It is imperative that exercise and sports science professionals follow best practice record keeping and clinical note taking processes to avoid adverse clinical, ethical or legal ramifications.

Accurate and complete case notes are a requirement of many regulatory bodies, and may also be drawn upon following any accusation of malpractice against a health professional. Many cases that proceed to litigation may occur a significant time after treatment, when a health provider’s memory of the treatment provided is less clear. Detailed clinical notes can often become the only reliable method of documenting what transpired, providing defence in a complaints scenario against a health professional.

The following points highlight some important considerations and best practice processes for health professionals to ensure effective record keeping.

1. ACCURATE AND COMPLETE CASE NOTES AND CLIENT RECORDS

Clinical notes are an essential component of a patient’s treatment session, whereby information should be accurate, objective, and necessary only for the purpose at hand. The ESSA National Code of Conduct highlights that the “maintenance of complete and accurate records is essential to the proper and professional conduct of the practice of an Exercise and Sports Science Professional”. Importantly, the patient’s clinical record must be contemporaneous, whereby the health provider must complete the clinical notes at the time the service was rendered (or initiated as soon as practicable afterwards). A practitioner should never alter previous clinical note entries. However, record review and information updating pertinent to the intervention process is appropriate.

Important details to include in your patient’s clinical notes include:

- Patient history and clinical details (e.g. name, presenting condition(s), medications, precautions and contraindications).
- Details of the contractual relationship.
- Dates that the service was rendered/initiated, including written and telephone correspondence.
- Patient appointment no-show, cancellation or late arrival.
- Practice location if other than the primary place of business.
- Reports of abuse, threats of self-harm or other highly concerning issues that meet provider legal responsibilities for duty of care.
- Details of supervision, consultation and coordination of patient care (e.g. liaising with other health professionals).
- Patient assessment and intervention plan (anticipated type, number and/or frequency of services and expected outcomes or results of the treatment regime).
- Patient progress toward established goals.
- Details of any aids or appliances required.
- Clinical judgements and conclusions, this may include evidence to support professional actions and demonstrate professional competence.
- Session termination details (plan for next appointment, review period or referral to another practitioner).
- Pre and post intervention warnings, instructions or advice provided to the patient. This includes communication regarding treatment options and costs, and any subsequent changes of the treatment plan.
- Patient written informed consent.

SOAP notes are a useful format for documenting the progress of a patient during treatment and are generally the approach preferred by many regulatory bodies. SOAP is an acronym for Subjective, Objective, Assessment and Plan.

- Subjective: what your patients says about the problem/intervention.
- Objective: your objective observations and treatment interventions (e.g. validated outcome measurement, diagnosis).
• Assessment: your analysis of the various components of the assessment.
• Plan: how the treatment will be developed to reach the goals or objectives.

2. KEEPING CLIENT RECORDS
Ethical standards require that patient records be kept confidential, secure, and free from unauthorised access. Health professionals are required to keep client records for a minimum of seven years since last client contact, unless legal or other requirements specify otherwise.

3. PRIVACY
The relationship between a health professional and client should be based upon confidentiality and trust. Health professionals should use several strategies to protect client records and transmission of confidential information, particularly with modern advances in information technology.

As highlighted by the ESSA Code of Conduct, “an Exercise and Sports Science Professional must not, save as required by Law, disclose Client information obtained professionally to any third party without the informed and written consent of the Client…” Exceptions and limitations of that principle include lawful requests made by any Regulatory Body, investigating authorities, or any other party entitled to records. Health professionals should inform the client in advance of such limitations of confidentiality.

Any released patient information should be marked Private and Confidential, and state that the information may not be released to anyone else. Confidential information obtained from another professional should not be released. Other strategies to protect client privacy include password protected or encrypted client files on a computer, avoiding storage of patient clinical information on unsecure cellular phones and devices and making provisions for protecting confidentiality in the disposal of client records.

4. REGULATORY BODY REQUIREMENTS
Regulatory bodies such as Australian Sports Anti-Doping Authority, Department of Veterans’ Affairs (DVA), Medicare Australia and Workers Compensation and health insurance agencies require health professionals to meet best practice clinical record keeping guidelines.

For example, DVA requires a health care provider to formulate a written Patient Care Plan following the first consultation with each entitled person, which should be revised with any changes in the entitled person’s clinical circumstances.

The Nationally Consistent Approval Framework for Workplace Rehabilitation Providers mandates certain clinical record keeping standards that treatment providers must meet within the Workers Compensation system. Specifically, this includes completion of comprehensive, accurate and accessible records pertaining to all clients and security of stored records in accordance with legislative requirements.

In many cases, regulatory bodies can request providers supply a copy of their clinical notes to substantiate billing of services or during annual random audits of treatment providers.

5. MANAGEMENT OBLIGATIONS
Managers play an important role in supporting and facilitating effective administrative record keeping in businesses. It is important managers articulate expectations of staff for record keeping that will enable communication, coordination and continuity of care and meet requirements of professional and regulatory bodies.

Staff should be provided with the support and resources needed to undertake their duties effectively. With respect to adequate record keeping this may include management provision of training and professional development, policies and procedures regarding record keeping, including record keeping responsibilities in employee job descriptions and performance criteria, a staff code of conduct that includes expected behaviours and legal responsibilities, and appropriate security systems to protect records.

FINAL POINT
Always keep in mind that clinical notes may potentially be requested by a third party such as a patient, another health professional, regulatory body or legal team. Insufficient or incomplete patient records risks a lack of protection in the unfortunate event of an adverse patient outcome, or worse, accusation of malpractice.