



# PHYSIOTHERAPY HEALTH RECORDS

## Purpose

Health records are essential for the provision of quality health care services and support enhanced outcomes for health consumers. Health records include all forms of documentation irrespective of the medium i.e. paper or electronic, held by patients/clients, private practices, or organisations.

## Introduction

Documenting and maintaining an appropriate patient/client health record is important for the following reasons:

- To ensure patient/client safety.
- To provide continuity of care.
- To provide a standardised way of communicating between physiotherapists and other health professionals.
- To provide an accurate record of the care the patient/client received. In the event of a dispute or investigation health records provide vital information.
- As required by third party funders (e.g. ACC).

Physiotherapists must be familiar with the law governing this area of practice including the Health Information Privacy Code 1994, Health (Retention of Health Information) Regulations 1996. A practical guide on the interpretation of health information privacy [‘On the Record’](#) is available on the website of the Privacy Commissioner.

References to supporting documents are in Appendix 1, and relevant law/s throughout the position statement.

## Creation and Content of Health Records

Patients should feel confident that their health information will be recorded with their consent, in a respectful manner, with regard to their cultural needs, and be kept confidential (except where legally required to do otherwise).

Patient/client health records should contain:

- Key demographic data such as full name, NHI number, date of birth, gender, ethnicity, contact details, and, where needed, residency status and name of the General Practitioner.
- The date (and in some instances time).
- The principal/primary diagnosis.
- Any relevant associated conditions or additional diagnoses.
- Any relevant family or personal history.
- Assessment of the patient/client’s symptoms and signs.
- Analysis of the patient/client’s signs and symptoms.

- Treatment plan all procedures and the date and time they took place.
- Progress made and discharge plan.
- Information given to the patient/client.
- A record of consent given or refused.
- Letters and reports from referring health professionals or other involved parties, and any clinical photographs and/or digital images.
- Note of risks and/or problems that have arisen and the action taken to rectify them.
- Electronic authentication or printed name, signature and designation of the physiotherapist responsible.

Information must be added to patient/client records after every physiotherapy encounter, including when the patient/client contacts the physiotherapist by telephone or other means, or does not attend. All reports (diagnostic procedures, letters from other professionals) must be initialled to indicate they have been seen, and stored with the patient/client records. The use of “copy and paste” as a method of documenting in an electronic system is discouraged due to the clinical risk associated with copying information.

**Abbreviations or acronyms:** Abbreviations or acronyms within patient/client records have the potential to cause confusion and threaten patient/client safety when care is transferred to another physiotherapist or another health professional. Care should be taken to only use those abbreviations or acronyms that are clear and widely understood. A list of approved abbreviations used by the clinic/physiotherapist should be available on request.

**Timing:** Patient/client records should be filled out during treatment or immediately after treatment.

**Correcting errors:** Any corrections to patient/client records must be identifiable. The person amending the patient/client record must date and initial the correction – or electronic authentication. The original statement should be struck through (making clear that it has been corrected) leaving it able to be read. Efforts to obliterate original statements may appear as an attempt to cover up errors in care in the event of a dispute. Patients can request a correction and/or ask for the addition of information.

*The [Health Information Privacy Code \(HIP\)](#), Rule 7 pertains to the correction of health information.*

### **Storage and Security of Health Records**

Storage of patient/client records

Patient/client records should be reproducible without loss of content and accessible for duration of storage time required.

Patient/client records must be stored securely to protect the information from loss, theft, tampering, and unauthorised access or disclosure.

Patient records should be kept away from public areas and access should only be possible by appropriate members of staff.

Electronic records should be password protected, and a system for regular back-up should be in place.

*See the [HIP Code Rule 5](#), and guidelines for ‘cloud’ storage in the [Cloud Computer Checklist for Small Business](#). All electronic documentation should comply with the standards set out in [Archives New Zealand’s S5: Digital Recordkeeping Standard](#)*

## Access and retrieval

All access to and retrieval of health records should be undertaken by identifiable authorised personnel.

Patients have a right of access to information in their records. The information belongs to the patient, whereas the document belongs to the place of practice.

Third party access to health records / information:

- This can only be provided with the patient/client's written consent (except when permitted or required by law), by Court Order; or as part of an existing signed contractual arrangement with a funder, such as ACC.

