**Introduction**

The Physiotherapy Council of New South Wales (the Council) is responsible for the management of complaints about the conduct, professional performance, health and competence (fitness to practise) of any physiotherapist practising, or student studying in an approved program leading to registration in NSW.

The Council is established by and functions in accordance with the *Health Practitioner Regulation National Law (NSW)* (the National Law). Council members are appointed by the Governor on the recommendation of the NSW Health Minister and their work is supported by the Health Professional Councils Authority (HPCA). The paramount consideration of the Council is the protection of the health and safety of the public.

Many of the complaints and notifications dealt with by Council concern issues regarding the making and maintaining of patient health records.

The information contained in this position statement represents the views of the Physiotherapy Council of NSW on this subject and this document is not intended to be, and cannot be construed as, a legally enforceable standard. Only a code or guideline approved by the Physiotherapy Board of Australia can be used as evidence of what constitutes appropriate professional conduct or practice for physiotherapists. The Physiotherapy Board of Australia’s Code of Conduct refers to the need to “maintain clear and accurate health records” as being essential to “continuing good care of patients or clients”[[1]](#footnote-1).

**1.0 PURPOSE**

 The purpose of this position statement is to alert physiotherapists in private and community practice about their professional and legal responsibilities in documenting and maintaining appropriate health records for their treatment and care of patients, whom they are seeing individually or in a group consultation, but excludes class interventions[[2]](#footnote-2).

**1.1 SCOPE**

 This position statement is directed at practitioners in private or community practice, whether in a multidisciplinary team, or a group or solo practice, including practice principals and employed physiotherapists, individuals undertaking research, working in rehabilitation or medico-legal work and practising physiotherapy.

**1.2 REFERENCES**

 Physiotherapy Board of Australia Code of Conduct (see www.ahpra.gov.au)

 Joint National Boards Social Media Policy (see www.ahpra.gov.au)

 NSW Ministry of Health Policy Directive on Health Care Records – Documentation and Management PD2012\_069

 Australian Standards for Physiotherapy – July 2006 by the Australian Physiotherapy Council (see [www.physiocouncil.com.au](http://www.physiocouncil.com.au))

 Complaint Management Policy Document Number PD2006\_073 Publication date 29- Aug-2006 (see [www.health.nsw.gov.au/policies](http://www.health.nsw.gov.au/policies))

**2.0 What information can be included in patient health records?**

 Patient health records can capture a wide range of information from various sources and are not limited to recording the patient’s attendance and clinical treatment.

 The following information can be included in an individual’s patient health records for physiotherapy treatment:

* Identifying information, contact details and health history, allergies, surgical procedures etc.
* Each clinical interaction with the patient, including initial and subsequent assessments, investigations, including test requests and results and treatment plans and any failure to attend
* Progress notes for each attendance by the patient for treatment
* Notes regarding informed consent of patient to examination and treatment(s) including the application of electrical stimulation modalities
* Notes regarding advice and/or warnings given, inclusive of electrical stimulation modalities, and the use of needles
* Imaging results
* Results of other tests, for example, nerve conduction
* Verbal or written (whether paper or electronic) communications between the practitioner and other health professionals involved in the patient’s care including referring practitioners, specialists and rehabilitation providers
* Notes of explanations/discussions with the patient’s family and where relevant, insurers
* All critical incidents and adverse outcomes from the treatment provided
* Notes regarding transfer of patient care and information provided at the request of the patient
* Notes relating to any video or pictures taken of the patient, and
* Notes relating to social media contacts with the patient.

**2.1** Patient health records may be made and maintained in a paper, and/or electronic, form. Irrespective of the format of the health records, there are a number of underpinning principles, which apply to the making and maintenance of patient health records.

**3.0 Principles regarding the making of patient health records**

* + Identification (of patient on every page/screen of record)
	+ Initial assessment and treatment and informed consent
	+ Documentation – process and format
	+ Frequency of record making and progress notes
	+ Alerts and allergies
	+ Imaging results
	+ Clinical Incident management
	+ Complaint management and procedures
	+ Telephonic/electronic records
	+ Video and picture records
	+ Social media records
	+ Refusal of physiotherapy advice
	+ Retention and availability of records
	+ Storage and security
	+ Disposal
	+ Cloud based communication and records.

**3.1 Identification (of patient on every page/screen of record)**

The following should ideally appear on every page of the paper patient health record or on each screen of the electronic record:

* Patient family name and given name
* Date of birth
* Sex of patient.

