NEW ZEALAND
CHIROPRACTIC BOARD
TE POARI KAIKOROHITI O AOTEAROA

GUIDELINES:

Clinical Records

July 2023

Associated Documents

- Competency-based standards
- Code of Ethics
- Health and Disability Commissioner's Code of Rights

Revision Schedule

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PREAMBLE

Te Poari Kaikorohiti o Aotearoa, the Chiropractic Board (the Board) is pleased to present this guideline to assist Chiropractors with their clinical record practice.

The Board often receives requests from chiropractors for guidance around clinical records. Furthermore, most complaints received by the Board relate to the communications between Chiropractors and their patients, failure to obtain valid informed consent or poor clinical records. These guidelines provide suggestions for best practice for chiropractors around informed consent.

Any clinical records processes Chiropractors have in place, should be developed in consultation with Board's standards, including the Competency-Based Standards for Chiropractors and the Code of Ethics. The Board also highlights the importance of the Health and Disability Commissioner's Code of Rights.

Not every eventuality can be envisaged, so developing an understanding of key concepts and how they may be applied in practice will help chiropractic practitioners manage issues of consent.

Chiropractors must create and maintain clinical records that serve the best interests of patients and that contribute to the safety and continuity of their care. The keeping of adequate clinical records is fundamental to the safe and effective care of a patient. Good clinical records provide transparency which may assist in any investigation or dispute resolution.

To facilitate safe and effective care, patient records must be accurate, legible, and understandable, and contain sufficient detail so that another practitioner could take over the care of the patient if necessary. These guidelines describe the minimum requirements for clinical records regardless of whether they are in paper or electronic form.

GUIDELINES: CLINICAL RECORD KEEPING

1. INTRODUCTION

Clinical Records are the pivotal information record relating to the care and treatment of individual patients. The importance of clear and complete records, completed in a timely fashion cannot be overstated.

Clinical Records are the subject of multiple Statutes, Codes and Guidelines issued in connection with several Government Departments and Agencies:

- Health Act 1956
- Health (Retention of Health Information) Regulations 1996
- Health and Disability Commissioner Act 1994
- Code of Health and Disability Services Consumers' Rights 1996
- Public Records Act 2005 (updated 2021)

Practitioners are particularly referred to the Health Information Privacy Code 2020 on the Privacy Commissioner website: https://www.privacy.org.nz/.

The implementation of policies and procedures regarding the creation, maintaining and handling of Clinical Records is the responsibility of the Chiropractor.

2. CLINICAL RECORDS FRAMEWORK

The Board has produced a framework for Clinical Records, in **Appendix 1**. Clinical Records should be completed in a timely manner: during or immediately following the relevant consultation. Subsequent additions or amendments should be clearly marked, dated, and initialled.

As well as recording requisite detail, clinical records taken as a whole, should paint a picture of the patient, their presentation, and their engagement with the chiropractor, that are readily understandable to another practitioner.

3. INFORMED CONSENT AND CLINICAL RECORDS

- Informed consent should be sought from patients in respect of confidentiality, data collection, storage, and the patient's right to access the information and records. Clinical records remain the property of the patient under the Privacy Act.
- This need not be done at each consultation – however it is appropriate whenever there is a new situation (other than exceptional circumstances). For example:
    i. For all New Patients
    ii. When referring to or contacting other health professionals
    iii. When receiving a request for information from a third party (except ACC for which consent has been given at the time of lodging a claim)
- Record of the patient's relevant informed consent can be integrated with other aspects of the consultation, i.e. examination, diagnosis and management.

4. PRIVACY OF CLINICAL RECORDS

Clinical Records are confidential. This confidentiality extends to all patient information, including, but not limited to, third party billing (ACC; diary records, payment details).

Release of such information is normally considered only under the following situations:

- To the patient, or an appropriate third party, at the patient's request.
- To another health practitioner as part of a referral, with the patient's informed consent.
- To another health provider, or government agency, where there is concern regarding patient safety (where prior consent may not have been obtained) or when required to by law.
- To ACC, under ACC release of patient information regulations.

The Ministry of Health provides a comprehensive framework on the subject.

