



dhcs | ACT

department of disability,
housing & community services

CLINICAL RECORDS

POLICY AND PROCEDURES

CONTENTS	PAGE
FOREWORD	3
INTRODUCTION	
FORWARD AND AUTHORITY	4
PURPOSE OF THIS MANUAL	4
SCOPE	5
AUTHORITY	5
DISTRIBUTION	5
LINKS TO OPERATIONAL AND LOCAL MANUALS	5
TYPES OF RECORDS	6
LEGISLATION	6
DEFINITIONS	6
GENERAL OVERVIEW	11
COLLECTION, USE AND STORAGE INFORMATION	11
PRINCIPLES	
PRINCIPLE 1: MANNER AND PURPOSE OF COLLECTION OF PERSONAL HEALTH INFORMATION	11
PRINCIPLE 2: PURPOSE OF COLLECTION OF PERSONAL HEALTH INFORMATION TO BE MADE KNOWN	12
PRINCIPLE 3: SOLICITATION OF PERSONAL HEALTH INFORMATION GENERALLY	13
PRINCIPLE 4: STORAGE AND SECURITY OF PERSONAL HEALTH INFORMATION	13
PRINCIPLE 5: INFORMATION RELATING TO RECORDS KEPT BY A RECORD KEEPER	13
PRINCIPLE 6: ACCESS TO HEALTH RECORDS BY PERSONS OTHER THAN THE CONSUMER	14
PRINCIPLE 7: ALTERATION OF HEALTH RECORDS	14
PRINCIPLE 8: RECORD KEEPER TO CHECK ACCURACY OF PERSONAL HEALTH INFORMATION BEFORE USE	15
PRINCIPLE 9: LIMITS ON USE OF PERSONAL HEALTH INFORMATION	16
PRINCIPLE 10: LIMITS ON DISCLOSURE OF PERSONAL HEALTH INFORMATION	16

PRINCIPLE 11: TRANSFER OR CLOSURE OF THE PRACTICE OF A HEALTH SERVICE PROVIDER	17
PRINCIPLE 12: TRANSFER OF CONSUMER TO ANOTHER HEALTH SERVICE PROVIDER OR OF HEALTH SERVICE PROVIDER TO ANOTHER PRACTICE	18
CLINICAL RECORDS	19
RECORD CONTENT	19
RESPONSIBILITIES FOR STAFF AND HEALTH SERVICE PROVIDERS	19
OBTAINING INFORMATION	20
SECURITY OF INFORMATION	20
CONFIDENTIALITY OF INFORMATION	21
ALTERATION OF RECORDS	22
STORAGE OF INFORMATION	22
ACCESS TO CLIENT RECORDS	22
ACCESS FEES	22
WRITTEN REQUEST	22
RESPONDING TO A REQUEST FOR ACCESS	23
FORMS OF ACCESS	23
RECORDS NOT AVAILABLE TO CONSUMERS	23
CONSENT BY MINORS	24
REQUESTS FOR INFORMATION BY RELATIVES OR OTHER VISITORS	24
INFORMATION SOUGHT BY ADOPTEE	25
ACCESS BY COURT AND AUTHORISED STATUTE	25
SUBPOENA/SUMMONS	25
NOTICE OF NON-PARTY PRODUCTION	26
PRIVACY ACT 1988 (ACT)	26
CORONERS ACT 1997	27
ACCESS AUTHORISED BY STATUTE	27
COMMISSIONER FOR HEALTH COMPLAINTS	27
REQUESTS FOR INFORMATION BY POLICE	27
SEARCH WARRANTS	28
OTHER FORMS OF ACCESS	28
ACCESS FOR MEDICO-LEGAL PURPOSES	28
REQUEST FROM A THIRD PARTY TO ACCESS CLIENT RECORDS	28
REQUESTS BY INSURERS	29
ACCESS FOR RESEARCH PURPOSES	29
ACCESS BY THE ACT GOVERNMENT SOLICITOR	30
REQUESTS FROM THE MEDIA	30
MEDICO-LEGAL CORRESPONDENCE	30
DISPOSAL OF CLINICAL RECORDS	31
DESTRUCTION OF RECORDS	33
PUBLIC ACCESS TO DEPARTMENTAL ARCHIVES	33
REVIEW	33
APPLICATION FORM – REQUEST FOR ACCESS TO INFORMATION	ATTACH A
PROCEDURES FOR GROUP HOMES – DISABILITY ACT	ATTACH B
GUIDELINES FOR FILE CONTENT – THERAPY ACT	ATTACH C

Foreword

I recommend this manual to the directors, managers and staff responsible for the active implementation, management and disposal of clinical records within Therapy ACT and Disability ACT. The collection and use of accurate health information is vital if the Department is to maintain the ability to promote and protect the health and wellbeing of the community. This manual will lay the foundation for a consistent approach to a clinical record management system across the portfolio.

Sandra Lambert
CHIEF EXECUTIVE

INTRODUCTION

FOREWORD AND AUTHORITY

This manual documents the policies and procedures for the effective implementation, management and disposal of clinical records for the Department of Disability, Housing and Community Services.

The Department supports the Minister in developing policies, allocating resources, administering legislation and evaluating health services for people with a disability and the developmental needs of children. While the Department is an important entity within the health system, it functions in an environment of partnership and collaboration with other stakeholders, including non-government and private health services, other government agencies and consumers.

To achieve these objectives and to provide effective service delivery the Department depends on accurate, efficient and confidential clinical records management.

It is imperative that management and staff maintain high levels of professionalism, integrity and confidentiality in all aspects of their work. Records must be created and kept about the development and management of treatment programs for people with a disability and children with regard to their development, including individual cases, policies, recommendations, special reports to Parliament and the handling of complaints by the Department. These records must be organised in a systematic way so that they can be retrieved over long periods of time.

PURPOSE OF THIS MANUAL

The aim of this document is to establish sound clinical records management based on the standards of best practice. The procedures documented in this procedure manual establish a consistent approach to the management of clinical records in many formats, including paper files, electronic records, clinical reports, legal advice and technical information, forms and selected printed materials. This manual includes detailed instructions on how the system should operate and outlines the tasks required to support an efficient clinical records management system.

The objective of this clinical records management system is to provide a common, shared source of information, which is accessible within security restrictions, to everyone who needs it, for as long as it is needed.

SCOPE

The clinical records management system covers all client records created in all disciplines of the Department.

The manual also covers procedures to support the records system, including:

- Responsibilities and accountabilities;
- Records management principles;
- Document handling;
- File construction;
- File classification and indexing;
- File movement recording;
- Quality measures;
- Retention schedule; and
- Disposal procedures.

That all staff:

- Create and maintain an accurate and complete set of client records, which document their decisions, policies and activities;
- Provide access to the official records by including them in registers and indexes; and
- Maintain the records in a secure manner, so that information can be found quickly when it is needed and respects the privacy of the individuals concerned.

AUTHORITY

This manual is authorised by the Chief Executive for use in Therapy ACT and Disability ACT. The Director (Organisational Services) is responsible for records management including responsibility for ensuring compliance with this policy. For enquires about this manual contact Tom Valentine on 6205 0273.

DISTRIBUTION

This manual is distributed to all departmental staff and is available on the Departmental Intranet along with all other record keeping documentation.

LINKS TO OPERATIONAL AND LOCAL MANUALS

This manual is complementary to the corporate and local operational manuals for other Units in the Department.

TYPES OF RECORDS

The Department creates many different types of records in all formats, such as client clinical records and medico-legal reports. All these are records which must be managed effectively.

This manual concentrates on the management of clinical records in any format index and location guide to all the record holdings of the Department. This will also provide a guide to disposal and off-site storage of records.

LEGISLATION

The principle legislation that relates to the management of clinical records includes:

- *Community and Health Services Complaints Act 1993*
- *Health Records (Privacy and Access) Act 1997*; and
- *Privacy Act 1988*

DEFINITIONS

The following definitions apply in relation to the contents of these procedures.

child, in relation to a person, includes an adopted child or stepchild of the person.

CLINICAL RECORD, refers to a record held by the Department containing personal or personal health information. This record includes records stored in a documentary or electronic form and includes photographs, pictorial or digital representation of any part of a patient, test results, medical imaging materials and reports and clinical notes.

collector means a person who, in the course of his or her profession, employment or official duty, collects personal health information.

commissioner means the commissioner for health complaints.

consent includes implied consent.

consumer means an individual—

- (a) who uses, or has used, a health service; or
- (b) in relation to whom a health record has been created;

and includes—

- (c) a person authorised by the consumer under section 13 (7) to have access to the health record;

- (d) where the consumer is a young person or a legally incompetent person—a guardian of the consumer; and
- (e) where the consumer has died—a legal representative of the deceased consumer.

deceased consumer means a deceased person who, before his or her death, was a consumer.

disability—see the *Community and Health Services Complaints Act 1993*.

factual matter, in relation to a consumer, means—

- (a) a history of the health, an illness or a disability of the consumer; or
- (b) any findings on an examination of the consumer in relation to the health, an illness or a disability of the consumer; or
- (c) the results of any investigation into the health, an illness or a disability of the consumer; or
- (d) a diagnosis, or preliminary diagnosis, of an illness or disability of the consumer; or
- (e) a plan of management, or proposed plan of management, of the treatment or care of an illness or disability of the consumer; or
- (f) any action taken (whether or not in accordance with a plan of management) by or under the direction or referral of a health service provider in relation to the consumer.

false representation means a representation that is—

- (a) false in a material particular; and
- (b) made—
 - (i) with knowledge that it is false in that particular; or
 - (ii) without belief that it is true in that particular.

