stored in hard copy within the practitioners premises or stored off premises in a client file storage facility. Practitioners also need to ensure the privacy of client records if stored electronically. In the case of electronically stored client records practitioners must ensure security measures that:

- Protect the privacy and confidentiality of a client’s health information
- Protect the integrity of the information against threats from hazards such as unauthorised use, loss, theft, technical malfunction, hacking and physical damage

These types of measures must include:

- Physical security
- Access and authorisation rules including encryption
- Back-up and restoration protocols

In case of theft, loss and damage, the practitioner must:

- Contain the breach
- Assess risks
- Determine if client and relating health professionals notification is required

When disposing of information, the practitioner must provide proof that the information cannot be recovered or reconstituted. Measures must include destruction of hard drives, discs and other electronic storage devices. If the information is stored on the computer’s hard drive, the hard drive itself should be either crushed or wiped clean with a commercial disk wiping utility. Similarly, any back-up copies of client records should be destroyed when the original records are destroyed.

**Electronic Records as Evidence**

As with paper-based client records, electronic client records or electronic health records are subject to use as evidence in College investigations and also for health department investigations, insurance claims and civil proceedings. As such, these records must be available and reproducible in a form that accurately reproduces the content and appearance when in use.
APPENDIX ONE

Contents of Client Records

Cumulative Patient Profile

- Patient identification – name, address, phone number etc.
- Personal and family data
- Medical history
- Allergies
- On-going health conditions
- Health maintenance
- Consultations/Referrals out
- Long term treatment – therapies, medications etc.
- Major health investigations

Progress Notes: (Treatment Episodes)

Each visit and communication (phone calls, home visits) is recorded/dated. Consider the following information to be included:

Subjective:

Patient presenting complaint, severity, frequency, duration
Whether the concern is new or ongoing
Changes in progress since last visit
Family history, clients past history
Negative responses of client

Objective:

Relevant signs
Physical examination – focus on current complaint
Positive physical findings
Negative findings related to the current problems

Assessment:

Risk factors
Ongoing health concerns
Plan:

- Discussions of treatment options
- Diagnostic tests required (if applicable to type of therapy)
- Consultations requests/referrals
- Client advice/education
- Follow-up

Warnings given to patients:

- Any problems with treatment
- Any extraordinary consent

Non-compliance:

- Document instances of patients refusing examinations/treatment
- Document reasons for client non-compliance, course of actions recommended

Telephone conversations/home visits:

It is strongly recommended that all phone conversations or home visits are documented in the client’s records.

Transferring Client Records:

When transferring client records, only a copy of the client record should be supplied. The original must always be kept by the practitioner. When a client requests a transfer:

- Ask for a written request
- A reasonable fee may be charged for administration such as time to prepare the material, copying, costs of sending
- Obligation to pay the account for the supply of a copy will rest with the client or the third party who requested the information
# APPENDIX 2

## Client record Self-Evaluation

The following list can be used for self-evaluation of your client records to identify strengths and weaknesses in record-keeping practices and documentation.

