

Health Records Policy

Approved by	Board of Healthia Limited
Approval date	01/05/2023
Next scheduled review	01/05/2025
Covered under policy	<p>Entities: Healthia Limited, My FootDr (Aust) Ltd, Allsports (Aust) Ltd, Extend Rehab Pty Ltd, iOrthotics Pty Ltd, D.B.S. Australia Pty Ltd, The Optical Company Pty Ltd, BIM Physiotherapy Group Holding Limited, Motion Health Group Holding Limited (NZ) and any other entity that is a subsidiary of Healthia Limited (collectively referred to throughout this policy as Healthia)</p> <p>Who: This policy applies to all Healthia staff and to people who work within Healthia including:</p> <ol style="list-style-type: none"> 1. Board of Directors of any Healthia entity and Board Sub-Committee Members 2. Executive, managers, clinic class shareholders and employees (whether full time, part time, casual, permanent or temporary), and 3. Volunteers, students, contractors and consultants
Related policies	<ul style="list-style-type: none"> • Code of Conduct and Behaviour Policy • Data Breach Policy • Health Records Audit Policy • NDIS Code of Conduct Policy • Privacy Policy
Related documents	<ul style="list-style-type: none"> • Ahpra and National Boards Code of Conduct June 2022 • Australian Privacy Principles (APPs) in the Privacy Act 1988 • Code of Ethics Speech Pathology Australia 2022 • ESSA Professional Code of Conduct and Ethical Practice 2021 • Good Medical Practice: A Code of Conduct for Doctors in Australia
Policy Owner/s	Clinical Advisory Committee

Purpose

The purpose of the Health Records Policy is to outline Healthia's guidelines and expectations relating to documenting, maintaining, storing and providing access to health records held by Healthia. For the purpose of this policy, the term health records refers to any documentation relating to care provided to our patients or customers.

Scope

Healthia's Health Records Policy applies to all Healthia staff and to people who work within Healthia including:

1. Board of Directors of any Healthia entity and Board Sub-Committee Members
2. Executive, managers, clinic class shareholders and employees (whether full time, part time, casual, permanent or temporary), and
3. Volunteers, students, contractors and consultants.

Policy

1. Principles

Healthia is committed to ensuring all team members involved in the delivery of care and services meet professional and medicolegal requirements pertaining to health records. These requirements include familiarisation with Ahpra, professional associations, state and federal legislation, to ensure adherence to all relevant professional and legal obligations related to health records.

2. Purpose of writing health records

Accurate, reliable and comprehensive health records are the foundation of providing excellence in care. Health records reflect the delivery of professional, ethical, safe and effective practice and demonstrate competent and accountable practice. Health records should be written at the time of the clinical/service encounter or as soon as practicable afterwards so that the interaction is clearly remembered and that the notes accurately reflect the encounter. Given the diversity of our clinics, stores and services, what is 'practicable' will range but should not exceed 5 days. Each individual team member is responsible for completing their notes in a timely manner, according to the clinic or store-specific guidelines and this will be monitored by the Clinic and/or Regional Partner. It is standard practice for clinical notes to be audited (refer to Healthia's Health Records Audit Policy).

Not meeting the requirements of this Policy is a breach of Healthia's Code of Conduct and could result in disciplinary action including termination.

3. Types of health records

This policy applies to all types of health records used at Healthia for the purposes outlined in 2.1 Health records may be maintained in electronic or handwritten formats, depending on the preference and convenience of the healthcare professional and patient (e.g., completion of outcome measures on paper). The choice of the type of health record should not compromise the quality, security or accessibility of the information. The following types of health records are commonly used at Healthia:

- Electronic records: these include electron health records (e.g., Nookal), digital documents (e.g., Microsoft word or pdf documents), other computerised systems (e.g., iOrthotics ERM).
- Handwritten records: these are physical records created using legible handwriting or completion of forms by patients (e.g., outcome measures, health questionnaires, clinical records).