It is the responsibility of all practice principals to ensure those accessing clinical records are aware of practice policies and procedures. Practice principals should ensure all employees and independent contractors have confidentiality of information clauses within their contracts.

5. Storage of Clinical Records

- Clinical Records may be on paper or in electronic media.
- Physical records must be securely stored and handled out of public areas.
- Electronic records must also be securely stored and extra care is required in this regard.
  i) Electronic data storage best practice is to comply with information and directives from the Ministry of Health. *Ministry of Health Policy is currently under review due to the changing nature of this field.*
  ii) As cloud computing storage and services proliferate and are becoming increasingly utilised, security and risk assessment must be undertaken. The Privacy Commissioner and Government Chief Information Office both provide guidance and resources in this regard.
  iii) All devices, including smart phones that have access to records require password protection.
  iv) Electronic records require regular back-ups to reliable sources: either cloud based (see i and ii above), or external media which should be encrypted (E.g. external hard drives or USB sticks).
- Particular care should be taken in preserving confidentiality during the transportation of Clinical Records, including considering risk management E.g. theft of physical or electronic media from vehicles.

6. Retention and transfer of Clinical Records

- In general, Clinical Records are under the care of the practice or clinic that the patient has attended, and not the individual practitioners, whether they be employees or self-employed contractors.
- Therefore, if a practitioner is absent from, or leaves a clinic, ordinarily the records remain at the clinic. Practices should grant former practitioners access to Clinical Records under appropriate circumstances E.g. Preceptorship or Audit.
- Clinical Records must be retained for a minimum of ten (10) years following the date of the last consultation - Health (Retention of Health Information) Regulations 1996.
- Clinical records may be transferred before the end of that period:
  i) To the patient, at their request, or their representative if deceased.
  ii) To another practitioner, at the patient's request.
  iii) To the patient, or another appropriate practitioner upon retirement or death of the practitioner concerned, or closure of the practice.
  iv) It is recommended under i) and ii) that copies of records are retained.

- Historic records aged beyond the minimum requirement may be kept on file, or securely destroyed E.g. Security-level shredding.

7. ACC and Clinical Records

- ACC treatment providers have additional responsibilities – see Appendix 2 for details.

8. Electronic Records

- Although not mandatory, practitioners should be mindful that the general trend is toward electronic record keeping and that at some point in the future it may become a requirement.
- There are benefits to keeping electronic record keeping for example the date/time stamp, eligibility of writing, and hand written records can be lost.
- However, electronic records are only as good as the data entered. Board's view is that if the format in **Appendix 1** is implemented, then this will stand practitioners in good stead for any future shift to comprehensive electronic records.

9. Abbreviations in Clinical Records

- Abbreviations should be kept to recognisable and commonly accepted format.
- Excessive use of abbreviations should be avoided.

10. Further Reading

The following agencies and departments have information and directives regarding clinical records:

- Ministry of Health
- Accident Compensation Corporation
- Health and Disability Commissioner
- Privacy Commissioner

APPENDIX 1: CLINICAL RECORD COMPONENTS

- The following list describes each area or field that should be incorporated into clinic records.
- In general, clinical records should follow the order of each item as presented.
- These components should be read alongside the Board's competency standards.
- In covering each of these areas, comprehensive notes should be produced which, when thoughtfully completed, tells the story of the patient, and, their interaction with their chiropractor.
- Use of pre-printed forms, or a software template, to be completed during consultation at may serve as a useful prompt.

