Importance of Good Health Record-Keeping

Reading time:
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Good health records, whether written or electronic, help ensure appropriate care, patient safety and continuity of care. Maintaining adequate and appropriate records is also critical to defending complaints, claims or disciplinary proceedings. Health records that are clear, accurate, complete and timely support a good defence.

AHPRA's Code of Conduct sets out the principles that characterise good healthcare practice in Australia. It defines the standards of ethical and professional conduct expected of healthcare practitioners by their professional peers and the community. Section 8.4 of the Code of Conduct outlines the standard of record-keeping expected.

8.4 Health Records (AHPRA Code of Conduct)

Maintaining clear and accurate health records is essential for the continuing good care of patients. Good practice involves:

- keeping accurate, up-to-date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management in a form that can be understood by other health practitioners
- ensuring that records are held securely and are not subject to unauthorised access, regardless of whether they are held electronically and/or in hard copy
- ensuring that records show respect for patients and do not include demeaning or derogatory remarks
- ensuring that records are sufficient to facilitate continuity of care
- making records at the time of events or as soon as possible afterwards
- recognising the right of patients or clients to access information contained in their health records and facilitating that access, and
- promptly facilitating the transfer of health information when requested by patients.

If your healthcare is investigated your records will be scrutinised and assessed against the requirements of the Code and to the opinion of expert peers.

Health records should contain:

- Relevant medical history
- Examination and other relevant clinical findings (both positives and negatives)
- Provisional diagnosis reached, and any differential diagnosis considered, tests or investigations requested
- Treatment plan, including the options discussed with patient, treatment recommended and prescriptions given
- Information provided and the patients consent (or lack of) to any treatments
- Any specific requirements as outlined by your employer.

Utilise the popular acronym **SOAPIF** as a prompt to help guide you to capture key information:

Subjective: information the patient (or others) provide to you

Objective – what you find on examination or on pathology or imaging

Assessment – your complete diagnostic formulation

Plan – total management plan

Information – information you provide to the patient

Follow-up – note the agreed plan, including the specific circumstances that would trigger follow up.

Health records include a wide variety of documents generated on, or on behalf of, all the health practitioners involved in patient care. This includes:

- Electronic or handwritten clinical notes including scanned records, emails and text messages
- Correspondence between health professionals eg. consultant reports, hospital discharge summaries

- Printouts from monitoring equipment, laboratory results, medical imaging and pathology reports, x-rays, photographs, videos, audio recordings

Correspondence and conversations between a practitioner and their indemnity provider and lawyers do not form part of the patient's health record. These documents should be kept separate from the patient's clinical file. Details on patient complaints should also be kept separate from the clinical file.

A BMJ study in 1996 of 209 health care professionals failed to support the conventional wisdom that doctors' handwriting is worse than others.

What the practitioner wrote: 

What most people see: **CuWyML**

What was intended: **aspirin**

Storage of records

Healthcare practitioners are responsible to take all reasonable and prudent steps to protect the security and confidentiality of a patient's health record.

- Records need to stored securely so that they can't be stolen, damaged or altered
- Make sure all records are backed-up and that the integrity of the back-up is also checked
- Have a disaster recovery plan in place, in case of the loss or destruction of records

Who owns the records?

Generally, health records remain the property of the health service provider (practice or employer) who created the health record. The introduction of Commonwealth and state/territory privacy legislation, patients have a right to gain access (except in a limited number of situations) to all the information held about them.

Disposal of records

The minimum period to retain health records vary between state and territory jurisdictions. We would strongly recommend that health records be maintained for as long as possible, especially if there has been an adverse outcome, a patient has expressed dissatisfaction regarding treatment or legal action has been threatened.

At a minimum, health records should be kept for at least seven years after the last consultation for Adults, while you should maintain a child's health records until they're 25 years old.

If you have received a request to transfer records, the new practitioner is entitled to all the relevant information to ensure patient safety and continuity of care. There is no obligation to provide original records, a copy of the health records should be provided.

In order to transfer health records to another practitioner, a patient must sign an authority requesting that a copy of records be transferred to the new practitioner containing:

- the name and date of birth of the patient whose records are to be transferred
- date and signature of the patient (or parent/guardian where applicable).

A register should be maintained if any records are transferred or disposed. This should include:

- authority (including details of patient)
- date of transfer/disposal
- period of time which the health records extends to
- details of new practitioner or if disposed details of the company utilised to dispose records (a certificate of destruction from the company should also be maintained).

Some further helpful tips:

- Health records should contain sufficient information that would enable another practitioner to appropriately takeover care of the patient.
- If it's not documented, then it didn't happen
- Record any advice or warnings you routinely provide
- Never use derogatory and offensive comments, assume someone else (including the patient) may see the record
- Use abbreviations with care, can be ambiguous or confusing
- Don't tamper with notes, new additions should be separately dated, timed and signed
- If a mistake is made, correct it with a single strikethrough. Then sign and date the correction

- Avoid cutting and pasting from previous records
- Explain to the patient what you are doing, and involve them in their record.

Related references

Good medical practice: a code of conduct for doctors in Australia (Dental, Medical radiation)

MIPS on-demand education - Health records unit (1 hour accredited CPD)

Australian Privacy Principles guidelines

Fact sheet: Privacy and your health information

Administrative record keeping guidelines for health professionals

How to document well

10 keys to good patient-centred record keeping

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