



<b>HEALTH PROFESSIONS LICENSING AUTHORITY</b>	
<b>TITLE: Medical Records Policy and Guidelines</b>	
<b>EFFECTIVE DATE:</b> 30 April 2007	<b>REVIEW DATE:</b> 30 April 2009
<b>BOARD:</b> Medical Board of the Northern Territory	

## **PURPOSE**

These guidelines have been developed to provide clear guidance to medical practitioners, providers of medical services and the public in the management of patients' medical records.

## **POLICY STATEMENT**

Medical Practitioners must maintain medical records in accordance with the guidelines below. Patients have a right to access their records.

## **BACKGROUND**

Medical Records are a fundamental part of any medical practice, they help to ensure good patient care and continuity of care in addition they form an essential guide to future management. Patient records are invaluable to assist reflection on care provided and provide evidence in the uncommon occasions when the outcome is unsatisfactory.

## **GUIDELINES FOR MANAGEMENT OF PATIENT RECORDS**

### **1. Maintaining Patient Records**

- 1.1 Records must be legible and should contain all information that is relevant to the patient's care.
- 1.2 A record must include sufficient information concerning the patient's case to allow another registered medical practitioner to continue management of the patient's case.
- 1.3 All entries in the record must be accurate statements of fact or statements of clinical judgment.
- 1.4 Information should be accurate and updated at each consultation.
- 1.5 Medical records should contain all of a patient's important medical history, such as, but not limited to illnesses and allergies.
- 1.6 A record must be made contemporaneously with the provision of the medical treatment or other medical service or as soon as practicable afterwards. This may be complied with by the making of further entries in a single record that relates to the patient concerned.
- 1.7 A record must contain:
  - a) Sufficient information to identify the patient to whom it relates.
  - b) Any information known to the registered medical practitioner who provides the medical treatment or other medical services to the patient that is relevant to his or her diagnosis or treatment (for example, information concerning the patient's medical history, the results of any physical examination of the patient, information obtained concerning the patient's mental state, the results of any tests performed on the patient and information concerning allergies or other factors that may require special consideration when treating the patient).

- (c) Particulars of any clinical opinion reached by the registered medical practitioner.
- (d) Any plan of treatment for the patient.
- (e) Particulars of any medication prescribed for the patient.
- (f) The record must include notes as to information or advice given to the patient in relation to any medical treatment proposed by the registered medical practitioner who is treating the patient.
- (g) A record must include the following particulars of any medical treatment (including any medical or surgical procedure) that is given to or performed on the patient by the registered medical practitioner who is treating the patient:
  - (1) The date of the treatment;
  - (2) The nature of the treatment;
  - (3) The name of any person who gave or performed the treatment;
  - (4) The type of anaesthetic given to the patient (if any);
  - (5) The tissues (if any) sent to pathology; and
  - (6) The results or findings made in relation to the treatment.
- (h) Any written consent given by a patient to any medical treatment (including any medical or surgical procedure) proposed by the registered medical practitioner who treats the patient must be kept as part of the record relating to that patient.

1.8 In general, the level of detail contained in a record must be appropriate to the patient's case and to the medical practice concerned.

1.9 Form of records:

- (1) Abbreviations and short hand expressions may be used in a record only if they are generally understood in the medical profession in the context of the patient's case or generally understood in the broader medical community;
- (2) Each entry in a record must be dated and must identify clearly the person who made the entry; and
- (3) A record may be made and kept in the form of a computer database or other electronic form, but only if it is capable of being printed on paper.

1.10 Alteration and correction of records

A registered medical practitioner or medical corporation must not alter a record, or cause or permit another person to alter a record, in such a manner as to obliterate, obscure or render illegible information that is already contained in the record.

1.11 Delegation

If a person is provided with medical treatment or other medical services by a registered medical practitioner in a hospital, the function of making and keeping a record in respect of the patient may be delegated to a person other than the registered medical practitioner, but only if:

- (a) the record is made and kept in accordance with the rules and protocols of the hospital; and
- (b) the registered medical practitioner ensures that the record is made and kept in accordance with this Schedule.

## 2 Practice Systems

2.1 Practitioners should ensure they have access to systems for recall of patients who need regular checks or treatment.

- 2.2 Practitioners should have systems in place to ensure that test results are acted upon in a timely manner, including notification of patients as appropriate.

