ATMS POLICY

Record Keeping Policy

Preamble

The healthcare record is a foundation document which is essential for the effective and proper management of the client's healthcare needs and is the principal vehicle for communication among members of a healthcare team.

The primary purpose of the healthcare record is to ensure that contemporaneous, accurate and relevant information on a client's care and history is maintained, to assist with ongoing treatment, and to ensure continuity of care when a client's care transfers to another health care worker. Proper healthcare records also help locum practitioners who may be filling in for you if you're unable to attend the clinic. In addition, these records form an important audit tool to monitor quality of care, are valuable tools for a health care worker to use to address client concerns about their treatment, and serve as the first line of defence against an allegation of negligence. The quality of these documents often forms the focus of malpractice and negligence law suits, and the necessity for rigour in this area should never be underestimated.

This policy document should be read in conjunction with the Australian Government National Privacy Principles and any other relevant federal, State or Territory privacy and health records legislation.

For the healthcare practitioner who supplies medicines to clients, either for internal or external use, it's essential that proper records are kept of these dispensing activities. Failure to do so puts both the practitioner and the public at risk.

Healthcare Records

The healthcare records that you construct must be legible, written in English and must be kept for at least 7 years, or where the client is under the age of 18 years at the time of treatment, records must be kept at least until that person turns 25. Your clinical notes should be written at or near the time of the consultation to which they apply, they should be exclusively clinical in nature, and contain nothing of a subjective, offensive or defamatory nature, or use abbreviations or terms that are not commonly understood.

They should be accurate and complete and should contain details such as:

- The date of the consultation;
- The client's name and contact details;
- The practitioner and clinic details;
- Client's date of birth;
- Client's healthcare insurance details;
- Client's nationality;
- Client's emergency contact;

- Details regarding children;
- The client's usual medical adviser;
- Client's medication history and current medication (including dosage);
- Client's medical history;
- The client's next of kin with contact details;
- Information regarding allergies or sensitivities to medications or any other substances;
- The reasons for the consultation;
- Clinical findings from the consultation and your reasons for making those findings;
- Medication prescribed (including the name of each individual ingredient, the amount of each ingredient used, and the dosage details) or services provided (within your scope of practice) and the reasons for providing these;
- Consents related to examination and/or treatment. Note that the consent given by the client must be informed consent- that is, the client must be fully aware of what it is that is being consented to. The form in which the consent is given should also be noted. Consent may be expressed, that is, verbally or in writing, or it may be implied, such as may be the case where a client rolls up a sleeve and extends an arm after you've asked if you can measure blood pressure. Consent must be made voluntarily and must cover the procedure or treatment that is provided. Each different assessment (that involves physical contact with the client) that you perform or treatment that you provide requires separate and fully informed consent. Copies of written consents must be kept with the client file and details of verbal or implied consents noted in the file.
- Any warnings or cautions given to the client in regard to their treatment or clinical condition;
- Further treatment plan and expected outcomes;
- Written copies of any advice that may be given, including copies of any referrals made for other investigations or services.

The notes related to subsequent or follow-up consultations should contain the same details that are referred to above and include the date of the consultation, the response to treatment and any comments by the client regarding the treatment (in their own words), details of the updated treatment plan and any further advice, as well as copies of referrals for any further investigations or services. Any unexpected outcomes that occur as a result of your treatment or adverse reactions to that treatment should also be recorded and where appropriate, and adverse reactions to ingested medicines (where provided within your scope of practice), or services provided, or therapeutic devices, must be reported to the Therapeutic Goods Administration.

Dispensary Records

If you're dispensing medicines, careful records should be kept of the medicines you dispense, and this is normally done through the use of a batch book. In the event of a product recall or a client experiencing an adverse reaction, it's essential to know exactly what was given to each client. It's also essential to be able to trace an ingredient or product back to the supplier. Without the capacity to do this, in the event of a client experiencing a serious adverse reaction through no fault of the practitioner, and the client taking legal action against the practitioner, the practitioner may not be able to avoid assuming the full extent of legal liability. The ability to provide evidence that the

supplier rather than the practitioner was at fault, or the ability to join the supplier in liability, is removed unless you can show evidence of the specific details of what was supplied to the client.

Batch book details may be kept on a computer (preferably using a spreadsheet program) or may take the form of a book into which you enter these details by hand. A snap-shot view of a batch book may look like that which is displayed on the following page.

The Happy Herbalist. Norman Happy DBM. 10 Helianthus Drive Happy Hill Qld 4006 Ph/Fax 07-31190004 Prov. No. J99904A ABN 99 777 001 555 www.happy1.com.au	*Dispensary Batch Book*

Client name				
Date prescribed				
Herb				
Dose form				
Supplier				
Batch number				
Expiry date				
Quantity supplied				
Herb				
Dose form				
Supplier				
Batch number				
Expiry date				
Quantity supplied				
Herb				
Dose form				
Supplier				
Batch number				
Expiry date				
Quantity supplied				
Total volume of herbs supplied				
Dose form				
Dose				
Mixture batch number				
Mixture expiry date				

The same method of entry should be used for every single product dispensed and given to clients, whether this be herbs, homeopathics or nutritional supplements. The mixture batch number mentioned in the above table is that which you apply to the medicine yourself. This is done so that the product is traceable back through to your batch book if the need arises and these numbers should be consecutive. The mixture expiry date mentioned above is the expiry date that you apply to the medicine. This date is derived from the earliest expiry date of any of the herbs used to make the mixture. For example, if you used a mixture of Sambuccus, Rubus and Andrographis for a client with influenza, and the expiry dates of these herbs were November 2019, June 2018 and July 2019 respectively, the expiry date that you apply to the mixture would be June 2018; again, the earliest expiry date of any of the ingredients in the mixture. The dose form refers to the form of the ingredients and finished product- liquid or powder for example.

When recording the details for herbal or homeopathic medicines, it's best to record the Latin rather than the common names, as there are several different plant species that are used to make medicines that share the same common names. Nutritional supplements should be labelled in the same way as herbal and other dispensed medicines and the expiry date you use on the label should be the same as that printed on the product label by the manufacturer.

As with healthcare records, the dispensary records that you construct must be legible, written in English and must be kept for at least 7 years, or where the client is under the age of 18 years at the time of treatment, records must be kept at least until that person turns 25.

Security

Healthcare and dispensing records should be stored securely, and accessible only by the receptionist and the treating practitioner. Where electronic files are used, the files must be password protected, those passwords made known only to the receptionist and the treating practitioner, the files backed up and those file copies stored securely offsite. Passwords must be updated regularly and must be changed when staff who had access to those passwords leave the employ of the clinic. Where hard copies of files are used, they must be held securely and not subject to unauthorised access. Files that are no longer required to be kept should, in the case of electronic files, be completely deleted as should any and all copies of those files, and hard copies should be shredded or incinerated under supervision with consideration to the environmental impact of these processes and steps should be taken to minimise that impact.

Privacy

Healthcare and dispensing records, including the client's personal information or images, must not be transmitted in any way, shared or reproduced, even if the person is not directly named or identified, without the written and informed consent from the client. If you relocate or close your clinic, you must facilitate arrangements for the transfer or management of all of these records in accordance with the Australian Government National Privacy Principles and all other relevant legislation governing privacy and health records.

Access to Healthcare and Dispensing Records

Except where one or more elements of section 6.1 of the National Privacy Principles (2011) can be demonstrated, should a client, their legal representative, their private health insurer, or an

organisation legally mandated to do so, request a copy of the client's healthcare record, you must promptly comply with that request.