2014

Massage Association of Australia Ltd
PO Box 2019 | Moorabbin VIC 3189
+613 9555 9900 office | +613 9555 9904 fax
office@maa.org.au email | www.maa.org.au web

Accredited Members
STANDARDS OF PRACTICE GUIDELINES

[MANAGEMENT OF CLIENT/PATIENT RECORDS]

The following guidelines, relating to the professional, legal and clinical requirements for keeping adequate client/patient records are provided to assist MAA accredited member therapists in clinical decision making.

This document should be read in conjunction with relevant provisions of the Commonwealth Privacy Act 1988 Act No. 13, 2013 and State Privacy and Health Records Acts

These guidelines are developed to provide guidance to MAA accredited member therapists or those seeking to become MAA accredited member therapists as to the minimum standards for clinical record-keeping. They apply to all MAA Accredited Member therapists and students and any personnel working under supervision in the practice of Massage Therapy / Remedial Therapy / Myotherapy.

These guidelines will be used in an investigation or other proceedings related to MAA Accredited Member therapists as evidence of what constitutes appropriate professional conduct or practice.

PRINCIPLES

- Standards in this section relate to all accredited member practices in all settings.
- For professional and legal reasons a MAA accredited member therapist is required to keep and maintain adequate client/patient records which clearly reflect the course of client/patient management.
- Records should be accurate, legible, and comprehensive so that a reviewer of these records can establish the essential relationship between the client/patient and the therapist in terms of past, present and future health care.
- Records are usually the only tangible evidence of examinations, findings and care provided.
- Relevant clinical findings, both positive and negative, should be recorded.
- Record keeping styles may vary from practitioner to practitioner.
- The health care record contains confidential information which, as a matter of law, should not be released except on the express consent of the client/patient or pursuant to a court order, a Health Fund direction or otherwise as compelled by law.
- The taking and recording of informed consent is an important aspect of record keeping.
- The larger the chart the more you tend to write - use large charts.
- Take notes while clients/patients give their history. Doing it from memory later is less detailed and less accurate.
- The general quality and content of client/patient records addresses client/patient safety issues and the purpose of the client/patient records is to create a comprehensive and accurate record

THE IMPORTANCE OF ADEQUATE RECORDS

MAA accredited member therapists are required to adhere to the **Private Health Insurance (Accreditation) Rules 2011 as amended 3rd January 2013.**

MAA accredited member therapists are specifically guided to Rule 10 of the Private Health Insurance (Accreditation) Rules 2011:

Rule 10:

10. Treatments provided by other health care providers

If the treatment is provided by a health care provider who is not referred to in subrule 7(1) or rule 8 or 9, the standard for that treatment is that the health care provider providing the treatment must be a member of a professional organisation which covers health care providers who provide that type of treatment (the ***profession***) and which:

(a) is a national entity which has membership requirements for the profession; and

(b) provides assessment of the health care provider in terms of the appropriate level of training and education required to practise in that profession; and

(c) administers a continuing professional development scheme in which the health care provider is required, as a condition of membership, to participate; and

(d) maintains a code of conduct which the health care provider must uphold in order to continue to be a member; and

(e) maintains a formal disciplinary procedure, which includes a process to suspend or expel members, and an appropriate complaints resolution procedure.

MAA accredited member therapists are specifically guided to the Terms and Conditions provided by each Health Fund relating to the Recognition of Providers for services to their members. For the purposes of these Guidelines, specific attention is drawn to the requirements of Receipting and Invoicing and Management and Maintenance of Client/Patient Records.

Adherence to the requirements of the Standards of Record Keeping offers protection in the event of a Health Fund Audit of your records of treatment and care of their members. If your Standards of Record Keeping is found to be lacking the Health Fund may revoke your Provider Number and you will no longer be able to provide the required service to their members.

Adhering to the requirements of the Standards of Record Keeping offers protection in the event of a complaint being laid against you or the treatment you have provided:

- Courts usually take the view that if there is nothing in the chart to support a therapist's contention that a certain action took place. (E.g. client/patient informed of certain risks), then that action is deemed not to have taken place at all.

- Legal actions typically take three to four years to be heard in court. Because of the limitations of the human memory, the record provides reliable details of the client/patient's care.

- Many legal actions may be nuisance claims. Accurate, legible and timely documentation can result in the early dismissal of these claims, thereby reducing the stress of the therapist.

Adherence to the requirements of the Standards of Record Keeping offers protection in the event of a complaint to MAA being laid against you. Therapists are drawn to their Membership Code of Conduct and the MAA Constitution Rules:

Code of Conduct - The Public Interest:

- Members shall ensure that within their chosen fields they have appropriate knowledge and understanding of relevant legislation; Federal, State, Territory and local council laws and regulations; and that they comply with such requirements.

Code of Conduct - Duty of Client/Patient Care:

- Members shall practice within the boundaries of their qualification/s and shall cause no harm to clients/patients either of a physical or emotional nature.

- Members shall carry out treatment with due care and diligence in accordance with the requirements of the client/patient and will treat according to the client/patient's informed consent.

- Where a client/patient is unable to give informed consent for any reason (for example medical condition, psychological state of mind, age), informed consent must be obtained from the client/patient's legal guardian.