guardian means—

- (a) in relation to a young person—a parent or legally appointed guardian of the young person; or
- (b) in relation to a legally incompetent person—a person who is—
 - (i) a legally appointed guardian of the legally incompetent person; or
 - (ii) an attorney, appointed under an enduring power of attorney that has become operative, of the legally incompetent person;

and who has power to make decisions about the medical treatment or health care of the legally incompetent person.

health record means any record—

- (a) held by a health service provider and containing personal information; or
 - (b) containing personal health information; or
 - (c) the clinical records held by Disability ACT and Therapy ACT
- and includes a part, or parts, of such a record.

health service means—

- (a) any activity that is intended or claimed (expressly or by implication), by the person performing it, to assess, record, improve or maintain the physical, mental or emotional health of a consumer or to diagnose or treat an illness or disability of a consumer; or
- (b) a disability, palliative care or aged care service that involves the making or keeping of personal health information;

but does not include any service that, under the regulations, is an exempt service.

health service provider means a person (including a body corporate, government agency or other body) that provides a health service in the ACT. This may include staff of a government agency who provide a health-related service to a client such as disability and therapy services.

health status report means a report—

- (a) that is prepared or substantially prepared—
 - (i) by a health service provider; and
 - (ii) in respect of a consumer who, at the time of the preparation of the report, resides or is present in the ACT; and
- (b) that relates to the physical, mental or emotional health of a consumer, or a disability or disease of a consumer; and
- (c) whose purpose, or main purpose, is not a health service for the consumer.

illness means a physical, mental or emotional illness, and includes a suspected illness.

immediate family member, in relation to a consumer, means a person who—

- (a) is—
 - (i) a parent of the consumer; or
 - (ii) a domestic partner of the consumer; or

- (iii) a child or sibling, at least 18 years of age, of the consumer; or

Note For the meaning of **domestic partner**, see Legislation Act, s 169.

(b) is—

- (i) another relative of the consumer; or
- (ii) a close friend of the consumer;

and a member of the same household as the consumer.

law of the Territory does not include this Act or the common law.

legally incompetent person means a person who is subject—

- (a) to an enduring power of attorney that has become operative; or
- (b) otherwise than as a person under the age of majority to a guardianship order.

legal representative, in relation to a deceased person, means a person—

- (a) holding office as executor of the will of the deceased person where probate of the will has been granted or resealed in Australia; or
- (b) holding office in Australia as administrator of the estate of the deceased person.

order of a court of competent jurisdiction includes a subpoena or similar process of such a court.

parent, in relation to a person, includes a step-parent or adoptive parent of the person.

personal health information, in relation to a consumer, means any personal information—

- (a) relating to the health, an illness or a disability of the consumer; or
- (b) collected by a health provider in relation to the health, an illness or a disability of the consumer; whether or not the information is recorded in a health record.

personal information, in relation to a consumer, means any information, recorded or otherwise, about the consumer where the identity of the consumer is apparent, whether the information is—

- (a) fact or opinion; or
- (b) true or false.

record means a record in documentary or electronic form that consists of or includes personal health information in relation to a consumer, and includes—

- (a) a photograph or other pictorial or digital representation of any part of the consumer; and
- (b) test results, medical imaging materials and reports, and clinical notes, relating to the consumer; and
- (c) a part, or parts, of any such record; and
- (d) a copy of any such record, part or parts;

but does not include research material that does not disclose the identity of the consumer.

record keeper means a person (including a body corporate, government agency or other body) that has possession or control of a health record.

sibling, in relation to a person, means a brother, sister, half-brother, half-sister, adoptive brother, adoptive sister, stepbrother or stepsister of the person.

treating health service provider, in relation to a consumer, means a health service provider who is involved in diagnosis, care or treatment of the consumer for the purpose of improving or maintaining the consumer's health.

treating team, in relation to a consumer, means health service providers involved in diagnosis, care or treatment for the purpose of improving or maintaining the consumer's health for a particular episode of care, and includes—

- (a) if the consumer named another health service provider as his or her current treating practitioner—that other health service provider; and
- (b) if another health service provider referred the consumer to the treating team for that episode of care—that other health service provider.

young person means a person under 18 years of age, other than a person who is of sufficient age, and of sufficient mental and emotional maturity, to—

- (a) understand the nature of a health service; and
- (b) give consent to a health service.

GENERAL OVERVIEW

Clinical records are the property of the Department and should be kept under adequate security and only removed from divisional units or associated services upon court subpoena, statutory authority, search warrant or coronial summons. However, clients have a right of access to their clinical records provided access does not lead to any harm on the part of the client or another person. No fees apply to right of access of clinical records.

The information given by a client to a treating health provider is given mainly for the purpose of the diagnosis and treatment of the client's condition. Other purposes for collecting such information include research and ongoing clinical education, health service planning, medico legal and quality assurance activities. Information may be shared across departmental line areas provided that information is used lawfully, and is reasonably necessary for the purpose for which it is to be used.

This information is contained in clinical records (primary) as well as in secondary records eg computer screens, computer printouts, registers, lists, indices and other reports containing clinical information.

All employees shall be made aware of the need to maintain confidentiality of information contained in these sources through the various line area Orientation Programs and through Line area in – service training programs.

COLLECTION, USE AND STORAGE OF INFORMATION

The collection of health information is governed by the *ACT Health Records (Privacy and Access) Act 1997* (the Act). Section 5 of the Act sets out a number of privacy principles that have the force of law. These principles are outlined below.

NB: These principles will not apply to all aspects of the work of the Department and some may have no relevance. This policy is an internal document – however, staff are asked to adopt best practice and to have regard to other Departmental policies and guidelines in regards to clinical records management.

PRINCIPLE 1: MANNER AND PURPOSE OF COLLECTION OF PERSONAL HEALTH INFORMATION

A collector shall not collect personal health information for inclusion in a health record or in a generally available publication unless:

- the information is collected for a lawful purpose that is directly related to a function or activity of the collector, and

- the collection of the information is necessary for or directly related to that purpose.

A collector shall not collect personal health information by unlawful or unfair means.

Where personal health information or health records are required to be collected by someone as part of his or her employment for the management, funding or quality of a health service received by the consumer, then that person is allowed access to the information only for those purposes, unless these Principles otherwise provide.

PRINCIPLE 2: PURPOSE OF COLLECTION OF PERSONAL HEALTH INFORMATION TO BE MADE KNOWN

Subject to clause 2 of this Principle, where:

a collector collects personal health information for inclusion in a health record or in a generally available publication, and the information is solicited by, the collector from the consumer concerned. The collector shall take such steps (if any) as are reasonable in the circumstances to ensure that, before the information is collected or, if that is not practicable, as soon as practicable after the information is collected, the consumer is generally aware of:

- the purpose for which the information is being collected;
- if the collection of the information is required or authorised by law – the fact that the collection of the information is so required or authorised;
- unless it is obvious from the circumstances of any health service provided - the identity of all members of the treating team, who will have access to the consumer's personal health information;
- the identity of any person to whom, or agency to which, the collector would, in accordance with the collector's usual practice., disclose the information for inclusion in a health record or in a generally available publication; and
- if it is, to the knowledge of the collector, the usual practice of any such person or agency to pass on such information to other persons or agencies – the identity of each of those other persons or agencies.

The collector is not required to notify the consumer of the identity of the individuals, or classes of individuals, who are employed by the collector and who are required for the management, funding or quality of the health service received by the consumer to handle health records or personal health information as part of their employment.

**PRINCIPLE 3: SOLICITATION OF PERSONAL HEALTH INFORMATION
GENERALLY**

Where:

- a collector collects personal health information about a consumer for inclusion in a record or in a generally available publication; and
- the information is solicited by the collector;
- the collector shall take such steps (if any) as are reasonable in the circumstances to ensure that, having regard to the purpose for which the information is collected;
- the information is relevant, up to date and accurate; and
- the collection of the information does not intrude to an unreasonable extent upon the personal affairs of the consumer.

PRINCIPLE 4: STORAGE AND SECURITY OF PERSONAL HEALTH INFORMATION

A record-keeper who has possession or control of a health record shall ensure that:

- the record is protected, by such security safeguards as are reasonable in the circumstances, against:
 - loss;
 - unauthorised access, use, modification or disclosure;
 - other misuse, and
 - if the record is given to another person – everything reasonable within the power of the record-keeper is done to prevent unauthorised use or disclosure of any information contained in the record.

PRINCIPLE 5: INFORMATION RELATING TO RECORDS KEPT BY RECORD-KEEPER

A record-keeper who has possession or control of health records shall, subject to clause 2 of this principle, take such steps as are reasonable in the circumstances to enable any consumer to ascertain:

- whether the record-keeper has possession or control of any health records, or personal health information, relating to the consumer; and if so-
 - the nature of the records or information;
 - the main purposes for which the records are, or the information is used; and
 - the steps the person should take if the person wishes to obtain access to the records or the information.

A record-keeper is not required to give a person information if, under a law of the Territory (including this Act) or a law of the Commonwealth,

the record-keeper is required or authorised to refuse to give that information to the person.

PRINCIPLE 6: ACCESS TO HEALTH RECORDS BY PERSONS OTHER THAN THE CONSUMER

A health service provider who is a member of a treating team may have access to the personal health information of a consumer so far as is reasonably necessary for the provision by that provider of a health service to that consumer.

If a person reasonably requires access, for the purpose of the management, funding or quality of a health service received, or being received, by a consumer, to personal health information relating to the consumer, the person may have such access, without the consent of the consumer, to the extent reasonably necessary for that purpose.

