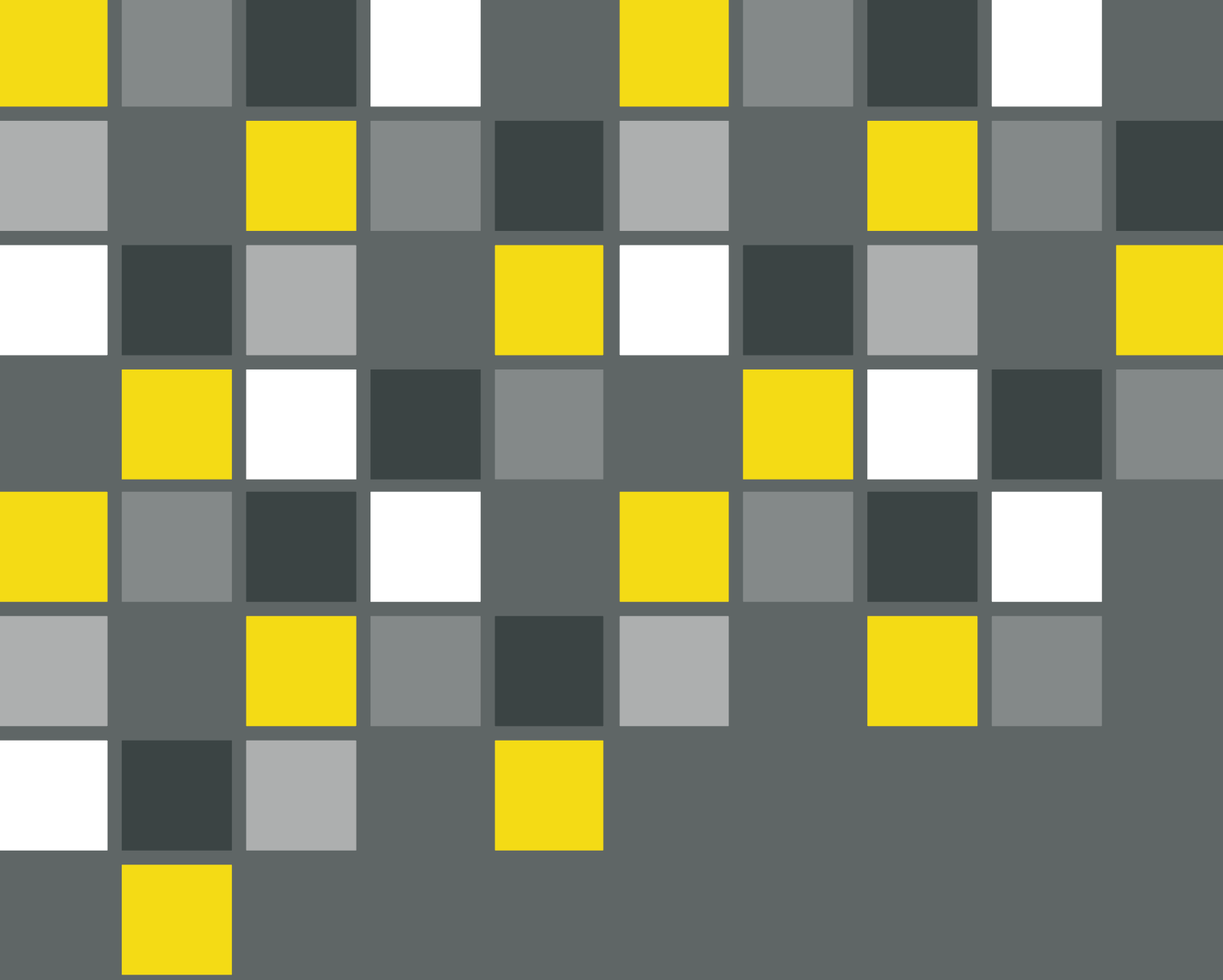

OCNZ
OSTEOPATHIC COUNCIL
NEW ZEALAND

Guidelines for Clinical Record Keeping

1. Introduction

These guidelines complement other Osteopathic Council of New Zealand *(Council)* essential-reading publications, found on the OCNZ website under **Policies and Guidelines**, including, but not limited to:

» **Capabilities for Osteopathic Practice**

» **Code of Ethics**

» **Guide to Abbreviation Use in Osteopathic Practice**

» **Informed consent: Guidelines for osteopaths**

» **Legislation and Osteopathic Practice**

2. Background

Clinical Records form the central evidence of patient interaction in osteopathic practice.

