Professional risks & responsibilities
Defensible documentation

Good record keeping is a vital part of practice for all practitioners. It helps them provide high quality care over long periods of time and it contributes to continuity of care across multiple providers. There are also clearly defined legal requirements in maintaining up to date and thorough records.

But records are also crucial in the legal context. In the event of a complaint, or legal claim, they are the single most important piece of evidence. What has been recorded, or in many cases have not recorded, will be crucial in the defence and justification of your conduct.

In the event of a complaint or a claim, the issue is often less what you did, and more what you can prove you did. And if it's not in the records, it didn't happen (or, at least, it's harder to prove it happened).

There are several sources of guidance which can help practitioners, in particular the AHPRA shared Code of Conduct, and the Federal Privacy Act.

The AHPRA shared Code of Conduct requires practitioners to:

- keep accurate, up-to-date, factual, objective and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management in a form that can be understood by other health practitioners; and
- make records at the time of events or as soon as possible.

Similar guidance can be found in the Federal Privacy Act, which requires people collecting health information to take reasonable steps to ensure that the information being collected or disclosed is accurate, up to date and complete.

In practice, the important information when responding to a claim includes:

- Details of assessments, including results of any testing;
- A summary of the history and presenting concern;
- Discussions with client;
- Client instructions, including about their expectations for the service; and
- Advice and recommendations, including risks, pros and cons of various options.

It is critical that practitioners implement appropriate methods of recording the details of the assessment, testing, instructions from the client, advice to the client and any other relevant information.

As an example, a practitioner might provide some perfectly reasonable advice based on what the client told them about their impairments and needs. However, if you cannot prove what the client told you, or the facts and assumptions upon which the advice was based, the defence of that advice becomes difficult.

The same goes for any advice provided about risks of a particular treatment or equipment. The level of detail matters - a note of 'risks discussed' might not be sufficient evidence. If the client has specific questions or concerns, try to capture those and how they were addressed.

So, it is crucial to record not only any advice and recommendations, but the basis for that advice, whether it's client instructions, results of an assessment, reports from other practitioners or their medical records.

Another common problem is records not being contemporaneous. The strongest notes are those written at the time of the assessment. This isn't just because they provide the best evidence in response to a complaint, it's also required under the AHPRA shared code of conduct. So, write those notes at the end of clinical sessions whenever possible.

While we all acknowledge there can be practical obstacles to good record keeping, it is vital to ensure that practitioners implement a workflow that allows an accurate summary of the relevant information from sessions with clients to be recorded.

*Disclaimer – this advice is only general in nature and cannot be relied on as formal legal advice. If you require information and advice specific to your own situation, please contact your insurer and/or the OTA

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