Except where required or authorised by:

- a law of the Territory;
- a law of the Commonwealth, or
- an order of a court of competent jurisdiction;
- a person or agency shall not require a consumer, whether directly or indirectly, to obtain or grant access to any health record relating to the consumer.

PRINCIPLE 7: ALTERATION OF HEALTH RECORDS

A person shall not delete information from a health record, even where it is later found or claimed to be inaccurate, unless the deletion is part of a program of archival destruction.

A record-keeper who has possession or control of a health record shall take such steps, by way of making appropriate corrections and additions as are reasonable in the circumstances, to ensure that the record is:

- up to date and accurate; and
- relevant to the purpose for which the information was collected or is to be used and to any other purpose that is directly related to that purpose.

Where:

- The record-keeper of a health record is not willing to amend that record, by making a correction or an addition, in accordance with a request by the consumer concerned; and
- No decision or recommendation to the effect that the record should be amended wholly or partly in accordance

with that request is pending, or has been made, under a law of the Territory (the Act) or a law of the Commonwealth;

- The record-keeper shall, if the consumer gives to the record-keeper a written statement concerning the requested correction or addition, take such steps as are reasonable in the circumstances to include the statement in the record.

Where the record-keeper accepts the need to amend the health record but:

- the record-keeper considers it likely that leaving incorrect information on a health record, even if corrected, could cause harm to the consumer or result in incorrect health care treatment or assistance being provided;
- The form in which the records is held makes correction impossible, or
- the corrections required are sufficiently complex or numerous for a real possibility of confusion or error to arise in relation to interpreting or reading the record if it were to be so amended:
 - The record-keeper shall place the incorrect information on a record which is not generally available to the consumer's treating practitioner or treating team, and to which access is restricted, and take such steps as are reasonable in the circumstances to ensure that only the corrected copy is generally available to the practitioner or treating team.

PRINCIPLE 8: RECORD-KEEPER TO CHECK ACCURACY OF PERSONAL HEALTH INFORMATION BEFORE USE ETC.

A record-keeper who has possession or control of a health record shall not use personal health information in that record without taking such steps (if any) as are reasonable in the circumstances to ensure that, having regard to the purpose for which the information is proposed to be used, the information is up to date and accurate.

Where a person gives information in confidence to a health service provider about a consumer, the provider shall:

- encourage the person to waive the requirement of confidentiality if the information remains confidential:
- records the information only if it is likely to assist in the treatment or care of the consumer; and

- take such steps (if any) as are reasonable in the circumstances to ensure that the information is accurate and not misleading.

PRINCIPLE 9: LIMITS ON USE OF PERSONAL HEALTH INFORMATION

Except where personal health information is being shared between members of a treating team to the extent necessary to improve or maintain the consumer's health or to manage a disability of the consumer, a record-keeper who has possession or control of a health record that was obtained for a particular purpose shall not use the information for any other purpose unless:

- the consumer has consented to use of the information for that other purpose;
- the record-keeper believes on reasonable grounds that use of the information for that other purpose is necessary to prevent or lessen a significant risk to the life or physical, mental or emotional health of the consumer or another person;
- use of information for that other purpose is required or authorised by:
 - a law of the Territory;
 - a law of the Commonwealth; or
 - an order of a court of competent jurisdiction;
 - purpose for which the information was obtained, or
 - health service, received by the consumer.

In relation to the sharing of information among a treating team, unless it is obvious from the circumstances or context of the health service, the co-ordinator of the treating team shall inform the consumer of the identity of all members of the treating team who will have access to the consumer's personal health information.

The treating team leader is not required to notify the consumer of the identity of individuals, or of classes of individuals, who are required for the management, funding or quality of the health service received by the consumer to handle health records or personal health information.

PRINCIPLE 10: LIMITS ON DISCLOSURE OF PERSONAL HEALTH INFORMATION

Except where personal health information is being shared between members of a treating team only to the extent necessary to improve or maintain the consumer's health or manage a disability of the consumer, a record-keeper who has possession or control of a health record shall not disclose the information to a person or agency (other than the consumer) unless :

- the consumer is reasonably likely to have been aware, or made aware under principle 2, that information of that kind is usually passed to that person or agency;
- the consumer has consented to the disclosure;
- the record-keeper believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent risk to the life or physical, mental or emotional health of the consumer or of another person;
- the discloser is required or authorised by –
 - a law of the Territory;
 - a law of the Commonwealth; or
 - an order of a court of competent jurisdiction;
- the discloser of the information is necessary for the management, funding or quality of the health service received by the consumer.
- obvious from the circumstances and context of the health service, the co-ordinator of the treating team shall inform the consumer about the identity of all members of the treating team who will have access to the consumer's personal health information.

The treating team leader is not required to notify the consumer of the identity of individuals or of classes of individuals, who are required for the management, funding or quality of the health service received by the consumer, to handle health records or personal health information. A person, body or agency to whom information is disclosed under clause 1 of this principle shall not use or disclose the information for a purpose other than the purpose for which the information was given to the person, body or agency.

Where there is an emergency and a consumer is unable to give or withhold consent to the disclosure of personal health information, the treating health service provider may discuss relevant personal health information with an immediate family member of the consumer to the extent that it is reasonable and necessary to do so for the proper treatment of the consumer.

Principle 11: Transfer or closure of the practice of a health service provider

This principle applies if the practice of a health service provider (in the principle called the “provider”) is, or is proposed to be:

Sold or otherwise transferred; or
 Closed down.

The provider or, if the provider is deceased, the legal representatives of the provider, shall:

Publish a notice in a newspaper circulating in the locality of the practice stating that:

- (the practice has been, or is about to be transferred or closed down (as the case may be), and
- the health records of the practice, other than those returned to a consumer or passed on to a nominated practitioner at the consumer's request, will be transferred to a specified person (being a person to whom paragraph 3 (a) or (b) of this Principle applies) at a specified address;
- take such other steps as are practicable to inform every such consumer;
- that the practice has been, or is about to be, transferred or closed down (as the case may be), and
- about the arrangements (as stated in the notice under paragraph (a)) for dealing with those health records.

Not earlier than 21 days after giving notice in accordance with clause 2 of this Principle, the person or persons giving the notice shall transfer each health record held by, or on behalf of, the practice:

- to the health service provider (if any) who takes over the practice;
- to a competent record-keeper for safe storage in the Territory (until such time, if any, as the record is destroyed as part of a program of archival destruction), or;
- to the consumer to whom the record relates or to a practitioner nominated by that consumer.

Subject to the restriction stated in clause 3 of this Principle, a person shall comply with the requirements of this Principle as soon as practicable. Despite any other provision of these Principles, a person who transfers a health record in accordance with this Principle does not, by so doing, contravene these Principles.

PRINCIPLE 12: TRANSFER OF CONSUMER TO ANOTHER HEALTH SERVICE PROVIDER OR OF HEALTH SERVICE PROVIDER TO ANOTHER PRACTICE.

Where:

- (a) a consumer transfers from one health service provider to another, or
- (b) a health service provider transfers from one practice to another and a consumer continues to see the provider;

- the record-keeper shall, on request, provide a copy of the consumer's health record, or written summary of it:
- if paragraph (a) applies – to the health service provider to whom the consumer has transferred, or
- if paragraph (b) applies – to the relevant health service provider.

CLINICAL RECORDS

There will be a clinical record maintained for every client seeking the services of Therapy ACT and Disability ACT.

There shall be a centralised clinical record management system within Therapy ACT and Disability ACT, where possible. Where there is a non-centralised record, the procedures contained in this policy will be followed by that area.

Records shall be maintained in accordance with the [\(Principals For Creation, Management, Storage and Disposal of Health Care Records\)](#) Department of Disability, Housing and Community Services Records Disposal Authority.

All observations made by the recorder concerning the client should be written without bias. A clear distinction should be made in the record with regard to observations made by the recorder and any information and/or opinions conveyed by the client or others.

All entries in the record must be written in ink within the sequential multidisciplinary progress notes or on other approved forms.

Clinical records are the property of the Department of Disability, Housing and Community Services and should be kept under adequate security and only removed from the Departmental locations upon subpoena, statutory authority, search warrant, Coronial summons or with the approval of the Divisional Executive Director. However, clients have a right of access to their clinical records provided access does not lead to any harm on the part of the client. No fees apply to right of access of clinical records.

RECORD CONTENT

That Health Provider, whereby the client's treatment is progressed, must document all occasions of client attendance by a Health Provider in the client's file.

RESPONSIBILITIES FOR STAFF AND HEALTH SERVICE PROVIDERS.

Recorded notes must be unambiguous and sufficiently detailed to ensure that;

- the client **is clearly identified;**
- The reason for the consultant's visit **is clear;**
- the client receives **effective continuing care;**

- the treatment team **has been effectively informed**;
- all information required for the effective delivery **of the client's care** is available to the consultant;
- another health provider can **conclusively** assume the care of the client;
- concurrent or retrospective evaluation of the client's care **is maintained; and**
- **the precise treatment and procedure is clear/complete.**

All entries must be legible, dated, signed (name printed as well) and designated. Entries by students must be counter signed by an appropriately qualified professional. Only those persons authorised can make entries in the client's progress notes.

Entries written in error **must** have only one line ruled through the incorrect entry; have "Written in Error" entered above or beside the entry, and the entry must then be **dated, signed** and designated.

No blank lines are to be left between entries.

Abbreviations that are identifiable may be permitted within the client record.