The importance of clear and complete records, completed in a timely fashion cannot be overstated.

In addition to the regular uses for clinical records, in the case of any patient complaint, audit (IRD, ACC, OCNZ) or disciplinary process, comprehensive records are critical.

In general, current requirements for clinical records usually exceed the level of detail and rigour that applied during the training period of most currently practising osteopaths. Therefore, all practitioners are asked to review their practice in line with the **Capabilities for Osteopathic Practice** document (6.5.2) which states osteopaths: "Ensure(s) all record keeping is in accordance with current best practice."

These Guidelines set out current best practice.

3. Clinical Records Standards

Clinical Records are the subject of multiple Statutes, Codes and Guidelines issued in connection with several Government Departments and Agencies – see further information section 12 below for details.

Council's standards for the information that is to be contained within Clinical Records is found in Appendix 1.

Practitioners are particularly referred to the following publication regarding records management:

On the Record: A practical guide to Health Information Privacy

The above link goes to the 3rd Edition published by the Office of the Privacy Commissioner 2011.

The implementation of policies and procedures regarding the creation, maintaining and handling of Clinical Records is the responsibility of practice principals.

4. Clinical Records Framework

Council has produced a framework for Clinical Records, supplied in **Appendix 1**. Diligent utilisation of this framework is necessary to ensure that Records are compliant with the variously required standards.

Clinical Records should be completed in a timely manner: during or immediately following the relevant consultation. Subsequent additions or amendments should be clearly marked, dated and initialled.

Clinical Records are specifically referred to in the following sections of the **Council's Capabilities for Osteopathic Practice** booklet:

1.1.1, 1.1.2, 1.1.3, 1.1.5
1.2.5
1.3.5
1.4.2
5.1.2
6.5.2, 6.5.3

As well as recording requisite detail, Clinical Records taken as a whole, should paint a picture of the patient, and their engagement with osteopathy, that are readily understandable to another practitioner.

5. Informed Consent and Clinical Records

- Informed consent should be sought from patients
  in respect of confidentiality, data collection, storage and the patient's right to access the information and records.
- This need not be done at each consultation – however it is appropriate whenever there is a new situation (other than exceptional circumstances) E.g.
  - i) For all New Patients
  - ii) When referring to or contacting other health professionals
  - iii) When receiving a request for information from a third party (except ACC for which consent has been given at the time of lodging a claim)
- Record of the patient's relevant informed consent can be integrated with other aspects of the consultation, i.e. examination, diagnosis and management.
- Please refer to Council's **Informed consent: Guidelines for osteopaths** for further information.
- Responsibility to gain informed consent is an ongoing process and must be recorded in patient notes.

6. Privacy of Clinical Records

Clinical Records are confidential. This confidentiality extends to all patient information, including, but not limited to, third party billing (E.g. ACC, diary records, payment details).

Release of such information is normally considered only under the following situations:

» To the patient, or an appropriate third party, at the patient's request

» To another health practitioner as part of a referral, with the patient's informed consent

» To another health provider, or government agency, where there is concern regarding patient safety (where prior consent may not have been obtained) or when required to by law

» To ACC, under ACC release of patient information regulations

The **Privacy Tips** document provided by ACC is particularly useful and relevant.

The Ministry of Health provides a comprehensive **Standard** on the subject.

It is the responsibility of all practice principals to ensure that all of those having access to Clinical Records are aware of practice policies and procedures regarding
their handling. Practice principals should also ensure
that all employees and independent contractors have confidentiality of information clauses within their contracts.

7. Storage of Clinical Records

» Clinical Records may be on paper or in electronic media.

» Physical records must be securely stored and handled out of public areas.