    - 🕮 Pages have patient ID – e.g. for computer data base, where appropriate.
    - 🕮 Contains spaces for biographical and/or personal data (name, address, contact details, date of birth, parental or guardian details for a minor).
    - 🕮 Current work and social history details are recorded (e.g. type of work, hobbies and sports, other interests).
    - 🕮 Space for chiropractor's name on records pertaining to the initial consultation, followed by initials alongside each treatment.
    - 🕮 Entries are dated.
    - 🕮 Entries are legible.
    - 🕮 Presenting problem is complete and clear, including onset and progression.
    - 🕮 History of presenting complaint is present and logically/systematically presented.
    - 🕮 The current state, including pain nature and magnitude, and effects on function, work, daily activities, and sleep are recorded.
    - 🕮 Consider employing the outcome measures referenced in Appendix 2, which have been identified as most appropriate for Chiropractic practice.
    - 🕮 Appendix 2 provides further detail for ACC cases.
    - 🕮 Appropriate past medical history is recorded including a systems review, drug history, accident/trauma history, investigations and general procedures / surgeries noted, and record of ongoing concurrent medical care noted.
    - 🕮 Psychosocial, lifestyle and past medical / healthcare experiences relevant to presentation are recorded.
    - 🕮 Smoking, alcohol, or substance abuse history documented (if appropriate).
    - 🕮 Imaging test results recorded as appropriate.
    - 🕮 Lab and other tests recorded as appropriate.
    - 🕮 Pertinent objective examination conducted and documented, with positive, negative and 'nothing abnormal detected' findings noted.

- 🕮 Considerations for differential diagnosis are noted.
- 🕮 Working diagnoses are noted and are consistent with findings and aetiology.
- 🕮 Chiropractic components of the case analysis (diagnoses) are identified and recorded.
- 🕮 Plans of action/ treatment are recorded and are consistent with diagnosis(es).
- 🕮 Patient self-help, health education, and rehabilitation options are recorded.
- 🕮 Relative or absolute contra-indications for treatment are clearly and prominently recorded.
- 🕮 Informed consent noted for all procedures.
- 🕮 Specific details of treatments given, including body site, patient position, and techniques administered are clearly recorded.
- 🕮 Use of personal professional jargon or shorthand that may be obscure is avoided.
- 🕮 Outcomes from previous visits recorded.
- 🕮 Any issues arising from previous visits are addressed.
- 🕮 Evidence of appropriate use of referrals.
- 🕮 Correspondence relevant to patient recorded and integrated into care.
- 🕮 Patients are adequately informed (i.e. there is documentation of patient education, follow-up instructions).
- 🕮 Missed/cancelled appointments noted.
- 🕮 Follow-up on missed/cancelled appointments noted.
- 🕮 Telephone calls regarding patient care noted.
- 🕮 Records are organized in a consistent manner.
- 🕮 Paper record contents are securely fastened together, or bound in folder, or similarly secure.
- 🕮 Electronic records relating to each patient should be accessible through one portal, or linked (e.g. ACC Accident details, imaging reports, letters).
- 🕮 Avoid inappropriate information in the record (e.g., subjective, or personal remarks about patient, family, or other caregivers).
- 🕮 Avoid inappropriate alterations or omissions (e.g., erasures, missing pages).

APPENDIX 2: CLINICAL RECORDS AND ACC

Where patient records include ACC covered treatment, care must be taken to make all the information relevant to the history, assessment, and management of the injury easily identifiable, and usually self-contained. Whilst it is normal and correct for patient records to be contemporaneous and chronological with the patient's presentation(s) over time, ACC's liability begins and ends only with management relating to each specifically covered injury.

In addition to including the components detailed in Appendix 1 within clinical records, take particular care with the following elements, to comply with ACC's requests for ACC Treatment Providers:

- Record details of the accident, including what occurred, the mechanism of injury and the nature of the client's symptom initially and currently following the reported accident.
- Record the ***causal link*** between the injury sustained in a reported accident that meets ACC criteria, and the current condition.
- Record pain levels.
- Record effects of the current condition on sleep, work, and activities of daily living.
- Record how pain and its' effects change at follow-up consultations.
- Consider use of outcome measures to simply track the above information.
- Any treatment given at the same appointment that does not relate to the ACC covered injury is to be clearly and separately noted, including the duration of this treatment.

ACC recommends the two outcome measures below, both contained in the: Guide to outcome measure reporting.

i) the Numerical Pain Rating Scale (NPRS) – also known as the Visual Analogue Scale
ii) the Patient Specific Functional Scale (PSFS)

Practitioners are directed to the ACC Treatment Providers Handbook (2016) pp26-29.

Also refer to ACC's Provider Tips for Privacy.