

**Chinese Medicine Board of Australia**

# **GUIDELINES: PATIENT HEALTH RECORDS**

August 2016

## Introduction

To facilitate safe and effective care, health practitioners are expected to create and maintain health records that are in the best interests of patients and that contribute to the safety and continuity of care. Patient health records are expected to be accurate, legible and clear, and contain sufficient detail so another practitioner could take over the care of the patient if necessary.<sup>1</sup> They are to include an accurate reflection of all consultations and other interactions relating to the clinical care and/or management of the patient, made at the time these consultations and interactions occur.

These guidelines show the Chinese Medicine Board of Australia's (the CMBA) expectations on the appropriate standards for patient health records, and describe the minimum requirements of how Chinese medicine practitioners should maintain patient health records, regardless of whether they are in paper or electronic form.

These guidelines have been developed to supplement the information provided in the CMBA *Code of conduct*<sup>2</sup> and should be read in conjunction with it.

## Who needs to use these guidelines?

The guidelines apply to all registered Chinese medicine practitioners, and anyone working under their supervision.

They will be used as evidence of what constitutes appropriate professional conduct or practice for Chinese medicine during an investigation or other proceedings about a registered Chinese medicine practitioner.

## Health records

### 1. Responsibilities

Registered Chinese medicine practitioners have both professional and legal responsibilities to:

- keep and maintain adequate health records for each patient containing all the health information held by the practice about the patient
- keep confidential the information they collect and record about patients and keep, transfer, dispose of correctly and provide access to health records in accordance with the requirements of relevant state, territory and Australian laws relating to privacy and health records information, and
- be familiar with the provisions of relevant state, territory and Australian laws relating to privacy and patient health records information.

### 2. General principles to be applied

- Patient health records can be kept in either paper or electronic format.
- A patient health record should be made at the time of the patient consultation or as soon as possible after. This also applies to consultations held afterhours, at home (or other) visits and via telephone or electronic communications. Other information (such as test results, for example) should be included as soon as they become available.
- Entries on a health record are expected to be made in chronological order and should identify the person making the entry.
- Patient health records are expected to be legible and clear and of such a quality that another health practitioner could read the record and be sufficiently informed to make decisions about their own safe care of the patient.<sup>3</sup>
- If documents are scanned to the patient health record, such as external reports, the scanning needs to be completed as soon as possible and in a way that keeps the legibility of the original document.
- All comments in the patient health record should be relevant to the care and/or management of the

<sup>1</sup> For the purpose of these guidelines, the term 'patient' is used to refer to the person receiving the treatment, care or healthcare services.

<sup>2</sup> The *Code of conduct* can be found on the Board's website at [www.chinesemedicineboard.gov.au/Codes-Guidelines](http://www.chinesemedicineboard.gov.au/Codes-Guidelines).

<sup>3</sup> The *Australian Dictionary of Clinical Abbreviations, Acronyms and Symbols* is a useful resource for practitioners about abbreviations. It may be helpful for individual practitioners to maintain a readily accessible glossary of common abbreviations that they use to help subsequent practitioners.

# GUIDELINES: PATIENT HEALTH RECORDS



patient, respectful of the patient and be expressed in appropriate objective language.

- g. Corrections can be made to a health record either at or after the time of original entry. The correction is to be initialled, dated and tracked by the practitioner and the original entry is to still be visible or digitally traceable.
- h. A registered Chinese medicine practitioner is not to delegate responsibility for the accuracy of information in the patient health record to another person.
- i. Patient health records are to be stored securely, protected from unauthorised access and safeguarded against loss or damage. For electronic records there should be a process for secure transmission and a backup must be maintained.
- j. Registered Chinese medicine practitioners are expected to recognise and facilitate a patient's right to access information contained in their patient health records. If a patient disputes the information then it should be removed, unless the health practitioner disagrees. In the latter situation, the record should be maintained with a note stating the patient's beliefs about the accuracy of the record.
- k. The transfer of health information is to be done promptly and securely when formally requested by the patient (preferably in writing). Patients should be advised of the location of patient health records on request. Practitioners should keep a record of any such requests.

### 3. Contents of a health record

The level of detail needed in a health record may vary according to the nature of the presenting condition and whether it is an initial or subsequent consultation. For example, in the case of subsequent visits for an ongoing condition, information recorded in earlier consultations need not be repeated, unless there are relevant changes. Progress details and treatment are, however, to be recorded clearly.