### **3. Confidentiality of medical records**

- 3.1 Medical records should remain confidential between the patient, the medical practitioner and relevant employees of the same medical corporation as the medical practitioner. They may sometimes be required occasionally in a court. Otherwise, information from the records should not be made available without the patient's written permission.
- 3.2 All reasonable steps must be taken to ensure that all records are kept in such a manner as to preserve the confidentiality of the information that is contained in them and to prevent them from being damaged, lost or stolen.
- 3.3 With due consideration to 3.1 and 3.2 above, a record must be reasonably accessible for the purpose of treating the patient to whom it relates.

### **4. How long is a medical practitioner required to keep patient records?**

- 4.1 It is recommended that records should be kept for at least 7 years from the date of last entry in the record, unless the patient was less than 18 years old at the date of last entry in the record.
- 4.2 If the patient was less than 18 years old at the date of last entry in the record, the record must be kept until the patient attains or would have attained the age of 25 years.
- 4.3 It is advisable to ensure administrative processes are in place to identify patient records that have a likelihood of being required in the future eg: records that may be required in litigation claims or contain rare or high public risk health issues. Practices should consider the value of retaining such records longer than the recommended period stated above.
- 4.4 In this "date of last entry in a record" means the date the patient concerned was last provided with medical treatment or other medical services by the registered medical practitioner or medical corporation who provided that treatment or those services.
- 4.5 It is recommended that practitioners seek advise from indemnity insurance services in regards to keeping patient records.

### **5. Patient Access to Records**

- 5.1 Medical records are the property of the medical practitioner or health care service attended by the patient, but the patient has a right to the information contained in the records. Therefore, the physical record belongs to the medical practitioner, but the public is entitled to access the contents. Commonwealth Privacy Legislation confirms this.
- 5.2 The records are the notes the medical practitioner makes. While they contain confidential information about the patient, they are made by the medical practitioner and are the medical practitioner's property. By a patient's attendance to see the medical practitioner, the patient has implicitly given him or her permission to take notes about the consultation.
- 5.3 X-ray reports, pathology reports and anything else obtained at the request of a medical practitioner usually remain the property of the medical practitioner. The medical practitioner may provide a copy of the reports, if the patient's consent has

been given for the release of the information. A patient is entitled to know the content of reports.

- 5.4 Some medical practitioners may charge a fee for handling and copying their records, but this should reflect only the administrative costs involved.
- 5.5 A practitioner may charge a fee for providing a summary, especially if the patient history is long and/ or complex.
- 5.6 Patients are entitled to access the information contained in medical records, and it is at the practitioner's discretion how he/she provides patients with that access. Access to information may differ in some specific circumstances such as persons who are prisoners or detainees. Please contact the Office of the Federal Privacy Commissioner on 1300 363 992 for further details.

## **6. Transferring Patient Records**

- 6.1 While there is no legal obligation for medical practitioners to transfer patient records, there is a professional expectation that medical practitioners will provide the new treating medical practitioner with relevant details of the patient's history upon request. The usual practice is for the patient to ask his/her new medical practitioner to arrange for the transfer of the records and to sign a consent form authorising this request.
- 6.2 It is advisable to transfer patient records using some form of registered mail so if required tracing the records is possible.
- 6.3 It is advisable to ensure a copy of the patient records is retained by the medical practitioner/ medical practice.

## **7. What happens when a practice changes hands?**

- 7.1 When a practice is disposed of, the medical practitioner disposing of the practice should make reasonable efforts to ensure the maintenance of the records eg: by providing the records to the patient to whom they relate. The records may also be provided to another medical practitioner identified by the patient at the request of the patient.
- 7.2 Unfortunately, there is no easy solution to the problem that arises when a medical practitioner in solo practice leaves the practice (for whatever reason) without handover arrangements. If the practitioner is deceased, technically, his or her estate is liable for the safekeeping of records. Patients involved in such a situation should approach the estate and ask for the records to be sent to another medical practitioner.

## **8. Disposing of Records**

A person who makes or keeps a patient record must ensure that when the record is disposed of it is disposed of in a manner that will preserve the confidentiality of any information it contains relating to patients.