FACT SHEET

Indicator C7.1>C Patient health records:

Inclusion of consultations and clinical related communications.

Indicator C7.1 > C supports the maintenance of comprehensive and complete patient health records to ensure the provision of high quality, accurate, safe and continuity of care. It is important that with each consultation at your practice or via a home or other visit, the patient health record is updated as soon as practical to ensure it contains accurate details of the consultation.

Complete patient health records provide the clinical team with reference to timely and accurate details to support informed care decisions while acting as a tool to effectively manage risk with reference to medical history and allergies for example.

The RACGP Standards also highlight that "medical defence organisations have identified that failure to follow up matters that patients have previously raised poses a considerable risk to practices and practitioners." As the saying goes 'it's better to be safe than sorry' so you must note all health advice given, treatment plans, medication and dosage, details of procedures, health summaries, follow-ups and outcomes while encompassing all details specified by the RACGP as deemed mandatory for inclusion.

The RACGP Standards 5th edition specifies that each patient's health record must be updated to include the f information contained in the checklist on the following page. The RACGP also suggests that maintaining a policy addressing the management of patient health information can support you in effectively managing, maintaining and updating your patient health records.

You may find it helpful to share this useful checklist with your clinical team to ensure everyone is always entering the required information into their patient health records:

INDICATOR C7.1>C
PATIENT HEALTH RECORDS: INCLUSION OF CONSULTATIONS & CLINICAL RELATED COMMUNICATIONS

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YOUR HELPFUL AGPAL PATIENT HEALTH RECORD CHECKLIST

To ensure you are providing your patients with high quality and safe care, it is vital that you accurately update their health record each time you see them for a consultation (either in your practice or via a home or other visit). Use this checklist below to make certain that you are entering all the required patient information each and every time.

- ☐ **Date of consultation**
- ☐ **Who conducted the consultation**
  This could be as easy as placing initials in the notes, or by audit trail in an electronic record
- ☐ **Method of communication**
  Was the consultation face-to-face, email, telephone or other electronic means?
- ☐ **Patient's reason for consultation**
- ☐ **Relevant clinical findings including history, examination, and investigations**
- ☐ **Allergies**
- ☐ **Diagnosis**
  (if appropriate)
- ☐ **Recommended management plan and, where appropriate, expected process of review**
- ☐ **Any medicines prescribed for the patient**
  (including the name, strength, directions for use, dose, frequency, number of repeats and date on which the patient started/ceased/changed the medication)
- ☐ **Patient consent for the presence of a third party brought in by the practice**
  This may include a medical student or registrar for example.
- ☐ **Record of patient emails**
  (if applicable)

In addition to the information that must be entered into a patient's health record following consultation, the 5th edition Standards recommend that it is helpful to note:

- Any referrals to other healthcare providers or health services.
- Medicines the patient takes that were not prescribed or advised by the practice
- Complementary and over-the-counter medicines (because many people now take complementary and over-the-counter medicines such as multi-vitamins that may react adversely with conventional medicines, you could document the patient's use of these as you would other medicines, whether prescribed by a member of the clinical team or reported by the patient).
- Any relevant preventive care information collected, such as currency of immunisations, blood pressure, waist measurement, height and weight (body mass index).
- Immunisations.
- An advance care plan.
- The presence of a third party brought in by the patient (e.g. carer).
- Any special advice or other instructions given to the patient.

INDICATOR C7.1>C
PATIENT HEALTH RECORDS: INCLUSION OF CONSULTATIONS & CLINICAL RELATED COMMUNICATIONS

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When writing, typing or scanning any information into a patient's health record, in order for it to be useful you should always be cautious of making sure it is legible. At times information scanned or faxed can become distorted or beautiful script handwriting may be difficult to read. Take the time to consider the legibility to others as this could be the difference in preventing or alleviating a medical emergency. If appropriate, you may need to re-enter information in the patient's notes section to ensure all information is easy to read and interpret.

As Indicator C7.1 >C is only one of seven Indicators contained within Criterion 7.1 Content of patient health records, your team must ensure they are demonstrating a holistic, effective and accurate approach to their patient health records by also familiarising themselves with all other six Indicator requirements. These relate to inputting details relating to demographic and emergency information, cultural and Aboriginal and/or Torres Strait Islander status, follow-up actions and outcomes, lifestyle factors and more.

To gain a comprehensive understanding of the entirety of Criterion 7.1 Content of patient health records, turn to page 77 of the RACGP Standards 5th edition (www.racgp.org.au). Maintaining accurate and comprehensive patient health records is a vital component of high quality and safe patient care across Australia. It is therefore important that your team manages this process efficiently and effectively to protect your patients and your team from any considerable risk.

Contact us

For any accreditation support contact your AGPAL Client Liaison team:

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