» Electronic records must also be securely stored and **extra care** is required in this regard.

  i) Electronic data storage best practice is to comply with information and **directives** from the Ministry of Health. *Ministry of Health Policy is currently under review due to the changing nature of this field.*

  ii) As cloud computing storage and services proliferate and are becoming increasingly utilised, security and risk assessment must be undertaken. **The Privacy Commissioner** and **Government Chief Information Office** both provide guidance and resources in this regard.

  iii) All devices, including smart phones that have access to records require password protection.

  iv) Electronic records require regular back-ups to reliable sources: either cloud based (see i and ii above), or external media which should be encrypted (E.g. external hard drives or USB sticks).

» Particular care should be taken in preserving confidentiality during the transportation of Clinical Records, including considering risk management E.g. theft of physical or electronic media from vehicles.

» *Ultimate responsibility lies with the practitioner to be responsible for Record Keeping.*

8. Retention and transfer of Clinical Records

» In general, Clinical Records are under the care of the practice or clinic that the patient has attended, and not the individual practitioners, whether they be employees or self-employed contractors.

» Therefore, if a practitioner is absent from, or leaves a clinic, ordinarily the records remain at the clinic. Practices should grant former practitioners access to Clinical Records under appropriate circumstances
E.g. Preceptorship or Audit.

» Clinical Records must be retained for a minimum of ten (10) years following the date of the last consultation – **Health (Retention of Health Information) Regulations 1996.**

» Clinical records may be transferred before the end of that period:

i) To the patient, at their request, or their representative if deceased.

ii) To another practitioner, at the patient's request.

iii) To the patient, or another appropriate practitioner upon retirement or death of the practitioner concerned, or closure of the practice.

iv) It is recommended under i) and ii) that copies of records are retained.

» Historic records aged beyond the minimum requirement may be kept on file, or securely destroyed
E.g. Security-level shredding.

9. ACC and Clinical Records

» ACC treatment providers have additional responsibilities – see **Appendix 2** for details.

10. Electronic Records

» Practitioners are not currently required to keep records in electronic format.

» The scope of the Ministry of Health's single electronic health record (EHR) project is still being determined, and it is therefore not yet clear which professions or services, including osteopaths, would be integrated into it.

» ACC do not currently require clinical records to be electronic.

» Nevertheless, it is recommended that practitioners are mindful that the general trend is toward electronic record keeping and that at some point in the future it may become a requirement.

» However, electronic records are only as good as the data entered. Council's view is that if the format in **Appendix 1** is implemented, then this will stand practitioners in good stead for any future shift to comprehensive electronic records.

11. Abbreviations in Clinical Records

» Abbreviations should be kept to recognisable and commonly accepted format.

» Excessive use of abbreviations should be avoided.

» Please refer to Council's **Guide to Abbreviation Use in Osteopathic Practice.**

12. Further Reading

The following agencies and departments have information and directives regarding clinical records:

» **Ministry of Health**

» **Accident Compensation Corporation**

» **Health and Disability Commissioner**

» **Privacy Commissioner**

The following Legislation Schedule is relevant:

» **Health Act 1956**

» **Health Information Privacy Code 1994 (amended 2015)**

» **Health (Retention of Health Information) Regulations 1996**

» **Health and Disability Commissioner Act 1994**

» **Code of Health and Disability Services Consumers' Rights 1996**

» **Public Records Act 2005**

» **NZ Standards NZS 8152:2002**

Appendix 1: Clinical Record Components

- The following list describes each area or field that should be incorporated into clinic records.
- In general, clinical records should follow the order of each item as presented.
- These components should be read alongside the **Capabilities for Osteopathic Practice** document.
- In covering each of these areas, comprehensive notes should be produced which, when thoughtfully completed, tells the story of the patient, and, their interaction with osteopathy.
- Use of pre-printed forms, or a software template, to be completed during consultation at may serve as a useful prompt.
  - Pages have patient ID – e.g. for computer data base, where appropriate.
  - Contains spaces for biographical and/or personal data (name, address, contact details, date of birth, parental or guardian details for a minor).
  - Current work and social history details are recorded (e.g. type of work, hobbies and sports, other interests).
  - Space for osteopath's name on records pertaining to the initial consultation, followed by initials alongside each treatment.
  - Entries are dated.
  - Entries are legible.
  - Presenting problem is complete and clear, including onset, aetiology and progression.
  - History of presenting complaint is present and logically/systematically presented.
  - The current state, including pain nature and magnitude, and effects on function, work, daily activities and sleep are recorded.
  - Consider employing the outcome measures referenced in **Appendix 2**, which have been identified as most appropriate for Osteopathic practice.
  - **Appendix 2** provides further detail for ACC cases.
  - Appropriate past medical history is recorded including a systems review, drug history, accident/trauma history, investigations and general procedures/surgeries noted, and record of ongoing concurrent medical care noted.
  - Psychosocial, lifestyle and past medical/healthcare experiences relevant to presentation are recorded.
  - Smoking, alcohol, or substance abuse history documented (if appropriate).
  - Imaging test results recorded as appropriate.
  - Lab and other tests recorded as appropriate.
  - Pertinent objective examination conducted and documented, with positive, negative and 'nothing abnormal detected' findings noted.
  - Osteopathic palpatory findings are recorded.
  - Considerations for differential diagnosis are noted.
  - Working diagnoses are noted and are consistent with findings and aetiology.
  - Osteopathic components of the case analysis (diagnoses) are identified and recorded.
  - Plans of action/treatment are recorded and are consistent with diagnosis(es).
  - Patient self-help, health education, and rehabilitation options are recorded.
  - Relative or absolute contra-indications for treatment are clearly and prominently recorded.
  - Informed consent noted for all procedures.

- Specific details of treatments given, including body site, patient position, and techniques administered are clearly recorded.
- Use of personal professional jargon or shorthand that may be obscure is avoided.
- Outcomes from previous visits recorded.
- Any issues arising from previous visits are addressed.
- Evidence of appropriate use of referrals.
- Correspondence relevant to patient recorded and integrated into care.
- Patients are adequately informed (i.e. there is documentation of patient education, follow-up instructions).
- Missed/cancelled appointments noted.
- Follow-up on missed/cancelled appointments noted.
- Telephone calls regarding patient care noted.
- Records are organized in a consistent manner.
- Paper record contents are securely fastened together, or bound in folder, or similarly secure.
- Electronic records relating to each patient should be accessible through one portal, or linked (e.g. ACC Accident details, imaging reports, letters).
- Avoid inappropriate information in the record (e.g. subjective or personal remarks about patient, family, or other caregivers).
- Avoid inappropriate alterations or omissions
  (e.g. erasures, missing pages).

Appendix 2: Clinical Records and ACC

Where patient records include ACC covered treatment, care must be taken to make all the information relevant to the history, assessment and management of the injury easily identifiable, and usually self-contained.
Whilst it is normal and correct for patient records to be contemporaneous and chronological with the patient's presentation(s) over time, ACC's liability begins and ends only with management relating to each specifically covered injury.

In addition to including the components detailed in **Appendix 1** within clinical records, take particular care with the following elements, in order to comply with ACC's requests for ACC Treatment Providers:

- Record details of the accident, including what occurred, the mechanism of injury and the nature of the client's symptom initially and currently following the reported accident.
- Record the *causal link* between the injury sustained in a reported accident that meets ACC criteria, and the current condition.
- Record pain levels.
- Record effects of the current condition on sleep, work and activities of daily living.
- Record how pain and its' effects change at follow-up consultations.
- Consider use of outcome measures to simply track the above information.
- Any treatment given at the same appointment that does not relate to the ACC covered injury is to be clearly and separately noted, including the duration of this treatment.

ACC recommends the two outcome measures below, both contained in the: **Guide to outcome measure reporting.**

i) the Numerical Pain Rating Scale (NPRS) – also known as the Visual Analogue Scale

ii) the Patient Specific Functional Scale (PSFS)

Practitioners are directed to the **ACC Treatment Providers Handbook (2016)** pp26-29.Also refer to ACC's **Provider Tips for Privacy.**

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