**3.2 Initial assessment and treatment and informed consent**

The initial assessment and treatment should be recorded in the patient’s health record together with the patient’s consent for the assessment and proposed treatment. The consent should adhere to the principles of being informed, voluntary and given by a competent patient and in other cases by the patient’s authorised carer/guardian. The adequacy of consent at the initial and subsequent consultations is contextual and depends on the level of risk. Consent can be implied, oral or written, however, the Physiotherapy Board of Australia’s Code of Conduct requires that consent is appropriately documented.

Consent should be documented for cervical manipulation. Results of the relevant pre treatment safety tests e.g. skin tests, should also be recorded.

Written consent is particularly critical before engaging in procedures such as dry needling in the thoracic region, cervical manipulation and for treatments which include electrical stimulation. The patient health record should include an explanation regarding the risks of such treatment, appropriate warnings or alternative treatments and evidence that the patient has been given the opportunity to raise any questions and that appropriate answers have been given.

A notation or entry should also be made of a patient’s refusal to consent to part or all of the proposed treatment.

**3.3 Documentation - process and format**

Entries should be legible, accurate, sequential, and where possible, made contemporaneously or soon after the patient consultation. If the entry is handwritten it should be in dark ink, not pencil.

Entries should be dated, and if appropriate, the time of the consultation included.

Handwritten entries should be signed by the treating physiotherapist with the physiotherapist’s name clearly recorded. Where the entry is made electronically, the identity of the physiotherapist making the entry should be included.

Entries by physiotherapy students (and therapy assistants) should be co-signed by the relevant supervising physiotherapist.

All abbreviations, terminology and symbols entered into the health records should be recognisable and readily understood by other physiotherapy and work colleagues.

As a general guide, records should contain sufficient information to allow another physiotherapist to continue the treatment of the patient, if required.

Correction of errors should not obscure the original entry and can be corrected by a strike through and initialled. Liquid paper should not be used to correct errors in paper records. With electronic records the history of audited changes should be retained and the replacement note indicating that the original entry was written in error - the original entry should not be deleted.

Gratuitous comments about a patient have no place in the patient health records.

**3.4 Frequency of record making and progress notes**

Entries should be made in the patient health record for each patient/client consultation and for failures by the patient to attend for treatment. These entries should match the billing record for the patient.

Ongoing consent for current treatment or consent for any new treatment should be documented. Progress notes should record changes to treatment.

The patient health record should reflect all relevant communication that occurs during the course of each treatment, including the obtaining of consent, verbal and written communication with health professionals involved in the patient care as well as any communication with the patient, carers, guardian and significant others.

The patient health record will also indicate the results of any subsequent investigation, assessment, treatment and changes in the patient’s condition, including reported adverse outcomes, if any, from treatment.

**3.5 Alerts and allergies**

Issues that will require a physiotherapist’s particular attention, and safety issues relating to the patient and to staff, should be flagged in the patient health record.

The manner of flagging should be clear to any other physiotherapists and/or registered health practitioner who may use the record. In paper records this should be on the outside of the record, and in electronic records this should be clear on the opening of the electronic file.

The following issues are indicative of, but not exhaustive of, the information that could be recorded regarding alerts and allergies:

* Infection prevention and control issues e.g. for blood borne viruses
* Allergies/sensitivities and adverse reactions, and known consequences
* Vertebral artery insufficiency
* Behavioural issues that may pose a risk to the patient or to staff
* Child protection issues.

**3.6 Imaging results**

 The patient health record should record imaging results when they have been presented to the physiotherapist.

**3.7 Clinical Incident management**

Patient/client adverse incidents should be documented in the patient health record, inclusive of:

* Clinically relevant information about the incident
* Interactions related to open disclosure processes

**3.8 Complaint management and procedures**

Complaint records are not to be kept in the patient’s health record.

However, the following should be considered during complaint management:

* Most complaints should be capable of resolution by frontline staff (staff physiotherapist, practice principal or clerical staff).
* An effective complaint management system should be in place at the workplace. The workplace should encourage an environment where complaints are handled seriously, thoroughly and in a timely and professional manner. This should include ensuring appropriate actions are implemented to eliminate or minimise similar problems from occurring in the future.
* Staff may, where appropriate, express remorse for the complainant’s situation or otherwise emphathise with the complainant, remembering that a statement such as *“I’m sorry this has happened”* or *“I’m sorry you feel this way”* will not be seen, legally, as an admission of guilt.
* Policies and local procedures that support staff, including staff training on complaint management, should be in place in the workplace. The staff member managing the complaint will be responsible for maintaining the appropriate file or record during the management of the complaint.
* Copies of letters/memos sent including up-date letters, acknowledgement letters, letters requesting information or clarification, letters notifying parties of a complaint, should become part of the record system. File notes should record the subject matter of telephone conversations and other actions.