<table>
<thead>
<tr>
<th>Client Record-keeping activity</th>
<th>Always</th>
<th>Needs Improvement</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>My record keeping system allows for ready retrieval of an individual patient file</td>
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<tr>
<td>My records are legible</td>
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<tr>
<td>The client’s identity is clearly evident on each component of the file</td>
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<tr>
<td>Each client file clearly shows full name, address, date of birth, gender</td>
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<tr>
<td>The date of each visit or consultation is recorded</td>
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<tr>
<td>The family history, functional inquiry &amp; past history (including significant negative observations) is recorded &amp; maintained</td>
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<tr>
<td>Allergies are clearly documented</td>
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<tr>
<td>Dates of immunizations (if relevant) are clearly visible</td>
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<tr>
<td>A “cumulative client profile” relating to each client is present &amp; fully maintained</td>
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<tr>
<td>The chief complaint is clearly stated</td>
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<tr>
<td>The duration of symptoms is noted</td>
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<tr>
<td>An adequate description of the symptoms is present</td>
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<td>Positive physical findings are recorded</td>
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<tr>
<td>Item</td>
<td>Details</td>
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<tr>
<td>Significant negative physical findings are recorded</td>
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<tr>
<td>Requests for laboratory tests &amp; other investigations are documented</td>
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<tr>
<td>Requests for consultations are documented</td>
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<tr>
<td>The diagnosis or provisional diagnosis is recorded</td>
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<td>The treatment plan and/or treatment is recorded</td>
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<tr>
<td>Doses &amp; duration of prescribed remedies are noted</td>
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<tr>
<td>Progress notes relating to the management of clients suffering from</td>
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<td>chronic conditions are made</td>
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<tr>
<td>There is documented evidence that periodic general assessments are</td>
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<tr>
<td>being made</td>
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<tr>
<td>There is documented evidence that health maintenance is periodically</td>
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<tr>
<td>discussed (topics such as smoking, alcohol consumption, obesity,</td>
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<td></td>
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<tr>
<td>lifestyles etc.)</td>
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<tr>
<td>There is evidence that the practitioner periodically reviews the list</td>
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<tr>
<td>of supplements, remedies etc. being taken by client’s suffering from</td>
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<td></td>
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<tr>
<td>multiple or chronic conditions</td>
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<tr>
<td>In the event that more than one practitioner is making entries in the</td>
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<tr>
<td>client file, us each practitioner identifiable?</td>
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## APPENDIX 3

### Cumulative Client Profile

<table>
<thead>
<tr>
<th>Patient Identification</th>
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<tbody>
<tr>
<td>Mr ☐ Mrs ☐ Miss ☐ Ms ☐</td>
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<table>
<thead>
<tr>
<th>Address:</th>
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<table>
<thead>
<tr>
<th>Home Phone Number:</th>
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<table>
<thead>
<tr>
<th>Business Phone Number:</th>
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<table>
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<tr>
<th>Mobile Phone Number:</th>
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<table>
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<tr>
<th>Email:</th>
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<table>
<thead>
<tr>
<th>Present Marital Status: S ☐ M ☐ Sep ☐ D ☐ W ☐ Other</th>
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<thead>
<tr>
<th>Gender: M ☐ F ☐</th>
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<table>
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<tr>
<th>Date of Birth:</th>
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<table>
<thead>
<tr>
<th>Personal &amp; Family Data (e.g. occupation, life events, habits)</th>
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</thead>
<tbody>
<tr>
<td>Dates</td>
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<table>
<thead>
<tr>
<th>Past History (e.g. past serious illnesses, operations)</th>
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<table>
<thead>
<tr>
<th>Risk Factors (e.g. genetic/familial diseases)</th>
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<table>
<thead>
<tr>
<th>Dates</th>
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<tbody>
<tr>
<td>Allergies/Drug Reactions</td>
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<table>
<thead>
<tr>
<th>Ongoing Health Conditions (e.g. problems, diagnosis, dates of onset)</th>
<th>Date Recorded</th>
<th>Date Resolved/Controlled</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Long term treatment plan (medications, therapies)</th>
<th>Date Started</th>
<th>Date Stopped</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Social &amp; Environment History (e.g. lifestyle, hobbies, occupation)</th>
<th>Dates</th>
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<table>
<thead>
<tr>
<th>Preventative Health Records</th>
<th>Indicate Dates</th>
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<tbody>
<tr>
<td>General assessment</td>
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<tr>
<td>Mammogram/thermal imaging</td>
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<td>PAP or PSA</td>
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<td>Flu vaccine</td>
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<td>Hepatitis A/B</td>
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<table>
<thead>
<tr>
<th>Problems List</th>
<th>Date Recorded</th>
<th>Date Resolved/Controlled</th>
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<thead>
<tr>
<th>Maintenance Medications, Supplements, Remedies, Herbs etc.</th>
<th>Date started</th>
<th>Date Ceased</th>
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<tr>
<th>Significant Family History</th>
<th>Relative</th>
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