OBTAINING INFORMATION

Staff shall only collect information that is lawful and relevant to their function or activity. Further, the information must be directly related to or necessary for the purpose of collection. (in accordance with Principle 1)

Staff should inform clients that the collection of the information is authorised, the purpose for the collection and to whom such information may be passed. (Principal 2)

When collecting information, staff need to ensure that the information collected is relevant, up to date and accurate and does not intrude to an unreasonable extent upon the personal affairs of the consumer. (Principle 3)

Clients should be able to ascertain what records are held by the various Divisions, the nature of those records and the procedure for gaining access to those records. (Principle 5).

SECURITY OF INFORMATION

Clinical information and records shall be kept in a secure environment, and not left unattended in areas accessible by unauthorised individuals.

An authorised person, to ensure confidentiality is not breached, shall supervise the destination of any clinical information.

Computers shall be logged off when not in use and patient details are to be removed from the screen after accessing information. Passwords shall not be displayed and shall be accessible only to authorised persons. The use of generic passwords, is not permitted.

Photocopying or printing, of clinical information that may identify a patient, shall be limited to only the necessary information requested for the following reasons;

- persons/institutions treating the client outside of the sponsor health facility;
- The Department of Veterans Affairs for the purpose of compensating the patient;
- The attending physician for the preparation of medico-legal reports;
- Authorised bodies in relation to cancers and notifiable diseases;
- Reproduction of the clinical records for teaching/case presentations is prohibited. The photocopy must conceal the identification of the patient; and
- Authorised individuals under the *Health Records (Privacy and Access) Act 1997*.

CONFIDENTIALITY OF INFORMATION

The information given by a client to a health provider is to be treated as confidential and used only for the purpose for which it is collected. (Principles 8 and 9)

Access to the clinical record should be restricted to treating team currently involved in the continuing care of the client, to student health professionals enrolled in recognised teaching institutions or authorised health professionals.

Photocopies of records are not provided to staff except as approved by the Director. Where provided, copies are to be returned to the Director upon termination with the client. Copies will be destroyed by the Director.

The client's consent shall be obtained before clinical information (either clinical or personal) is disclosed other than;

- to members of a treating team of the client in order to maintain and manage the health of the client;
- if the consumer is reasonably likely to have been aware, or made aware that information of this kind is usually passed to a certain person or agency;

- disclosure is required by law; and
- disclosure is required for the management, funding or quality of the health service provided.

ALTERATION TO RECORDS

Any information held in clinical records, cannot be deleted or obliterated. In keeping with Principle 8 and the need to maintain accurate records, known errors should be corrected where possible. Incorrect entries should be identified as such with the correction signed and dated by the writer.

Where a consumer requests amendment or correction to their record, the record itself cannot be altered but a written statement to that effect from the consumer can be added to the record.

Privacy principal 7 prohibits the deletion of any information contained in a health record and outlines the methods for altering a health record if it is necessary to do so.

STORAGE OF INFORMATION

Departmental client records must be stored under adequate security at all times, whether in paper or electronic format. All staff are responsible for ensuring the safety of the records and confidentiality of the information held there in. Reasonable measures must be taken to prevent unauthorised access to the information.

ACCESS TO CLIENT RECORDS

ACCESS BY CLIENT

The *Health Records (Privacy and Access) Act 1997* (Section 12) provides patients with a legal right to access their clinical record.

ACCESS FEES

No fees apply to the access of clinical records by clients.

WRITTEN REQUEST

All requests for access to clinical records must be in writing. At **Attachment A** is an application form for access to information. The form is in two parts. Part A enables an applicant to seek access to information about a client and Part B enables the client to give consent to the release of information. Part B will not apply with respect to the following:

- Court Orders/Authorised Statute;
- Subpoena/Summons;

- *Coroners Act 1997*;
- Commissioner for Health Complaints;
- Search Warrants.

RESPONDING TO A REQUEST FOR ACCESS

Where a request for access to a clinical record is received the record must be reviewed to determine if the information is available and if the information can be provided. Within 14 days of receiving the request, the Director, Policy and Organisational Services must either:

- offer access with the details of where and when it is to be provided;
- give notice that the record cannot be produced and provide the reasons; and
- give notice that the record or part of the record is exempt from access and provide the reasons.

FORMS OF ACCESS

There are three forms of access provided by section 10(3) of the Act. The consumer can request access in any of these forms:

- Inspecting the record or a print out of the record;
- Receiving a copy of the record;
- Viewing the record and having the contents explained.
-

The choice of which form of access lies with the consumer. However, the record keeper can offer options to the consumer when the request is made:

- A record keeper can offer to discuss the record, even if an explanation has not been requested; and
- A record keeper may offer to provide a summary of the record rather than provide the whole record.

RECORDS NOT AVAILABLE TO THE CONSUMER

There are three circumstances where a health record or part of a record will not be made available to the consumer.

RISK TO THE CONSUMER

where the record keeper believes on reasonable grounds that the provision of the information would constitute a significant risk to the life or health of the consumer;

RISK TO ANOTHER

where the provision of the information would constitute a significant risk to the life or health of another person;

INFORMATION GIVEN IN CONFIDENCE

where the record or part of the record, consists of material or information given in confidence, to the person writing the record, then access would constitute a breach of confidence.

Information is considered to be confidential if a health record contains information that was given in confidence to the health provider, **other than** information given by the consumer, their guardian or another health service provider in the course of the provider's treatment to the consumer. A health record can also be considered confidential if, firstly, the consumer notifies the health provider that they request the information to remain confidential, second, this request is documented, and, thirdly, the consumer becomes a legally incompetent person or dies.

The requestor must be notified in writing of any decision to exempt all or part of the record and the reason for the exemption, noting the section of the Act that applies. Any such decision regarding exemption can be the subject of review by the Community Health Services Complaints Commissioner (who is responsible for all health related complaints) at the request of the consumer. The Commissioner's decision can also be subject to review by the Magistrate's Court.

CONSENT BY MINORS

Where the client is classified as a Young Person under the Act (under 18 years) or otherwise subject to a guardianship order, consent for access to information should be given by the client's parent or legal guardian.

Where a patient is under 18 years, the client may be provided with access without parental consent if the client is capable of giving informed consent. If a child has sufficient understanding to give consent to his or her own treatment, then the client is usually considered to be capable of consenting to access their record. The HEALTH PROVIDER MUST MAKE THE ASSESSMENT OF THE CLIENT'S CAPABILITY.

REQUESTS FOR INFORMATION BY RELATIVES OR OTHER VISITORS

In general, no information may be released without the client's consent. With the client's consent, information as to the location and general condition of the client may be given to relatives or other visitors. In advising of the client's condition, a general statement only should be given. Where a client requests that NO information be released, his or her wishes must be respected.

Where a client is a young person and the request for access to the client's clinical record is by a parent or guardian against whom an action in relation to child abuse may result, the treating health provider may refuse access if it could be prejudicial to the physical or mental health of the child.

Otherwise where a client is a young person, access to information may be given to family members provided approval has been given by parents or legally appointed guardians. Non-guardian parents seeking access to information will need the consent of a legally appointed guardian.

INFORMATION SOUGHT BY ADOPTEE

Access to a client's record cannot be given without the written consent of the client. Requests by adoptees for information from their parent's record must be refused under the *Health Records (Privacy and Access) Act 1997*.

However, in some circumstances, release of information may be authorised under legal Statute (e.g. *Adoption Act 1993* Part V). Any requests for access to information under the *Adoption Act 1993* must be in writing and provide specific details of the section authorising access and sufficient information to meet the necessary requirements of the Act.

ACCESS BY COURT ORDER AND AUTHORISED STATUTE

Section 5 of the *Health Records (Privacy and Access) Act 1997*, Privacy Principle 10, allows for the disclosure of health records when it is required or authorised by a law of the Territory, Commonwealth or an order of a court of competent jurisdiction.

SUBPOENA / SUMMONS

All Subpoenas for the production of Departmental clinical records are to be addressed to and served on the **Senior Manager, Strategic Policy and Organisational Governance** who will action the subpoena.

Subpoenas involving staff members should also be served on the Senior Manager, Strategic Policy and Organisational Governance who will then notify the appropriate staff member.

Subpoenas and summons are effectively the same. A subpoena refers to an ACT Supreme Court Order and a summons is the term used by the Magistrate's court. If a writ or Statement of Claim is inadvertently received it must be immediately directed to the Civil litigation Section of the Government Solicitor's Office.

Upon receipt of a Subpoena For Production, the Senior Manager will locate all necessary records as specified in the schedule of the Subpoena and forward, under adequate security to the Clerk of the Court in question. Records may be in paper or electronic format. (Clinical Record Information System) In both cases the original record shall be forwarded to the Court, for CRIS records a printout of the Imaged record shall serve as the original.

"Adequate security" should involve hand delivery of the clinical records, directly to the Clerk of the Court by an employee of the Department, or by registered post or by courier service.

NOTICE OF NON-PARTY PRODUCTION

Pursuant to order 34B(2) of the Supreme Court Rules, a party to an action can apply to the Registrar of the Supreme Court to issue a Notice requiring a person (or in our case, the Department of Disability, Housing and Community Services) to produce documents for inspection.

The documents required for inspection must be specified in the Notice for Non-party Production. The documents must be produced to the Applicant or the Applicant's solicitor within 14 days (or longer if specified in the notice).

All other parties to the action are served with a copy of the Notice of Non-Party Production. Any other party can inspect the documents for the purpose of deciding whether or not to make a claim to the Court for privilege or objection in relation to certain documents, before the Applicant inspects them.

The Department will provide copies of the documents produced to the Applicant (and any other parties) if requested.