The physiotherapist should seek organisation/legal advice if there are concerns regarding right to access.

*The [HIP Code](#) Rule 6 outlines the requirements for access of health information. Legal access to patient/client records is outlined in Parts 4 and 5 of the [Privacy Act 1993](#).*

## Transportation and transfer of information

Every effort should be made to ensure safe physical or electronic transportation / transmission of patient/client information in order to minimise the risk of loss or damage.

Steps may include:

- Secure stowage of patient/client health records between clinical sites;
- Password protection or encryption on all electronic transfers of information;
- Using authorised encrypted electronic record sharing services such as Healthlink;
- Having published guidelines for the use of mail, faxes and email for transmitting health records, which protect the privacy of the health information.

*The [HIP Code](#) Rule 5 outlines requirements and suggests guidelines for transmission of health information.*

## Retention and Disposal of Health records

### Retaining patient/client documentation

All health records must be retained for a minimum of 10 years from the day following the last day of the patient consultation.

Retention of records for longer than 10 years maybe required where the patient's condition warrants it (some orthopaedic or paediatric conditions etc).

*This is detailed in Regulation 5 and 6 of the [Health \(Retention of Health Information\) Regulations 1996](#). The [Public Records Act 2005](#) applies to most records held by government agencies. New Zealand Standards Health Records 8153:2002 provides requirements for all physiotherapists practising in New Zealand.*

*Rule 9 of the [HIP Code](#) outlines the requirements for retention of all health information related to an individual patient/client.*

### Disposal of patient/client documentation

Documentation must be disposed of in a manner which ensures its confidentiality. Privacy and security requirements must be met, and everything necessary and practicable must be done to ensure that the destruction of records is complete.

*The [HIP Code](#), Rule 5 outlines the requirements for disposal of health information related to an individual patient/client.*

## Transfer of patient/client documentation

Planning should take place to ensure responsibility for patient documentation is transferred if the practice closes for any reason, in keeping with their risk management policies and procedures.

- If a practice is sold, there should be a contractual negotiation between the proprietor and the purchaser for the transfer of the health records.
- In the case of planned closure, such as retirement, the physiotherapist should make arrangements for another practitioner to accept responsibility or for patients/clients to pick up their own records.
- In the case of unexpected closure due to such causes as illness, incapacity, suspension, deregistration, bankruptcy, or death, the physiotherapist should have arrangements for another physiotherapist or an attorney to take responsibility for the safe transfer of patient/client documentation in the best manner to maintain continuity of care.
- In the case of unexpected closure, such as natural disaster, every practical action should be taken to ensure security and retention of patient/client documentation.

*This is further detailed in Regulation 6,7 and 8 of the [Health \(Retention of Health Information\) Regulations 1996](#)*

## Disputes or complaints

In the event of a dispute or a complaint, the patient/client record may be the key source of information about what occurred in the physiotherapy/patient encounter, and a copy may be requested by disciplinary bodies. It is therefore imperative to maintain high quality records to recall why decisions were made, whether consent was obtained and what treatment was undertaken. Appropriate, and high quality patient/client records are therefore important for the safety of the patient and the physiotherapist.

### In summary:

*Patient/client records must:*

- *Represent an accurate record of the physiotherapist/patient encounter*
- *Include the date, patient symptoms, signs, diagnosis, treatment plan, information provided to the patient and consent given, and progress made.*
- *Be completed during treatment or as soon as possible after treatment*
- *Be legibly written and contain only widely accepted acronyms and abbreviations*
- *Not contain inappropriate comments, as records may be accessed by patient/clients*
- *Must contain sufficient detail to adequately represent the clinical reasoning and actions of the physiotherapist in the event of a complaint or dispute*

## Appendix

[Aotearoa New Zealand Physiotherapy Code of Ethics and Professional Conduct](#) (2011) in particular Principle 3

[On the Record](#) A practical guide to health information privacy. Office of the Privacy Commissioner (2011)

[Physiotherapy Competencies for Physiotherapy Practice in New Zealand](#) (2009) in particular: Competencies 2.11, 3.5, 4.3, 6.5, 6.6, 6.8, 9.1 and 9.2

Physiotherapy New Zealand's [Standards of Practice](#) (2012) "Documentation" pages 28-29

Standards New Zealand, [Health Records Standard](#) - 8153:2002