Any patient health record should contain the following information:

- Sufficient and reasonable information, in English, to adequately identify and manage the patient.<sup>4</sup>
- Up-to-date contact details, in English, of the person to be contacted in an emergency.
- The patient's explanation for seeking treatment and the presenting signs and symptoms.
- A current health summary, including but not limited to relevant past health and family history, known allergies, adverse drug reactions, current medications and cultural background, where clinically relevant.
- The date of any entry made and if different, also the date of each consultation and/or interaction.
- The time of consultation where there is more than one consultation or treatment on the same day.
- Relevant notes on obtaining informed consent (or its withdrawal) as per section 3.5 of the CMBA's *Code of conduct*.<sup>5</sup>
- Any assessments and examinations carried out.
- Relevant clinical impression, reasoning, interpretation or diagnosis where applicable.
- Relevant diagnostic data and reports (for example, laboratory, imaging and other investigations) when available.
- Where relevant, estimates or quotations of fees.
- Any referrals to other healthcare providers or health services and relevant communication (written or verbal) with or about the patient, including telephone or electronic communication.
- Information relating to any therapeutic intervention, advice, management plan or referral provided should include:
  - i. other treatments and/or therapies being used (where known)
  - ii. Chinese medicine diagnosis, treatment principle(s), recommended treatment plan<sup>6</sup> and, where appropriate, expected process of review

<sup>4</sup> For example, full name, date of birth, gender and contact details, (and patient's parent or guardian where applicable).

<sup>5</sup> Available at [www.chinesemedicineboard.gov.au/Codes-Guidelines](http://www.chinesemedicineboard.gov.au/Codes-Guidelines).

<sup>6</sup> If a patient refuses a proposed management plan wholly or partially the practitioner is expected to record what treatment has been accepted and what has been declined and the reasons if known.

- iii. procedures conducted, including details of all acupuncture points and needle manipulation method, particularly where a variation from a common procedure is applied
- iv. any medicine prescribed, administered or supplied for the patient (including name, strength, quantity, dose, instructions for use, number of repeats and details of when started or stopped); the details are expected to comply with the CMBA's *Guidelines for safe Chinese herbal medicine practice*
- v. a record of any discussion with a dispenser, for example to authorise substitution of herbs
- vi. relevant details of discussion about possible side effects or alternative forms of treatment
- vii. any unusual reactions which may follow treatment or possible adverse events
- viii. the outcome of any therapeutic interventions and patient progress, and
- ix. details of anyone contributing to the Chinese medicine care and health record.

## 4. Retention and management of health records

Registered Chinese medicine practitioners are expected to comply with their own state and territory laws as they may have specific requirements for the retention of records and other relevant matters.

Patients have a right to access their health information and in some jurisdictions this right is enforceable under legislation. Such requests are most likely to arise when patients are moving address or seeking another opinion.

The requirements to keep and destroy patient health records vary between states and territories. Good practice involves being aware of the relevant laws and practices wherever the practitioner practices, and observing those standards.

In addition, practitioners who work in multi-practitioner clinics should be mindful of their contractual arrangements about retention and management of health records.

## 5. Language of health records

The primary purpose of the health record is to create a comprehensive and accurate record of the healthcare that has been provided.

Records should be kept in English, with the exception of practitioners registered with English language conditions under grandparenting provisions<sup>7</sup>. These practitioners must keep certain information in English for example, patient identity and up-to-date emergency contact details.

Health records in English include profession-specific terminology as per all health professions and in Chinese medicine also includes terms written in *pin yin* (with optional addition of Chinese characters). In Chinese medicine, examples include terms such as *qi* or *chi*, names of syndromes such as *Bi Syndrome*, acupuncture point names such as *Zu san li* and number-based acupuncture points such as *ST36*.

Chinese medicine practitioners are also expected to comply with the nomenclature requirements in the CMBA's *Guidelines for safe Chinese herbal medicine practice*.

## 6. Translation of health records

Where records are maintained in a language other than English, on occasion it may be necessary to provide translated information to a third party.

Acceptable ways to respond to such requests include:

- a. writing a letter in English summarising the person's condition (s) and treatment (s), or
- b. translation of the record by a practitioner with no conflict of interest and no English-language conditions of registration, or
- c. where available, a certified translation of the record from a National Accreditation Authority for Translators and Interpreter (NAATI)-accredited translator.

The registered practitioner's responsibility is to be fully satisfied that the option they choose is adequately

<sup>7</sup> Transitional arrangements from 1 July 2012 to 30 June 2015 for registering existing Chinese medicine practitioners under section 303 of the National Law.

# GUIDELINES: PATIENT HEALTH RECORDS



comprehensive for the purpose of the request and accurately reflects the content of the original record.

## 7. Accounting records

While accounts are not part of the health record, registered Chinese medicine practitioners also have a professional and legal responsibility to maintain accurate, legible, contemporaneous accounting records of each visit. This section is included in the guidelines as a reminder to practitioners of their obligations to keep proper financial records of services rendered to and charged to each patient.

An itemised tax invoice is to be created for each consultation/treatment which includes:

- the patient's identity information<sup>8</sup>
- the date and types of each service
- fees charged for all treatment(s) provided and all product(s) supplied
- the date of the payment/s if different from the date of service/s provided
- date and number of the tax invoice issued
- name of the practitioner/s who provided the service/s, and
- address where the service was provided with contact telephone number.

## 8. Authority

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

## For more information

Visit [www.chinesemedicineboard.gov.au](http://www.chinesemedicineboard.gov.au) under *Contact us* to lodge an online enquiry form.

**Date of issue:** 16 August 2016

**Date of review:** These guidelines will be reviewed at least every five years.

<sup>8</sup> See section 3(a)