PRIVACY ACT 1988 (ACT)

In circumstances where the *Health Records (Privacy and Access) Act* is silent regarding the disclosure of personal information, Information Privacy Principle 11 of the *Privacy Act 1988* can be relied on. This principle limits the disclosure of personal information to the following circumstances where:

- The individual is reasonable likely to have been made aware (or made aware under PI 2) that such information is normally passed to that person;
- The individual has consented to the disclosure
- The record-keeper has reasonable grounds to believe the disclosure is required to prevent or lessen a serious and imminent threat to life or health of the individual or some other person.;

- he disclosure is required or authorised under law; or
- he disclosure is reasonably necessary for the enforcement of criminal law or a law imposing a pecuniary penalty, or for the protection of public revenue.

CORONERS ACT 1997

Under Section 43 of the *Coroners Act 1997*, the Coroner may issue a Summons requiring a person to produce a document, including a Clinical Record, to the Coroners Court. This Summons must be complied with in the same manner as subpoenas and summons generally. Further, under Section 21 of the *Coroners Act 1997*, the Coroner may order the Department to provide the clinical records for the assistance of a post-mortem examination.

ACCESS AUTHORISED BY STATUTE

Before clinical records are released in response to a statutory demand, the precise authority of the person requesting access and the nature of the access requested should be checked to ensure that only material relevant to the statutory demand is released. If unclear about your obligations regarding a statutory authority, contact the ACT Government Solicitor's Office for advice.

COMMISSIONER FOR HEALTH COMPLAINTS

The *Community and Health Services Complaints Act 1993* provides the Commissioner with the authority to obtain records without the consent of the client. If client consent is provided this is a courtesy and not a legal requirement and therefore the three - month rule for a valid authority need not apply. *The Community and Health Services Complaints Act 1993* overrides Section 5 (1) of the *Ombudsman Act 1989* in relation to complaints about health services.

When requested by the Health Complaints Commissioner to supply information, the Director, Policy and Organisational Services should be informed as soon as possible. The ACT Government Solicitor should be informed at the same time.

REQUESTS FOR INFORMATION BY POLICE

Where the client has authorised police to have access to information from his or her health records, this may be supplied at no charge.

There is a common law obligation for a health provider to warn a third person or persons regarding a risk of harm posed by a client, if the health provider becomes aware, during the clinical management of a client, of such a risk. This may conflict with the health provider's duty of confidentiality to the client. If such a situation arises, the ACT Government Solicitor should be contacted for urgent advice.

SEARCH WARRANTS

Law requires compliance with a search warrant and data keepers are advised that they should inform their immediate supervisor of any official demand for access to data. The supervisor should notify the ACT Government Solicitor as soon as the warrant is served, if possible.

OTHER FORMS OF ACCESS

Requests for access by persons other than the consumer are governed by Principle 6, Section 5 of the *Health Records (Privacy and Access) Act 1997*.

ACCESS FOR MEDICO-LEGAL PURPOSES

The Senior Manager, **Strategic Policy and Organisational Governance** shall provide copies of clinical notes in response to requests for Clinical Reports. All such requests should be forwarded to the relevant line area for actioning. The line area (in this case Therapy ACT and Disability ACT) will maintain a Register of all requests, verify the client's authorisation, and copy appropriate documents.

REQUEST FROM A THIRD PARTY TO ACCESS CLIENT RECORDS

The client may authorise his solicitor, or a third party, to, have access to his or her clinical record. The client's original written authority no less than three months old is required. Where appropriate an original authority from the client's parent (if a minor) or legal guardian is required. If the client **is deceased**, authority from the **Executor of the client's will** or **Administrator of the client's estate**, must be presented before any information may be released. Faxed requests will be processed but the original authority and request must be received prior to dispatch of the documents.

The authority must contain sufficient detail to identify the client, the requestor and the records required and should include the following:

- Client's full name;
- Date of Birth;
- Present address (current and at the time of health treatment of interest.);
- The date of the written consent, which should be less than three months;
- The purpose for which access is sought;
- The records or information sought; and
- The dates between, which the nominated treatment of took place.

REQUESTS BY INSURER'S

All requests for access to clinical records/files requires the client's written authorisation. The authority must be dated within the last three months and should not have been revoked by the client. A photocopy of the insurance application or compensation claim form, signed and dated by the client, containing the client's consent to the disclosure of relevant confidential information, should be considered sufficient for the release to the client's insurer of information related to an insurance application or compensation claim.

ACCESS FOR RESEARCH PURPOSES

Access to health records for research purposes must be in accordance with Privacy Principles, 2, 9 and 10 of the *Health Records (Privacy and Access) Act 1997*, which limits the use and disclosure of Personal Health Information.

CLIENT DATA

Requests for information required for research activities, using client data in a Departmental clinical record or secondary data such as morbidity or statistics generated from these, should be made to the Director, Policy and Organisational Services prior to the commencement of the study.

Applications must be in writing and include the following information;

- name, qualifications and title of requestor/s;
- department or institution/organisation to which they report;
- statement of problem or purpose of study; (clarify statement of problem);
 - information required, time period to be included, methodology; (clarify methodology)
 - use to be made of results;
 - date required by; and
 - signature and date.

requests should be presented to the Director, Policy and Organisational Services in person and identification produced. The records Manager will direct the requests to the appropriate body for approval and will be available to provide advice on applications, approval times etc.

Statistical information and case studies, which do not identify the client and are for use only within the Department may be approved immediately.

Extensive studies, proposals where clients are to be contacted, or requests from personnel outside the Department, require the approval of the Chief Executive.

NON-CLIENT DATA

Requests for information for research purposes using non-client data should be made in writing and directed to the Director, Policy and Organisational Services.

RESEARCH REQUESTS BY STUDENTS

Applications from students to undertake research activities will be processed according to these guidelines on presentation of a written application countersigned by their Co-ordinator.

QUALITY IMPROVEMENT ACTIVITIES

Approval to collect data for quality improvement projects being undertaken by Departmental staff in their own areas is not necessary, unless the client is to be contacted. Projects overlapping into other areas require the approval of the relevant Department Senior Manager, or submitted through channels as outlined above.

ACCESS BY THE ACT GOVERNMENT SOLICITOR

Information and/or access to the clinical record may be given to the ACT Government Solicitor when acting on behalf of the Department. Release is to be made through the Senior Manager, **Strategic Policy and Organisational Governance**.

REQUESTS FROM THE MEDIA

No information about any particular client should be released without the client's express permission. Enquires should be referred to the Senior Manager, **Strategic Policy and Organisational Governance**.

MEDICO – LEGAL CORRESPONDENCE

Requests for clinical reports from solicitors, employers, insurance companies, other doctors etc. may be addressed to the Senior Manager, **Strategic Policy and Organisational Governance**.

All requests for information must be accompanied by a **current written authority (an authority must be dated within the last 3 months)** to release information, signed by the client (or parent or guardian in the case of minors and the next of kin in relation to diseased clients). The

only exceptions to this are when the request is from a health provider currently treating the client or from the client him/herself.

The Senior Manager will:

- Record the date of receipt on the top of the front page of the request;
- Read the request and highlight the information requested;
- Pass on the request to the Director of the appropriate line area;
- Enter relevant details in the Medico – Legal Correspondence Register such as date of receipt, name of client, name of requestor etc, and complete the statistics form in the front of the Medical Legal register. **Line areas should develop their own register if they don't already have one;**
- The request and the client file is then forwarded to the appropriate manager for the preparation of the report. The manager will either write the report or assign the appropriate staff to do so. This should be done within 30 days of the original request. Once the report is complete it should be returned to the Senior Manager.
- Affidavits when required should only be written by staff trained in the procedure;
- Photocopy the report and place on the patient file, the original of the report is then forwarded to the requestor; and
- The Medico – Legal Correspondence Register is completed, by notating the date the report was sent.

DISPOSAL OF CLINICAL RECORDS

POLICY

Information is useful for a certain period. Over time the need to refer to records diminishes, and records must be retired regularly. Otherwise records accumulate and it becomes harder to find information within the growing volume of records.

Retiring records is made easier by using pre-determined guidelines. This requires an understanding of the legal requirements for records

(which can be quite complex), and estimating the value of records. Some records can be destroyed very soon after they are created, while others will be valuable for many years and will be retained for as long as they can be physically preserved, effectively the lifetime of the paper.

Guidelines for the retirement of records are called disposal schedules. Disposal schedules indicate how long records are to be kept, whether records have archival values or how long they should be kept before they can be destroyed.

The Department has created a **Records Disposal Authority**. Some clinical records created by the Department are archival (whole of life) because of their intrinsic administrative, legal and historical value in documenting the clinical activities of the Department.

PLANNING

Disposal action should occur at regular periods to ensure that the records system remains efficient.

Retiring records is the responsibility of the Director, Policy and Organisational Services in conjunction with line area Directors or Executive Directors.

There are a number of steps to take before action can commence. These include:

- Acquire the appropriate disposal guidelines, in the form of a disposal schedule. This guides staff to know, what to keep and what to discard. Refer to the Departmental General Disposal Authority;
- Arrange space and staffing resources necessary to undertake the review and obtain equipment (such as storage boxes);
- Arrange the location for the storage of retired records;
- Alternatives include storing the records off-site. Off-site storage is preferred, however consideration should be given to the resources and costs associated the transportation to deliver and recall records;
- Ensure that staff are familiar with procedures for disposal and can complete box listings. Disposal processing of clinical records is the responsibility of the Director, Policy and Organisational Services in conjunction with line area Directors or Executive Directors; and

- Provide space within the local work area and/or off-site for the processing of files and boxes. It is important to provide adequate space to minimize any risk of injury if people fall over boxes and records left on the floor.