4. Information to be included in health records

For clinicians, how to write health records forms a significant part of their programs of study. Additionally, Apha and each professional association provide guidelines regarding keeping good health records. It is incumbent on each individual clinician to ensure they are adhering to the requirements as set out by these bodies, particularly relating to what information should be included in the records. As a guiding principle, any information or activity that adds value to a clinical encounter and/or explains a clinical encounter or activity should be included in the records. Additionally, information that occurs outside of a clinical encounter (e.g., cancellations, outcomes of phone conversations) should be included in the person's records.

It is imperative that information included in the record is factual, accurate, comprehensive, reliable and that non-judgmental language is used. It is also imperative that 'negative' information is documented where relevant (e.g., the findings of a specific test, or response to a specific question, was negative) to highlight comprehensive care and reflective practice.

4.1 Group and class consultations

A person's suitability to participate in a group or class activity should be documented in their health record. Evidence could include a pre-participation assessment including identification of risks to participation, induction or orientation, agreement on the person's goals and consent. In a group or class, individual interaction is limited compared to one-to-one consultations, nevertheless a clinician is required to document any relevant history/interview information including a change in health status, activity undertaken, response to activity including any adverse response, review of goals/plan and any other information considered relevant to the encounter.

5. Consent

5.1 Collection of personal and health information

In accordance with the Privacy Act 1988, Healthia will ask all patients/clients to provide consent to collect their personal and health information and this consent also applies to the collection of information from other professionals associated with their health care. Healthia's privacy policy, and a contact for further information, is made available to all patients.

5.2 Consent process for new patients/clients

All new patients/clients are given the opportunity to choose to consent to the following individually (i.e., a patient/client is able to consent to all, none or only some of the following):

- Collection of personal information included on the Patient Registration Form for the administrative purposes of running the clinic.
- Use of correspondence regarding my personal and health information to other healthcare providers and administrators which may include some, but not all, of the following: referring general practitioners, orthopaedic surgeons, psychologists, public or private hospitals, rehabilitation providers (e.g., gyms or pools) as necessary.
- Use of information for billing purposes including collection of fees and compliance with Medicare, Health Insurance Commission, Workers Compensation, Department of Veterans Affairs (DVA), and National Disability Insurance Scheme (NDIS).
- My details may be provided to telehealth providers to provide remote health services during times when I am unable to attend the clinic in person (if applicable).
- That, from time to time, [business unit] may seek to contact me to provide me with information about new benefits, discounts or products. (patients/clients are provided the opportunity to opt out by selecting a box on the consent form).

At any time, patients/clients may elect to change their consent. If that is the case, they are asked to, contact Healthia's Privacy Officer either by email (privacy@healthia.com.au) or telephone (07 3180 4900). This change must be recorded in the patient/client's health record.

5.3 Informed consent

To ensure a patient is able to provide informed consent for a proposed treatment, intervention or therapy, health professionals must comprehensively outline the nature, purpose, risks, and potential alternatives of the proposed procedures, fostering a transparent and collaborative patient-practitioner relationship. Patients/clients must be given opportunity to ask questions, contribute their own insights and then voluntarily provide their agreement based on an appropriate level of understanding. To do this, consent for a specific treatment, intervention or therapy must be obtained at the time of the encounter and at each and every encounter.

5.3.1 Documenting consent

Documenting consent in health records serves as a fundamental ethical and legal safeguard, ensuring that patients/clients are fully informed and have willingly agreed to the proposed treatments, interventions, and therapies. Clear documentation not only upholds the principles of autonomy and patient-centred care but also safeguards against any potential disputes or misunderstandings that may arise over the course of treatment. By meticulously recording the details of consent in health records, health professionals bolster the quality and accountability of healthcare delivery, further solidifying the trust and confidence that patients place in their care.

In some cases, it is sufficient to document verbal consent has been provided. In other cases, particularly with specific treatments or activities that carry higher risk (e.g., dry needling, manipulation, internal examinations), written consent is required. It is the individual clinician's responsibility to ensure they are adhering to best practice guidelines specific for their discipline.

5.3.2 Waivers

Empowering patients to actively participate in treatment decisions is fundamental to our client-centred approach. We recognise that patients should have the opportunity to comprehend potential risks before making choices to participate in treatment choices related to their healthcare. A waiver allows patients to voluntarily waive certain aspects related to their care, provided in writing after receiving comprehensive information about the associated risks and implications. Waivers may be enforced in exercise testing, exercise classes, dry needling, manipulations, surgeries and any other high-risk procedure. Healthia places paramount importance on ensuring patients' informed consent, striving to create an environment where patients can make well-informed decisions that align with their individual preferences and health needs.

