Senate Community Affairs Committee inquiry into the Professional Services Review

Question: What resources are available to doctors that provide education and advice on proper forms of patient consultation note taking and medical record keeping?

AMA response: The medical colleges set an expectation that medical practitioners will maintain contemporaneous clinical notes. They do this in various ways, and we have provided two examples to illustrate this:

The Royal Australian College of General Practitioners *Standards for general practices 4th edition* provides:

> Standard 1.7 Content of patient health records
> Criterion 1.7.3 Consultation notes
>
> Each of our patient records contains sufficient information about each consultation to allow another members of our clinical team to safely and effectively carry on the management of the patient.
>
> Indicators
> A. Our patient health records document consultations including consultations outside normal opening hours, home or other visits and telephone or electronic communications where clinically significant, comprising:
>
> - Date of consultation;
> - Patient reason for consultation;
> - Relevant clinical findings;
> - Diagnosis;
> - Recommended management plan and, where appropriate, expected process of review;
> - Any medicines prescribed for the patient (including name, strength, directions for use/dose frequency, number of repeats and date medicine started/ceased/changed);
> - Complementary medicines used by the patient;
> - Any relevant prevention care undertaken;
> - Any referral to other healthcare providers or health services;
> - Any special advice or other instructions;
> - Who conducted the consultation (eg. by initial in the notes, or audit trail in the electronic record).

The Royal Australasian College of Surgeons *Code of Conduct 2011* provides:

> **8.3 RECORD KEEPING** The surgeon should ensure that records are available that document clinical assessment, decisions and plans for a patient. The records must be of sufficient detail to allow another practitioner to assume immediate management of a patient in the event that the treating surgeon is no longer available to continue management of the patient. This documentation is important not only for in-patient care but for the exchange of information between health professionals (clinical letters), discharge summaries, referral, transfer and handover. The following apply regardless of whether records are maintained on paper or electronically.
>
> ***The surgeon will***
>
> 1. maintain legible, contemporaneous patient records
>
> 2. ensure that clinical notes are dated and that the author is identifiable
>
> 3. ensure operation notes outline the procedure performed, including any specific problems encountered
>
> 4. document a postoperative plan that includes treatment until the patient is next to be reviewed
>
> 5. comply with privacy legislation and ensure records are not subject to unauthorised access

Most college curricula require trainees to demonstrate the ability to make contemporaneous, legible and accurate notes. From time to time medical colleges may offer short refresher courses which include good record keeping principles.

The Committee may be aware that Part 2 of the *Health Insurance (Professional Services Review) Regulations 1999* provides definitions for adequate and contemporaneous records for the purposes of the payment of Medicare benefits.

5 An adequate record

For the definition of adequate and contemporaneous records in section 81 of the Act, the standard to be met in order that a record of service rendered or initiated be adequate is that:

a) the record clearly identify the name of the patient; and
b) the record contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
c) each entry provide clinical information adequate to explain the type of service rendered or initiated; and
d) each entry be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

6 A contemporaneous record

For the definition of adequate and contemporaneous records in section 81 of the Act, the standard to be met in order that a record of a service rendered or initiated be contemporaneous, is that record must be completed:

a) at the time the practitioner rendered or initiated the service; or
b) as soon as practicable after the service was rendered or initiated by the practitioner.