DESTRUCTION OF RECORDS

Under the authority of the Department's General Disposal Authority, the Director, Policy and Organisational Services will undertake regular destruction of records, which are no longer needed by the Department. When signed authorisation from the Director, the destruction of the records can proceed.

Destruction must be conducted in a manner, which meets the requirements of confidentiality. The destruction authority (**ACT Records Services**) should supply a certificate of confidential destruction to the Department as proof that the records have been appropriately destroyed. The Certificate of Destruction should be retained on file by the Director as a measure of accountability for the authorised destruction of its unwanted records. The file indexes should be updated to reflect this action.

PUBLIC ACCESS TO DEPARTMENTAL ARCHIVES (SEE ALSO ACCESS AND SECURITY)

Many records of the Department have archival value. These records will be preserved initially in the custody of the Department pending the Territory providing a more centralised facility.

Under archival legislation the public can access public records after 20 years (unless for certain exempt records eg Clinical Records). Specific records have a much longer restrictive access period eg certain health files are restricted for 80 years (in this case, check with ACT Health). The records do not need to be in the custody of the Department to allow public access.

The Department must notify the Territory of its intentions about public access to its records at the time of transfer to any archival custody. The agency, and, the archival authority must document this access agreement. Note that it is unusual for archived records to remain, fully restricted to public access.

REVIEW

This policy will be reviewed in December 2008.

ATTACHMENT A

CONSENT BY CONSUMER TO OBTAINING PERSONAL HEALTH INFORMATION UNDER SECTION 7 OF THE HEALTH RECORDS (PRIVACY AND ACCESS) ACT 1997

CONSENT TO RELEASE OF PERSONAL AND CLINICAL INFORMATION

NB: PLEASE READ THIS FORM CAREFULLY BEFORE SIGNING

PART A – Request to consumer by applicant

Name of consumer.....

Name of health service provider (Department) from whom personal health information is sought.....

.....

Name of person requesting personal health information.....

.....

Name of person or organisation applicant represents.....

.....

Address of person requesting personal health information.....

.....

.....

Details of personal health information requested or part of health record requested.....

.....

.....

Reason for requesting information.....

.....

.....

Signature of Applicant_____Date: / /

Name of Applicant_____

PART B – Request to record keeper by consumer

I understand that any personal health information about me is protected under the *Health Records (Privacy and Access) Act 1997* and may not be disclosed to a third party without my express consent. By signing this consent, I authorise the release of the information specified in this form.

Name of consumer.....

Name of health service provider (Department) from whom personal health information is sought.....

.....

Name of person/organisation requesting personal health information.....

.....

.....

Details of personal health information requested or part of health record I agree to be released to named person.....

.....

.....

.....

Name and address of person to whom I would like the information sent

.....

.....

.....

Signature of Consumer_____Date: / /

Signature of Witness_____Date: / /

Name of Witness_____

ATTACHMENT B

DISABILITY ACT - GUIDELINES FOR FILES MAINTAINED BY INDIVIDUAL SUPPORT SERVICES – GROUP HOMES

WHEN COMPLETING AND MONITORING INFORMATION ENSURE THE FOLLOWING STANDARDS ARE MAINTAINED. THIS INCLUDES ALL INFORMATION HELD IN THE OFFICE FILES AND AT SERVICE UNITS.

ALL FILES

All Office based files are to be folioed correctly

- Number sequentially
- Not more than 200 pages - if it is over 200 or close, is a new file ordered.
- If a large number of similar documents, eg file notes, are folioed then a date range should be noted on the entry.
- Double-sided pages should be folio number on both sides.
- All Folio entries should have the date of the document on the entry.

All File Notes / Entries / Documents are to be written correctly

- Written clearly and legibly.
- All file notes are dated and signed by the person completing the note.
- Each file note has been folioed.
- Notes should be written objectively, not subjectively.
- Documents should be signed, name of author printed below signature and the date of creation.

The file is in a satisfactory physical condition

- The file should not be bulging.
- The cover should not be torn or wearing.
- There should be a folio page inside the front cover attached to the office based file.

The language in the document is professional

- All entries in the file should be written professionally.
- All entries in the file should be written objectively, not subjectively.
- No inappropriate language is used in documents.

The office file system is secure and accessible to those who have access

- Each file should be in an individual separate suspension sleeve.
- The name of the file subject should be clearly visible in a tab on the suspension sleeve.
- The file should be in alphabetical order within the file system.
- The file system should be in a secure and have restricted access area.
- If a file is missing from the suspension sleeve, an entry is made in the file register to indicate who has the file and its location.

E-mails

E-mail is an important means of carrying out business in ACT government agencies. E-mail sent or received may contain information about business activities and can function as **evidence** of those transactions. As a result, it must be captured into the record keeping system.

E-mails **should not** be treated any differently to other business documents in paper format.

It is each **sender's responsibility** to capture the e-mail into the record keeping system by printing and placing the e-mail on file. E-mail messages can often become a string of replies. In this case, any person who is required to action the email and forwards it on to others is responsible for capturing the e-mail.

It is the **receiver's responsibility** to capture an e-mail record received from outside the organisation.

E-mail messages should be captured when they:

- Approve and /or authorise an action;
- Contain advice, guidance or direction;
- Relate to activities or projects being undertaken; and
- REPRESENT FORMAL BUSINESS COMMUNICATIONS BETWEEN STAFF AND/OR EXTERNAL RECIPIENTS.

EXTRACT FROM DH DEPARTMENT OF DISABILITY, HOUSING AND COMMUNITY SERVICES RECORDS MANAGEMENT PROGRAM RECORDS MANAGEMENT POLICY

1 OFFICE BASED FILES - CLIENT

Each file has a Client Information sheet

- This sheet is to be written clearly, with all sections completed, dated.
- This sheet should be protected inside a plastic sleeve on the top of the file

Each file has a copy of Client's Current Individual Plan

- Contained inside a plastic sleeve on the top of the file, not folioed.
- Part A – Profile with Client's photograph
- Part B, signed by guardians, keyworker, Management Representative (Network Coordinator, Network Manager or Senior Manager).
- Part C – Individual Plan Goals
- Individual Plan is no more than 12 months old.
- Copy of the Client Medical Profile to be updated annually.
- Respite Client files would only contain a current Respite Care Plan.

All Incident Reports are actioned and sent to Families / Guardians by the Network Coordinator

- Copies of Incident reports should be clear to read, not faded, darken the photocopier settings before copying the incident report.
- Copies of Part 1 (Details of the Subject of the Incident) and Part 3 (Management Report) should be stapled together and placed on the office file.
- Part 1 should be written clearly.
- Part 1 should have any immediate outcomes of the incident written in the Describe what happened section of the report.
- Part 3 – Senior Staff Member's Comments Section should have an action and be signed.
- Part 3 – Incident Outcomes should have a level selected. All relevant sections completed.
- A record of copies sent to Families / Guardians is located with the incident reports. If Families and Guardians have requested not to receive these documents, there is a letter stating this on the office based file.

All clients have their Individual Plan monitored on a monthly based through Keyworker Monthly Reports

- The original Keyworker Monthly Report should be folioed on file each 4 weeks, after the team meetings.
- Actions from the Team Meeting should be written on the Keyworker monthly Report.
- Each Report should be written clearly, have a progress comment for each goal.
- The Team Leader is to have signed the Keyworker Monthly Report.
- A copy of the Keyworker monthly Report is to be kept in the Individual Plan (IP) Folder for 3 months, then destroyed confidentially.

Guardianship Records are kept to ensure correct permission / authorisation is given. Where relevant a copy of guardianship Report should be folioed. The guardianship order reference number should be noted on the client's IP.

2 OFFICE BASED FILES - GROUP HOUSE

Each Group House is monitoring on a monthly basis for compliance with the Periodic Service Review (PSR) System.

- A completed PSR Monitoring booklet should be folioed within the last month.
- A completed PSR Action Plan should be folioed within the last month.

Staff Team Meetings are minuted.

- A copy of the Staff Team Meeting Minutes should be folioed within the last 4 weeks.
- The minutes should be written with clear actions, person responsible and timeframes for action completion.

Family / Guardian Meeting are minuted.

- Family / Guardian Meeting Minutes are folioed within the last 3 months.

Other Documents

- All documents should be folioed correctly to clearly identify the nature of the document.

3 HOUSE BASED FOLDERS

Client Folders

IP Folder

Section 1

- Copy of IP Part A – Profile – Original to be located in the front section of the office based file.
- LATEST GUARDIANSHIP PAPER, IF KEPT IN HOUSE. – OLD ONES TO BE ARCHIVED – ENSURE A COPY IS ON CLIENT FILE.
- LATEST INVENTORY, COPY HAVING BEEN SENT TO FINANCIAL MANAGER. OLD INVENTORIES TO BE ARCHIVED WHEN UPDATED.
- COPY OF CURRENT RISK ASSESSMENT TOOL COMPLETED BY THE KEYWORKER AT THE LAST IP MEETING OR REVIEW – ORIGINAL TO BE LOCATED IN THE FRONT SECTION OF THE OFFICE BASED FILE.
- IF A FACILITATED RISK ASSESSMENT WAS CONDUCTED PLACE COPY OF ASSESSMENT IN THIS SECTION. – ORIGINAL TO BE LOCATED IN THE FRONT SECTION OF THE OFFICE BASED FILE.

