Health Records as Key Legal Risk Management

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Health records are essential to professional practice and quality healthcare. Records also provide crucial evidence of care provided. However, maintaining quality records is not easy when faced with competing demands, and their importance can be overlooked.

With our expert panel, this session will focus on the critical importance of keeping appropriate records and how they are your number one risk-mitigation tool.

From a medico-legal perspective, this webinar cover:

- The value of records in determining the strengths & weaknesses of a claim.
- Requests for records by patients/solicitors.
- How your records will be analysed.

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Q and A

⊕How do you recommend consent should be documented for an anaesthetist?

⊕How to be time efficient in completing notes and avoid irrelevant information.

⊕When documenting examination findings - i may write - patient consented to examination. I will detail examination findings and the end with examination completed without issues. Is this sufficient if later the patient complains that something happened untoward during the exam. Of course a chaperone is the best solution but not possible sometimes e.g. late and admin.nursing team have gone home.

⊕I did private practice as a child psychiatrist, patients aged 3-18 yrs old. How long do I need to keep my records?

⊕If a patient gives written consent to you forwarding their report, say from specialist to a GP by email, is it safe to do so?

⊕Can you speak a little on the topic of occupational medicine concerns? i.e. WorkCover records, pre-employment medicals, employers requesting medical information/reports, when and how they can do this, and how to protect ourselves as, etc.

⊕We require a signed agreement to use information only for the specified purpose and not to copy to other parties but legal firms often refuse to sign our (legally drafted) form. We feel this leaves us open and do not provide information but this often results in harrassment and even abuse of our admin staff. Please

comment and advise.

⊕What is MIPS' position on the use of voice-recognition software to create verbatim medical records?

⊕Looking to the future, is there any scope for AI tools to assist with reviewing or completing medical records to support the role of doctors?

⊕With regards to requests by insurance companies ,TAC, Workcover etc where the patient has signed an authority to release their medical information at some point in time (often months or even years ago) , should we be requesting a more recent signed authority ? What is a valid time frame?

⊕What are the expected standards for opioid prescribed patients, what does the coroner expect to see recorded

⊕Medical records requested by patients solicitors for eg MVA claim , who goes through the records it another GP or a specialist.

⊕If medical records are requested by the patient are we obliged to give it to the patient?

⊕Every one of my clinic letters contains the following line at the very end of it: "The contents of this letter and any attachments may not be forwarded to any third party without prior written consent of (my name)". Is that useful at all?

⊕How to estimate the service fees for time spent to print health summary and correspondences

⊕Are statements like these adequate: red flags discussed with patient/ side effect discussed

⊕Any comments about "Chart warfare?" https://www.nejm.org/doi/full/10.1056/NEJMp1917277 Something that comes up quite a lot in Emergency - its senior led, so people rarely call a registrar for "advice", we expect the patient to be admitted or at least seen. Sometimes easiest way with 'problem' inpatient team is "I will document you refused to see the patient."

⊕Even routine documentation causes occ dissent - with 4 hour targets we record the time for decision to admit and "surg/medical/xxxx referral." Usually mandatory practice. "Uncontactable" docs (scrubbed etc) see this as a form of aggression and want the time of actual contact, not message-left-in-theatre. Usually try to explain - documentation has led to proof you're understaffed & you got more, but it can be an ongoing problem with juniors being pressured from both sides. (The answer to the latter of course is 'tell the reg to talk to me/my boss.') But many don't want to be seen as confrontational - they might be working with the guy next term.

⊕If a patient asks for a letter from the specialist addressed to the GP ,can the copy be handed over to the patient without the specialists consent

⊕How much notes we shall write for item codes like consultation?

⊕How to streamline and maintain consistency in records on a busy practice day/ running late?

⊕How and when can you access your medical records from a practice you previously worked at as a contractor. Do you need to apply through a lawyer?

⊕What do we do with the medical records after retirement? Can they be given to the patients?

⊕The general public is constantly reminded about rights of the patients in media, magazines and other platforms. In this age of technology where doctors can be very easily defamed by negative reviews on facebook and other social media platforms. This is on the top of that patients can go to HQCC, ombudsman, or write a letter to the practice manager. Doctors are always giving patients the benefit of doubt still an unpleasant scenarios can arise due to complexity of the consultation process itself and sometimes the time pressures in general practice whilst the doctor just go home and analyse the situation how to make it better next time patients can head to the Facebook and social media to take out their anger. I wonder what are the rights of doctors in this situation? Where should they go ? who should they complaint to? How to counter the Facebook revenge?

⊕When patients or us doctors request clinical notes for continuity of care and the patient's prior doctor refuses to provide them, what are the options then?

⊕I have a cloud based practice management system, where a patient's online medical record might be shared by more than one clinician in the same practice who are involved in their care, with the knowledge and consent of the patient (e.g. psychiatrist and psychologist). Is there a confidentiality issue with this, and should the patient have a different record for each clinician?

⊕Would you agree that " Attention to COMMUNICATION ' is THE Tool to risk mitigation

⊕Any guide for writing concise notes but not too long so important details don’t get lost in long detailed notes

⊕When checking results there are options with reception to advise, doctor to speak to, urgent appt etc in Best Practice - one of our clinical colleagues advised that we do not tick the doctor to speak to but rather tick reception to advise and add a note in the comments section that doctor wants to speak to patient, apparently this pertains to when accreditation is done and the auditors are checking on how results are reviewed. Could you please comment on this.

⊕Legally do I have to discuss normal results with patient ? Can I mark electronically no action for normal result

⊕Often no details provided by the patient are correct , ie phone or address . What to do?

⊕How much further should patient recall be taken if there is no pt. response to phone recalls and registered letters ?

⊕Confirming that when pts want records for new health provider, a summary of her care will be sufficient? Or I do not release her notes

⊕What is the legislation regarding providing health information when the patient is deceased?

⊕Just wondering I am wrong if a patient came to me for a completely unrelated condition ,eg eczema and I mentioned that I did not want to review her latest imaging /bloods etc as I did not organise them, and to tell the patient to return to that doctor for full explanation? If I document my actions ,am I legally protected?

⊕How valid is 'autofill'? ie a pasted pre-prepared paragraph for common encounters?

⊕is it important to document quantification of risk rather than listing risks of complications?

⊕medical records can be destroyed when legally allowable but is it a bad idea?

⊕Do patients have any responsibility if they keep only seeing doctors who have the earliest appointments in a group practice ? Can they expect all the doctors will read the notes from previous doctors and Ip to what reasonable period?

⊕should a report we write for a lawyer or workcover insurance should be stored in the record

⊕If patient female patient decline chaperon can I decline like rectal/ vaginal and breast examination?

⊕Please comment . I had a patient have a fall of a horse. 2 weeks later fell on my verandah. 3 years later she sued the practice for back pain. Due to confidentiality could not advise she had a fall off horse !!! Luckily the business insurance lawyers did eventually subpoena my records but confidentiality should not stop your defence in other areas

⊕When patients complained to AHPRA and they were wrong are those patients reprimanded

⊕In our practice, we have multiple patients who do not attend referrals, and are contacted several times by referred health service. Should we be double-checking whether they still want the referral (with informed consent), and if we perpetually re-refer is this ok??

⊕Where and how to record information about a patient shared with you in confidentiality?

Learning outcomes

At the end of this webinar, participants will be able to:

- Discuss professional obligations for medical record-keeping requirements for good clinical practice.
- Identify essential health record information that may be used to defend any claim.

- Reflect on current health record keeping practices and identify areas for improvement to minimise clinico-legal risk.

MIPS resources

- MIPS on Demand Online modules with CPD

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