6. Confidentiality and privacy

Access to medical health records is limited to authorised personnel solely for legitimate purposes such as patient care, treatment coordination, billing and compliance with legal requirements. Healthia enforce strict access controls, regular training and technological measures to prevent breaches.

Healthia respects a person's privacy and is committed to complying with the Australian Privacy Principles (APPs) in the Privacy Act 1988 as well as other State and Territory laws such as the Health Records Act 2001 (VIC), Health Records (Privacy and Access) Act 1997 (ACT), the Health Records and Information Privacy Act 2002 (NSW) and the Health Information Privacy Code 1994 in New Zealand (Privacy Laws). For further information, please refer to Healthia's Privacy and Policy.

7. Access to health records

When writing health records, it is important to remember that the record may be reviewed or requested by colleagues for the purposes of providing care or services, by the patient/client and/or by third parties.

7.1 Colleagues

Recording our notes with a view that a colleague or peer may read them helps ensure notes are clear and aligns with Healthia's policy of continuous improvement. See also Healthia's Health Records Audit Policy.

7.2 Clients

Our clients have a legal right to access their health records. Where a patient/client requests access to their records, it can be useful to have a purposeful conversation to help them better understand any aspect of the record which may be technical or challenging to understand. See also Healthia's Privacy Policy.

7.3 Third parties

It is important to remember that health records may be requested by a third party such as a funding body (e.g., Medicare, NDIS, Motor Accident Insurers), professional indemnity insurers or legal entities (e.g., court of law, policy). Healthia team members are accountable to our funders to provide safe and effective services and we reflect this in our clinical notes, by completing required progress reports, forms and other documentation required to meet compliance.

7.4 Disclosure of health records

If health records are requested, all information encompassing medical history, diagnoses, treatments, and related information and documents, will only be disclosed with explicit consent from the individual or as required by law. Healthia is committed to maintaining the highest standard of privacy and confidentiality and this policy reflects our dedication to safeguarding sensitive health information while enabling necessary sharing for the provision of quality healthcare and related services.

7.5 Transfer to third parties, another health professional or government organisation

When a patient requests that their health records be transferred to third parties, another health professional or government organisation outside of the practice, the staff member has an obligation to provide a copy or summary of the patient health record in a timely manner if it is to facilitate care of the patient.

Transfer of health records from Healthia can occur in the following instances:

- When a patient asks for their health record to be transferred to another practice
- For legal reasons e.g., record is subpoenaed to court
- Where an individual health record report is requested from another source.

Team members must notify the therapist about all requests for patient health information. Healthia records the request by the patient to transfer health information on the health record, and this includes:

- Details on the date and the address the information was sent to, and
- Who authorised the transfer.

Before any team members of Healthia transfer the patient's information, they must first receive written consent from the patient to the transfer of their information to any third parties, other health professionals and government agencies.

For medicolegal reasons, Healthia retains the original record and provides the third party with a summary or a copy. If a summary of the patient's health record is provided to the third party, a copy of the summary should be kept on file for record purposes.

Healthia retains the right to charge a reasonable fee to the practice or the patient for transferring a copy or summary of the health record.

Procedure

Healthia follows this procedure when transferring health records to another practice:

- Ensure that the patient has provided written consent and this is incorporated into the patients' health record.
- Send the health record to the requesting practice via registered post / patient / courier with a fee indicated (if appropriate).
- Make a note in the patient's health record of the date and destination of the records transferred.

7.6 Transfer from another practice

If it is necessary for a therapist to become familiar with a new patient's history via their health record from a previous practice, written patient consent must be provided to the former practice by the patient. Healthia assists new patients by providing a consent form and posting to the former practice.

Procedure

Healthia follows this procedure when requesting health records from another practice:

- Ask the patient to write a letter / sign a form indicating consent for their previous practice to forward a copy or summary of their health record.
- Send a letter to the previous practice requesting that they provide a copy or summary of the patient's health record and enclose the original copy of the patient's consent.
- Prior to sending the request, photocopy the letter and consent from the patient and attach it to the patient's new health record.