Practitioners should also be aware of the obligations in the Physiotherapy Board of Australia’s [Code of Conduct](http://www.physiotherapyboard.gov.au/Codes-Guidelines.aspx) to:

(i) co-operate with legitimate investigations into the treatment of a patient or client and any applicable complaints procedure, and

(ii) disclose relevant information regarding the investigation into the health, conduct or performance of a practitioner or colleague.

**3.9 Telephonic/electronic consultation with patients**

 When there is a telephone or electronic communication with a patient/client this should be recorded in the patient health record.

**3.10 Video and picture records**

If a video or picture record is made with the consent of the patient/client, the patient health record should indicate:

* A brief description of the imaging
* The nature of the imaging media
* Its storage and location details.

**3.11 Social media records**

The Physiotherapy Board of Australia in conjunction with the other profession specific National Boards have jointly developed a social media policy. This policy together with the Code of Conduct restrict clinicians from using social media as a form of patient record keeping or in any manner which would infringe the confidentiality or privacy obligations of and on the treating physiotherapist. Responsible use of social media consistent with the physiotherapist’s legal and ethical obligations is expected.[[3]](#footnote-3)

**3.12 Refusal of physiotherapy advice**

When a patient communicates an election to refuse some or all of the physiotherapist’s advice, the refusal should be recorded in the patient’s health record. The advice from the treating physiotherapist may include the provision of a management plan and follow up as relevant to the patient; the consequences of treatment versus no treatment and assurances that the patient may return for treatment again without prejudice.

**3.13 Retention and availability of records**

Patient health records can be made, maintained in paper or electronic form or a combination of both forms.

The relevant patient records should be accessible and on hand when treating the patient. If the patient attends multiple practice locations within the same practice, then appropriate arrangements should be made for the secure transfer of patient health records to the treating practice location. Any transfer of patient health records should safeguard against loss or disclosure of patient information, which will contain personal and sensitive health details.

Patient health records should only be accessible to the treating health practitioners in the same practice, including supervised physiotherapy students and therapy assistants and the relevant patient/client or their authorised agent. From time to time external agencies such as courts, health funds or regulatory and investigative bodies may require access to patient records but such access should be authorised by a court order or legislative process or existing contractual arrangements.

Although there is no defined legal requirement stipulating how long physiotherapists in private practice should retain patient health records, some guidance can be gleaned from the medical profession. It is advisable to keep patient records for at least 7 years from the date of the last entry. If the patient health records are for a patient less than 18 years old at the date of the last entry, the patient health records should be kept until the patient is 25 years old.[[4]](#footnote-4)

If the physiotherapy practice is being sold then all reasonable steps should be taken to ensure the patient health records are maintained, which can include transferring the records to the person or entity that acquires the practice or providing the records to the patient/client to whom they relate.

**3.14 Storage and security**

All reasonable steps should be taken to ensure the careful and secure storage of patient health records to maintain their integrity, preserve confidentiality and to prevent loss or damage.

Where patient health records are in paper form both the paper and ink should be of sufficient quality that degradation of the record does not occur, for instance, the ink becomes illegible over time or the paper becomes fragile.

For electronic patient health records a secure electronic operating environment should be maintained with appropriate security and audit trails and tracking systems. Appropriate back- up and storage of electronic data should occur so that regardless of changes in an operating system or software, electronic information is not compromised and can be retrieved and if necessary, able to be printed.

**3.15 Disposal**

Whether in paper or electronic form, patient health records should be disposed of in a secure manner such that they cannot be reconstructed.

Paper patient health records should be shredded or pulped in a secure fashion. There are businesses which can provide secure document disposal. Under no circumstances should patient health records be put into local council rubbish or recycling collection bins as such action contravenes professional practice standards.

**3.16 Cloud based communication and records**

The practitioner should ensure a secure electronic operating environment for all cloud-based communication and recording.

# 4.0 ACKNOWLEDGEMENTS

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**Document control**

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1. Paragraph 8.4 “Health records” in the Physiotherapy Board of Australia’s Conduct of Conduct [↑](#footnote-ref-1)
2. Group consultation involves six or less patients, and the delivery of both a common intervention and an individual intervention, and where there is initial and ongoing assessment.

 A class is where there is a common intervention or educational session of seven or more participants, without assessment. [↑](#footnote-ref-2)
3. The National Boards social media policy can be accessed from the AHPRA website www.ahpra.gov.au [↑](#footnote-ref-3)
4. These comments reflect the requirements for medical practitioners maintaining patient health records under clause 10 of the *Health Practitioner Regulation National Law (NSW) Regulation 2010* and the APA position statement on Health Records 2010. [↑](#footnote-ref-4)