Guide to Clinical Record Keeping

The purpose of this document is to clearly set out the essential components to include in your client records. The term “Client records” pertains to the documented account of a client’s personal health information, presenting condition and treatment in paper or electronic form. The following sets out the minimum requirements for the “Client file” and individual “Treatment Records”. More detail may be required or helpful for your individual circumstances.

All information must be written in English, understandable by a third party and in a format that allows for continuity of care. Files should be stored in chronological order, stored in a manner that allows prompt retrieval

It is the practitioner's responsibility to be aware of what should be included in clinical records and what detail is required. All information, assessment, treatment and recommendations must be within the practitioners *Scope of Practice* and must be made at the time of providing the services or goods or as soon as practicable afterwards. More information and helpful links can be found below.

1. ***Client files*** should contain the following information:

    - Full name
    - Address
    - Date of birth
    - Gender (including options for non-binary genders)
    - Contact details including phone and email
    - Relevant medical history including medications
    - Emergency contact details
    - Evidence of Informed consent to receive treatment

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2. ***Client treatment records*** should include the following information for <u>every consultation:</u>

Standard components for clinical notes for <u>ALL</u> modalities	Specific requirements for ***Manual Therapies*** Including Remedial Therapies, Myotherapy, Acupuncture	Specific requirements for ***Ingestive Therapies*** Including Naturopathy, Nutrition, Western Herbal Medicine, Traditional Chinese Medicine, Homeopathy
• Date and time of consultation • Identifying details of the therapist providing treatment • Update of health information (if required) • Purpose of treatment • Details of presenting condition including symptoms • History of other treatment/s, outcomes/results of treatment and/or adverse effects from treatment • Any concurrent medical/therapeutic treatment		• Current medications including dosage • Known allergies
• Details of physical assessment *NB: purpose of treatment, presenting condition, and physical assessment should indicate the need for*	Including findings of: • Observations such as posture, signs of inflammation, degeneration • ROM testing and Special/Orthopaedic testing results	**Specific diagnostic measures / physical assessments used should align with modality specific skills and be relevant to the case presentation and scope of practice. These may include:* • Pulse* • Iris* • Nails* • Eyes, skin, hair*

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treatment. These should also provide a baseline measure for progress.	Acupuncture specific • Pulse • Tongue • Hara + other reflex areas (if used) • Capillary refill	• Capillary refill* CM Herbal Medicine specific: • Pulse • Tongue • Hara reflex areas (if used) • Capillary refill
• Treatment plan	Including details such as: • Client goals, • intended treatment, • number of sessions required Acupuncture Diagnosis – treatment principle or strategy	• Chinese Medicine Diagnosis – treatment principle (+ methods) • Treatment strategy (e.g., in complex cases, what to address first, what to address later, also including approximate length of the course of treatment) • Holistic understanding • Treatment aims, short and long term goals
• Evidence of consent to treatment. This may be Written, Verbal or Implied		
• Treatment provided	• Region/structure/muscle treated • Technique/s applied • Modalities used Acupuncture specific:	• Medicine/s used • Dosage • Number of days prescription lasts • Prescription provided to patient with full ingredient list, labelling to CMBA standard

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NB: the treatment plan and treatment provided should align with client goals and must be clearly indicated based on details of physical assessment.	• Specific points, for insertive, non-insertive, micro bleeding & moxa • Electro points, volume, polarity etc.	• Detailed prescription with all ingredients
• Evaluation of treatment (or reassessment) including effectiveness of treatment, condition improvements, outcomes and clients perceived evaluation of treatment	• Equivalent detail as for physical assessment above relevant to modality	• Equivalent detail as for physical assessment above relevant to modality
• Condition based recommendations such as lifestyle advice, corrective exercises, etc. • Any referrals to other practitioners • Any other relevant communication with or about the client (for example phone consultation, health information brochures etc.)	• Exercise/rehabilitation prescribed including volume and frequency	• Dietary and Lifestyle advice

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Additional information

- The Health Records Act 2001: https://hcc.vic.gov.au/sites/default/files/health_records_act_2001_authorised033.pdf
- CMBA Patient health records guidelines https://www.chinesemedicineboard.gov.au/Codes-Guidelines.aspx

- CMBA Guidelines for safe Chinese herbal medicine practice https://www.chinesemedicineboard.gov.au/Codes-Guidelines/Guidelines-for-safe-practice.aspx
- ANTA Code of Ethics - http://ftp.australiannaturaltherapistsassociation.com.au/downloads/anta_codeofethics.pdf
- TGA regulatory guidelines for complimentary medicines - https://www.tga.gov.au/sites/default/files/australian-regulatory-guidelines-complementary-medicines-argcm.pdf
- Medibank provider recognition: https://www.medibank.com.au/providers/requirements/
- Medibank Patient Records Standards: https://www.medibank.com.au/content/dam/retail/providers/Patient%20Records%20Standards.pdf