7.7 No other access

Other than is set out in sections 7.1 to 7.6 above, no other access will be given or allowed to a patient's health records.

8. Medicolegal reports

The preparation and handling of medicolegal reports require meticulous attention and adherence to ethical and legal standards. Such reports, generated for legal or insurance purposes, will be compiled based on accurate and comprehensive health records, ensuring that only relevant and authorised information is included. We acknowledge the dual responsibility of providing accurate information while safeguarding patient privacy. Once payment is received, the reports will be sent to the requesting party.

9. Storage and disposal of health records

9.1 Storing health records

All health records of patients located in Australia will be stored in Australia. All health records of patients located in New Zealand will be stored in New Zealand. Health records can be kept as physical files or electronically. Electronic files must be capable of being printed.

All health records, regardless of how they are kept, must be stored in a manner that:

- Preserves the confidentiality of the patient;
- Protects against misuse or unauthorised access, disclosure or modification;
- Prevents damage, loss or theft; and
- Allows reasonable access to ensure continuity of treatment.

Healthia will take all reasonable steps to protect the security of patients' health records. The requirements for securely storing records have different practical applications for electronic and hardcopy records.

Electronic health records are password protected and are backed up regularly. Hardcopy records will be stored in a locked filing cabinet or in a secured dedicated room at the specific practice, or by a secure storage provider.

9.2 Accessibility of health records outside of Australia

Health records must not be accessed by Healthia staff outside of Australia or New Zealand (as applicable) unless they are required to provide services or advice regarding a specific patient.

9.3 Retaining health records

Healthia recognises that different jurisdictions and organisations have different requirements for retaining health records.

As set out by Ahpra, Healthia will retain the complete health record of an adult patient for at least seven years from "the date of last entry" in the record. This usually means the patient's last consultation with the clinician but could also include entries such as the date the patient was last telephoned or results were updated on the file.

If the patient was aged under 18 years at the date of the last entry in the clinical record, the record will not be disposed of until that patient would have turned 25 years.

9.4 Disposing of Clinical Records

Healthia will take reasonable steps to delete, destroy or de-identify health information that is no longer needed for any further purposes. The destruction of documents, whether they be electronic or hard copy, will be carried out in a secure and confidential manner.

Some Healthia clinics may use a private contractor to destroy health records. Where a private contractor is used, the practice should obtain a certificate of document destruction.

If you dispose of any health records in NSW, VIC or the ACT, you must keep a record of the:

- Name of the person that the clinical record related to;
- Time period of the health record (i.e. the date of the first entry through to the date of the last entry); and
- Date that the record was destroyed.

In the other states and territories, it is best practice to keep a record with this same information.

10. Ownership of health records

Individuals have ownership of their health records, and Healthia recognises a person's inherent right to access, control and make decisions regarding their personal health information. Patients have the right to request copies of their records, seek corrections, and understand how their information is used and disclosed. We commit to upholding patients' rights to their health records while ensuring compliance with applicable laws and ethical standards, promoting collaborative and patient-centred care.

11. Continuous improvement

As part of Healthia continuous improvement cycle, Healthia provide annual training regarding health records, conduct health records audits and Healthia's Clinical Advisory Committee, in conjunction with Healthia's legal team, review any changes required to our processes in response to changes in legislation or third party requirements. Feedback following the health records audit process is provided to the individual clinician and the Clinic and/or Regional Partner with a copy to be uploaded and held in Healthia Hub.

Relationship with Other Policies

Other Healthia policies that should be read in conjunction with this policy are:

- Code of Conduct and Behaviour Policy
- Data Breach Policy
- Health Records Audit Policy
- NDIS Code of Conduct Policy
- Privacy Policy

Related Documents

Other relevant resources in relation to this policy are:

- Ahpra and National Boards Code of Conduct June 2022
- Australian Privacy Principles (APPs) in the Privacy Act 1988
- Code of Ethics Speech Pathology Australia 2022
- ESSA Professional Code of Conduct and Ethical Practice 2021
- Good Medical Practice: A Code of Conduct for Doctors in Australia