Record Keeping for Occupational Therapists

Record keeping is, on a risk management basis, one of the most critical tools you have to protect you and your business.

Why record?

- Maintains a record of treatment carried out or offered.
- Aids as a tool in maintaining the accountability of staff.
- Assists when supervising and teaching staff.
- Assists when another Occupational Therapist assumes responsibility for treatment.
- Evidence of facts gathered, tests performed, research undertaken to decide the appropriateness of treatment recommended or disregarded by you or an insurer or client.

What should be kept in a patient's record?

Privacy legislation gives the patient access to records – there are various modes and methods for access to be facilitated.

Patients cannot remove information or have information removed from the record.

For example: If a client disputes what is written, an annotation can be made with the client's version of events or additional information included in the record.

Records should be kept on the basis that the patient will access and read them.

Records can be required to be disclosed for a variety of reasons e.g. compensation litigation purposes.

The record should comply with the Occupational Therapy practice's privacy obligations:

- Only collect and record information necessary for you to perform your function.
- Information recorded must be correct and accurate.
- You must have the patient's consent to collect information.

Good record keeping

Comprehensive notes should be kept. This is important in order to:

- Provide proper and complete care to patients.
- Refresh your memory.
- Provide a basis for any reports that may be required.
- Provide a sequence of events if necessary.
- Protect you from allegations of inappropriate or negligent treatment.
- It should be a summary and not a transcript. Dot points are acceptable.

The records should be **relevant** (Weight, dress, demeanour could be relevant. Jokes, weather, general discussion are not).

The records should be **appropriate**. Avoid inappropriate or derogatory comments or notations which might be interpreted as discriminatory or offensive:

- The patient may see the notes.
- Someone else may see the notes.
- Your treatment may be the subject of a complaint.

The records should be **contemporaneous**:

- What was said, done or observed by you.

If not contemporaneous the notes may be questioned as to their accuracy.

The records should reflect your **observations and beliefs**:

- Be objective and be self-aware to look out for any unconscious biases creeping into decisions.
- If documenting something you did not observe, identify who told you.

We teach lawyers that records may end up before a professional body, court or in the media.

The records should be **clear and legible**:

- The meaning of records should be clear and records should be legible and readily understood.
- Others may need to read and understand the records.
- You may need to refer to the records months and possibly years after they were taken.

Recording the patient's history

Carefully record the objective facts in detail.

The circumstances giving rise to an injury can often be controversial and disputed by an insurance company – carefully record the patient's instructions. Insurers will target notes of practitioners for inconsistencies in how accidents have occurred (example – the difference between a fall, a slip or a trip and can decide the outcome of a case).

Be very careful when documenting previous injuries or conditions: a history of three discrete episodes of (resolved) back pain over the years, is not a "history of chronic back pain".

Never alter records

Altering records after they are written is unethical and could lead to criminal/negligence allegations.

If it is believed a note was made in error or if you subsequently need to amend a record, you should make an additional or correcting note – do not erase or otherwise delete the old note.

Who has access to the record?

Right to Information Act 2009 and *Information Privacy Act 2009* (public health sector); *Privacy Act 1988* (Commonwealth) (private health sector).

Patients (and their representatives) have a legal right to access health records.

Any request for records must be accompanied by an authority. Read the authority carefully as the authority may only be requesting only part of your records or reports.

Records must be provided to a court if subject to a direction from the court e.g. Notice of Non-Party Disclosure or a Subpoena.

How long do records need to be kept?

Records need to be kept for 7 years.

If the patient is a minor, the records need to be kept until the patient 25th birthday (7 years from when they attain their majority).

However, in this day and age, where you are treating clients in schemes like NDIS or NIIS with lifetime care, and the cost of keeping records is minimal, it may be more appropriate to keep records for much longer, for your own protection.

Litigation

Occupational therapy records can be an important document in a claim brought by a patient being treated.

Types of litigation where medical records are relevant include:

- Inquests.
- Disciplinary proceedings arising out of medical treatment.
- Medical negligence claims (e.g. Misdiagnosis and failure to diagnose).
- CTP, workers' compensation, public liability claims, NDIS, NIIS, wills or estate or sexual abuse matters.

Thorough records may protect the treatment provider from a potential legal claim.

Summary

- Various people will have access to your records.
- Records should be comprehensive, relevant, appropriate and contemporaneous.
- Record in detail relevant facts, assessments, research, objective observations, recommendations made and disregarded.
- Records should be clear and legible.
- Never alter records.
- Keep for minimum of 7 years, to age of 25 for children or longer if possible.

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1800 111 222
mauriceblackburn.com.au

maurice blackburn lawyers

Occupational Therapy AUSTRALIA

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