SECTION 2

- COPY OF IP PART B – ORIGINAL TO BE LOCATED IN THE FRONT SECTION OF THE OFFICE BASED FILE.
- COPIES OF ANY INSTRUCTIONAL LETTERS FROM GUARDIANS.- EG LETTER REQUESTING OR DISCOURAGING PARTICULAR ACTIVITIES. ORIGINALS TO GO ON CLIENT'S OFFICE BASED FILES.

SECTION 3

- IP GOALS
- IP PROGRESS NOTES – USE THE ONE PAGE FOR ALL GOALS. NUMBER GOALS ENTRIES FOR EASIER REFERENCE WHEN REVIEWING PROGRESS FOR KEYWORKER MONTHLY REPORTS AND IP REVIEWS.

SECTION 4

CURRENT IP WEEKLY PLANS

COPY TO BE PLACED IN THE FRONT SECTION OF THE CLIENT'S OFFICE BASED FILE.

SECTION 5

ANY BEHAVIOUR PLANS / PROTOCOLS AND RECORDING SHEETS FOR BEHAVIOUR PLANS.

COPIES OF PROTOCOLS AND PLANS TO GO ON CLIENT'S OFFICE BASED FILE.

SECTION 6

- ANY BUDGET WEEKLY SPENDING PLAN / PROTOCOLS DRAWN UP WITH FINANCIAL MANAGERS. *COPIES OF PROTOCOLS TO BE PLACED ON THE CLIENT'S OFFICE BASED.*
- ANY SPECIFIC COMMUNICATIONS REGARDING THE CLIENT'S BUDGETS AND EXPENSES. *COPIES TO GO ON CLIENT'S OFFICE BASED FILE.*

Section 7

Communication records with families and guardians - *Family and Guardian Contact record notes* - and Communication records with other agencies.

- To be filed on the client's office based files after 3 months.

Section 8

Tear out pages of incident reports for review on keyworker monthly reports to the guardians. These tear out pages can be destroyed confidentially after 3 month.

Section 9

Keyworker monthly reports. Following the staff team meeting the keyworker reports are to be copied.

- Original to be placed on client's file
- Copy to go to guardians, unless written into Section 2 above
- Copy to be kept in this section for 3 monthly until the IP review.

Section 10

Optional section. Many have used this section for employment, aCe program records, CLS, CAPS, Sharing Places etc. Letters received should be placed on the client's office based file and a copy remain in the folder for 12 months or less if minor issue.

IP – MEDICAL FOLDER

PART 1

THIS SLEEVE CAN BE LEFT AT THE HOSPITAL IF ADMITTED; THE REMAINDER OF

THE FOLDER IS TO RETURN WITH THE STAFF MEMBER AFTER ADMISSION.

Inside blue plastic medication sleeve

- Medication Signing Sheets
- Copy of IP Part A – Client Profile.
- Blank Treatment Summary Form
- Copy of Emergency Procedures and Disability Policy for Admission to and Discharge from hospital.

PART 2

SECTION 1 - MEDICAL PROFILE

INFORMATION FROM PAST MEDICAL INFORMATION IS KEPT HERE UNTIL THE PROFILE FORMS ARE COMPLETED. TO BE UPDATED ANNUALLY AT THE INDIVIDUAL PLANNING MEETING. A COPY OF THIS TO GO WITH THE IP ON THE FRONT OF THE CLIENT OFFICE BASED FILE.

SECTION 2

MEDICAL HISTORY – UPDATED ANNUALLY, A COPY TO GO ON THE CLIENT' OFFICE BASED FILE.

MEDICAL PROGRESS NOTES. TO BE PLACED ON THE CLIENT'S OFFICE BASED FILE ON A MONTHLY BASIS. ANY URGENT NOTE TO BE ADDED TO THE MEDICAL HISTORY FORM OR A COPY OF ENTRY KEPT IN THIS SECTION OF THE FOLDER.

SECTION 3

APPOINTMENT CHECKLIST

COMPLETED TREATMENT SUMMARIES. – ORIGINAL TO BE PLACED ON THE CLIENT'S OFFICE BASED FILE, A COPY TO BE KEPT FOR 6 MONTHS IN FOLDER OR LONGER IF SERIOUS ISSUE. NOTE ISSUES ON THE MEDICAL HISTORY FORM.

SECTION 4

TREATMENT CHARTS

THESE ARE GENERIC FORMS – SOME CLIENTS MAY NOT NEED THESE EACH MONTH. IDEAS FOR RECORDING:

- *DAILY PROTOCOL RECORDING, IF NECESSARY.*
- *DANDRUFF SHAMPOO*
- *THERAPY ACT RECORDINGS OF TREATMENT.*

SECTION 5

ANY CURRENT SPECIALIST REPORTS - ORIGINALS TO BE PLACED ON THE CLIENT'S OFFICE BASED FILE AND A COPY TO BE KEPT AT THE HOUSE FOR 12 MONTHS THEN CONFIDENTIALLY DESTROYED AFTER BEING NOTED ON THE CLIENTS MEDICAL HISTORY FORM.

SECTION 6

GENERAL MEDICAL REVIEWS ARE SUGGESTED ON A YEARLY BASIS. THIS IS TO BE DONE IN CONSULTATION WITH, AND WITH CONSENT FROM FAMILIES AND GUARDIANS. IT IS SUGGESTED THAT THIS BE DONE PRIOR TO THE

ANNUAL IP TO ALLOW ANY ARISING ISSUES TO BE ADDRESSED IN THE IP MEETING FORUM.

SECTION 7 - WEIGHT CHART

ANNUAL FORM DESIGNED FOR MONTHLY RECORDING OF WEIGHT. FILE ON THE CLIENT OFFICE BASED FILE IN JANUARY.

SECTION 8 - HEALTHCARE CHECKLISTS.

SOME CLIENTS MAY NEED MORE FREQUENT MONITORING OF SOME CONDITIONS DUE TO THEIR SUPPORT NEEDS. OTHER CLIENTS MAY ONLY NEED FORTNIGHTLY OR MONTHLY FULL OR PART CHECKS WITH THEIR PERMISSION. RECORD FOLLOW-UP NEEDED ON THE FORM. KEEP THE FORM IN THE FOLDER FOR 1 MONTH AFTER COMPLETION AND THEN PLACE ON OFFICE BASED FILE.

SECTION 9 - DENTAL INFORMATION

GENERAL OR SPECIFIC INFORMATION ON THE DENTAL NEEDS OF THE CLIENT. IMPORTANT INFORMATION SHOULD BE BRIEFLY NOTED ON THEIR MEDICAL HISTORY.

SECTION 10 - NUTRITION

THIS INCLUDES DIET PLANS – DESIGNED IN CONJUNCTION WITH NUTRITIONISTS / MEDICAL PROFESSIONALS – AND SPECIFIC ASSISTANCE NEEDED WITH MEALS. COPIES OF PROTOCOLS ARE TO BE IN THE CLIENT'S OFFICE BASED FILE.

SECTION 11 - MONTHLY MEDICATION AUDIT

CLIENT'S MEDICATION IS TO AUDITED BY THE DSO2 (TEAM LEADER) ONCE A MONTH, BY USING THE MEDICATION AUDIT TOOL THAT IS LOCATED IN THE MEDICATION PRACTICE AND PROCEDURAL GUIDELINES. THIS MEDICATION AUDIT IS TO INCLUDE ALL NON SCRIPTED /OVER THE COUNTER/NON WEBSTER PACK MEDICATION I.E. CREAMS, EYE DROPS ETC.

INDIVIDUALISED SECTION

THIS DEPENDS ON CLIENT NEEDS AND WHAT PROFESSIONAL NEEDS ARE RECORDED.

- Seizure Records – Yearly chart should be summarised and placed on the client's office based file in January.
- Toileting chart – Summaries to be placed on office based file and charts to be archived.
- Manual Handling Information – copies of protocols to be placed on the client's office based file.
- Continence Aids Assistance Scheme Records – Records to be sent to the Financial Manager after the financial year.
- Diabetes Information - Blood Sugar Levels – Summaries to be paced on client's office based file, charts to be archived after 12 months.
- Specific Protocols – copies to be placed on client's office based files
- Sleep Record Chart – summaries to be placed on client's office based files, charts to be archived after 12 months.

- Bruising Chart – To be placed on client's office based file after follow up has been completed and recorded.
- Information on relevant syndrome. – To be kept in this folder, review and update as necessary.
In the sleeve pocket at the back of the folder, is the location for old medication records, to be filed after 6 months on the client's office based file.

HOUSEHOLD PSR SYSTEM FOLDERS

4 GENERAL INFORMATION FOLDER

SECTION 1 - TRAINING NOMINATIONS

CURRENT, ONCE TRAINING IS FINISHED TO BE REMOVED AND DESTROY.

SECTION 2 - STAFF NEWSLETTERS

STAFF ISSSU – KEEP FOR 6 MONTHS AND THEN DESTROY.

SECTION 3 - STAFF FACT SHEETS

*ISSUED STAFF FACT SHEETS. KEEP UNTIL UPDATED AND THEN DESTROY.
STAFF INFORMATION ON CURRENT ISSUES SENT OUT. KEEP FOR 12 MONTHS AND THEN ARCHIVE.*

SECTION 4 - MINUTES

IMPORTANT MINUTES SENT OUT OF PROTOCOLS. – STAFF TO INITIAL THESE MINUTES AFTER READING. KEEP FOR 12 MONTHS AND THEN ARCHIVE.

5 MEETING FOLDER

SECTION 1 - STAFF MEETING MINUTES

*RETAIN COPIES OF MINUTES FOR 6 MONTHS THEN CONFIDENTIALLY DESTROY.
ORIGINAL MINUTES TO BE PLACED ON HOUSE FILE AFTER THE MEETING.*

SECTION 2 - DSO2 MEETING MINUTES

KEEP FOR 3 MONTHS, THE CONFIDENTIALLY DESTROY. DISSEMINATE AT STAFF TEAM MEETINGS.

SECTION 3 - COFM MEETING MINUTES - PARENTS/ GUARDIAN MEETINGS.

KEEP FOR 6 MONTHS THEN CONFIDENTIALLY DESTROY. ORIGINAL TO GO ON GROUP HOUSE OFFICE BASED FILE.

SECTION 4 - CLIENT MEETING MINUTES

TO BE DISCUSSED AT STAFF MEETINGS, ATTACHED TO THE MINUTES AND FILED AS PER MINUTES.

6 DAILY HOUSE INFORMATION FOLDER

SECTION 1 - HANDOVER FORMS

HANDOVER CHECKLIST AND UPDATE FORM ARE TO BE REFRESHED AND SENT TO NETWORK COORDINATORS ON A FORTNIGHTLY BASIS.

SECTION 2 - CURRENT ROSTER

COPY OF WORKING ROSTER FOR THAT FORTNIGHT AND NEXT FORTNIGHT. COPIES OF THE ROSTERS ARE TO BE SENT TO NETWORK COORDINATOR AS PER DOCUMENT PACK PROTOCOLS.

SECTION 3 - CURRENT BACKFILL AND SHIFT ALTERATION FORMS

COPY OF WORKING BACKFILL FOR THAT FORTNIGHT AND NEXT FORTNIGHT. ANY SHIFT ALTERATION FORMS FOR THE CURRENT AND NEXT FORTNIGHT. APPROVAL NEEDS TO BE SOUGHT FROM LINE MANAGERS FOR ALL SHIFT ALTERATIONS. FORMS TO BE SENT TO NETWORK COORDINATOR AS PER DOCUMENT PACK PROTOCOLS.

SECTION 4 - LOCATION OF FORMS SHEETS.

LISTS LOCATION IN HOUSE OF FORMS. UPDATE ON A 6 MONTHLY BASIS AND CONFIDENTIALLY DESTROY OLD COPY.

SECTION 5 - MENU PLANS

COMPLETED MENU LIST ARE TO BE KEPT IN THE FOLDER FOR 3 MONTHS THEN ARCHIVED.

SECTION 6 - PHONE NUMBERS

CONFIDENTIALLY DISPOSE OF OLD PHONE LISTS WHEN UPDATED.

SECTION 7 - HOUSE ROUTINES

HOUSEHOLD ROUTINES. COPY OF ROUTINES TO BE PLACED ON THE GROUP HOUSE OFFICE BASED FILE WHEN UPDATED.

7 MAINTENANCE FOLDER

SECTION 1 - KEY REGISTER

FORM ISSUED WITH PSR IMPLEMENTATION. REGISTERED TO BE UPDATED ANNUALLY, OLD REGISTER TO BE ARCHIVED.

SECTION 2 - ASSETS REGISTER (HOUSE INVENTORY)

INVENTORY OF ALL ITEMS OWNED BY DISABILITY ACT, INCLUDING MODEL NUMBERS WHERE NEEDED. COPY TO BE PLACED ON GROUP HOUSE OFFICE BASED FILE.

INVENTORY OF ALL HOUSEHOLD ITEMS WITH MODEL AND SERIAL NUMBERS. TO BE UPDATED ANNUALLY AND OLD DOCUMENT IS TO BE ARCHIVED.

SECTION 3 - EQUIPMENT SERVICE RECORD

ALL EQUIPMENT THAT NEEDS SERVICING TO BE NOTED HERE. GIVE DETAILS OF SERVICE GROUP PHONE NUMBERS AND HOW OFTEN SERVICES ARE NEEDED. SERVICE RECORDS ARE TO BE FILED IN THE GROUP HOUSE OFFICE BASED FILE. COPY TO REMAIN IN FOLDER FOR 12 MONTHS.

SECTION 4 - CAR MAINTENANCE RECORDS

CAR MAINTENANCE SHEETS ARE PART OF HOUSEHOLD REPORT TO NETWORK COORDINATOR IN SUPERVISION. COMPLETED FORMS TO BE KEPT FOR 3 MONTHS AND ACTIONED AS REQUIRED THEN ARCHIVED.

SECTION 5 - MAINTENANCE RECORDS.

FORM PROVIDED IN PSR IMPLEMENTATION. TO BE KEPT FOR 12 MONTHS AND THEN FILED ON THE OFFICE BASED FILE.

SECTION 6 - COMPLETED FIRE DRILLS

FIRE DRILLS ARE PART OF HOUSEHOLD REPORT TO NETWORK COORDINATOR IN SUPERVISION. COPIES TO BE KEPT IN THIS FOLDER FOR 3 MONTHS, ORIGINAL TO BE DISCUSSED AT THE TEAM MEETING AND ATTACHED TO THE MINUTES AND FILED AS PER MINUTES..

SECTION 7 - HOT WATER REGULATOR INFORMATION

COPIES OF HOT WATER CHECK RECORDS TO BE KEPT HERE FOR 2 YEARS, ORIGINALS TO BE PACED ON GROUP HOUSE OFFICE BASED FILE.

Periodic Service Review Folder

Section 1 - Audit Outcomes - Copies of the summary sheets presented at the team meetings and the monthly action plan are to be placed here after the team meeting. These are to be culled confidentially after 6 months.

Section 2 - Monitoring Records - Copies of completed audit forms are to be placed once they have been entered into the computer, original filed and returned to the house.

Section 3 - Guidelines - Information on completing PSR audits and flow charts.

Section 4 – STANDARDS – A COPY OF THE CURRENT PSR STANDARDS DOCUMENT.

Section 5 - Local Standards (optional at this stage) - Location for Unit PSR's and summaries.

Procedural Update Folder

ANY ISSUES TO THIS FOLDER ARE TO BE ACTIONED IMMEDIATELY UPON RECEIPT OF THE UPDATE PACK.

Diary, Communication Book and Financial Handover Record

INFORMATION CONTAINED IN THESE BOOKS IS TO FOLLOW THE GUIDELINES PROVIDED IN THE PERIODIC SERVICE REVIEW SYSTEM.

THERAPY ACT - Guidelines for File Content

General

These guidelines cover client files organisation and content requirements for Therapy ACT. All documentation and notes to be in book form.

Cover

- Intake /registration sheet (staple to inside cover)

Front

- Client Details form (contact details. Diagnosis, medical intervention) medication
- Key Information form (Note re any addition to file eg referral/reports, significant events in clients / family's life)
- Consent form (Original with signature)
- Taxi application form
- Photo/video/audio consent form

Divider 1 (REFERRAL DOCUMENTATION)

- Documentation relating to original referral
- Correspondence relating to referral
- Other external agencies referrals eg letters to Fabric, Respite Care, TASC, TCH videofluoroscopy, Wheelchair and Posture Clinic, Dietician, TAD
- Internal referrals to other disciplines
- Family / client information forms
- School questionnaire
- Speech Pathology / Physiotherapy Drop In forms

Divider 2 (ADMINISTRATIVE CORRESPONDENCE)

- Originals of outgoing correspondence, emails, letters (Photocopy the original and sign both). Correspondence is defined as letters that are for administrative purposes only eg appointment times, offer of group. No specific client information should be contained in the letter.
- Incoming correspondence (administrative as above)

Divider 3 (FORMAL REPORTS / PLANS)

Reports are defined as any documentation that makes a comment about a client's skills/ condition/ needs. Therefore if a letter is written that contains this information it is considered a report. (Incoming and outgoing) eg Paediatrician, Aus. Hearing Service, Medical Specialists, School Counsellors, psychologist

- Individual Plans
- Care Plans – Intervention Plans
- Respite Assessment Summary
- Client Management forms
- Team Plan of Action
- Multidisciplinary reports
- Individual Discipline reports
- Reports received from other sources
- Clinical Case Reviews

Divider 4 (PROGRESS NOTES)

- On site teams to keep consecutive notes across all disciplines
- Consecutive notes to be signed (name printed), dated after each occasion of service, and discipline identified. Continuous notes – discipline of author needs to be written in the date column under date
- Areas where therapist on a different site for service delivery eg Special School, Group homes, Speech Pathology outreach (Kippax and Civic) to keep separate progress notes. Where all disciplines in a team keep separate notes coloured pages for each discipline to be used. Social Work to maintain separate notes (green pages) Team program notes may be kept on computer progress notes.

Divider 5 (TEST PROTOCOLS/ OBSERVATION RECORDS)

- Test forms/ protocols and checklists
- Home program/ activity suggestions/ school programs
- Intervention Protocols (Mealtimes, equipment use, mobility strategy)
- Work samples (name of client, date)

Divider 6 (EQUIPMENT)

- Information about any equipment purchased or suggested for the client
- Equipment requests
- Purchase dates, contact details
- Maintenance schedules
- Provider warranty
- Correspondence requesting funding for equipment eg nappies, formula, continence aids, transport vehicles, wheelchairs, home modifications, communication aids, meal time equipment
- Augmentative and Alternative Communication (AAC) eg PECS signs / signs

All pages are to have the client's name, date of entry, signature and discipline of person making the entry.

Use **black** or **blue** pen, whiteout **must not** be used. Errors are to be crossed out (single line), dated and signed. Lines to be put through any blank lines and spaces and signed. No spaces are to be left between entries.

8 HISTORY

<u>DATE</u>	<u>VERSION</u>	<u>Comments</u>	<u>Officer</u>
Date Here	1:00	File Content	Pauline Brown