- When treating minors (under 16 years of age - *refer to your state definition of persons considered to be 'children and youth'.)* the client/patient must be accompanied for treatment by a parent or guardian and have permission for any treatment.

- Uphold client/patient confidentiality.

- Members must maintain accurate clinical records in a secured environment, for the duration necessary to meet legal requirements.

- Members must recognise their professional limitations and be prepared to refer a client/patient to other health service practitioners as appropriate.

- Members shall not engage in services that are sexual in nature with the client/patient.

Code of Conduct - Privacy:

- Members will abide by the requirements of Federal, State and Territory privacy and client/patient record law.

- Members shall honour the information given by a client/patient in the therapeutic relationship.

- Members shall ensure that there will be no wrongful disclosure, either directly or indirectly, of personal information.

- Records must be securely stored, archived, passed on or disposed of in accordance with Federal, State and Territory record law.

- The client/patient has a right to be adequately informed as to their treatment plan and have access to their information as far as the law permits.

Code of Conduct - Disciplinary Procedures:

This Code sets out certain basic principles that are intended to help members maintain the highest standards of professional conduct. All members must accept professional, legal and ethical responsibilities in order to protect themselves and the public's interest.

Should a case arise where a member is in breach of the Code of Conduct, MAA has the right to cancel a therapist's membership or take other action in accordance with Section 11 of the MAA Constitution.

Section 11 of the MAA Constitution:

11 If any member shall wilfully refuse or neglect to comply with the provisions of the Constitution and Regulations of the Company or shall be guilty of any conduct which in the opinion of the Board is unbecoming of a member or prejudicial to the interest of the Company the Board shall have power by resolution to censure, fine, suspend or expel the member from the Company.

GUIDELINES FOR RECORD KEEPING

1. Responsibilities

MAA accredited member therapists have a professional and legal responsibility to:

- keep as confidential the information they collect and record about clients/patients
- retain, transfer, dispose of, correct and provide access to clinical records in accordance with the requirements of the laws of the relevant states, territories and the Commonwealth as well as in accordance with Private Health Fund Provider terms and conditions
- therapists must be familiar with the requirements of the *Privacy Act 1988* (Cth) as well as their state or territory privacy and health records legislation, including the provisions that govern the retention of health records (retention for seven years) and the retention of records relating to children and youth under 16 years of age *(refer to your state definition of persons considered to be 'children and youth'.)*
- third party access is subject to the provisions of the relevant privacy and health records legislation and terms and conditions relating to provision of treatment for their members
- assist clients/patients to make well-informed decisions about treatment procedures and not impose unnecessary treatment on clients/patients
- refrain from committing acts of fraud and if you suspect that a person or group is engaged in insurance fraud, report fraud or suspected fraud to MAA and directly to your Private Health Fund **
- retain client/patient records for a minimum period of 7 years and where the client/patient is under 21 years for a period of 7 years after he or she would have reached 21 years of age
- client/patient records are to be maintained in English or must be translated at your expense
- client/patient records relating to claims must be made available on request for audit purposes^^

****Note: Common Types of Fraud**

Experience has shown that providers and Health Fund members are not always aware of what constitutes fraud or inappropriate claiming. In relation to claiming benefits, fraudulent or inappropriate behaviour is defined as the member or provider, individually or in collusion, knowingly or recklessly giving, supplying or providing information, whether written, electronic or verbal, that is intended or likely to mislead a Health Fund into paying a level of benefit to (or on behalf of) the member, to which they would otherwise not be entitled.

Misleading information on accounts/receipts may include:

- Treatment not actually provided
- Incorrect itemisation/description of treatment

- Incorrect dates the services were completed
- Incorrect client/patient name
- A fee for a service that was not what the client/patient was actually charged e.g. the client/patient was charged less than the fee documented on the account, however the 'discount' given to the patient was not disclosed on the account
- Incorrect provider identification

The result of such behaviour is the payment of invalid/inappropriate claims. This leads to increased costs, which affect the overall viability of Health Funds, and ultimately leads to increased member premiums.

All Health Care providers have a responsibility to ensure that all documentation, including clinical records and accounts, are maintained in a true and accurate manner.

^^Note: Audit Purposes/Procedures

Health Funds conducts regular reviews of their claims database in order to determine the treatment patterns of individual providers as well as groups of providers.

On some occasions during these reviews, it is necessary to seek further information from providers in regard to particular claims or their treatment profiles. These requests are usually made in writing and it is a condition of registration as a provider that you comply with these requests and co operate in good faith with your Health Funds. Failure to comply with such requests which may involve sending a full copy of the client/patient records may result in Health Funds issuing you with a compliance notice.

During a review Health Funds may, depending on the nature of the review, contact their members' subject to the claim. The health care provider may not always be contacted prior to such an approach to the member.

All Health Care providers are considered responsible for any actions by staff members or others who may have authority to access client/patient files. All Health Care providers are considered responsible for keeping safe their client/patient records and are considered to take full responsibility for the actions of others in relation to maintaining security of their Health Provider numbers issued to them.

2. General principles to be applied

- each client/patient should have an individual health record containing all the health information held by the practice about that client/patient.
- a MAA accredited member therapists clinical record must be made at the time of the consultation or as soon thereafter as practicable or as soon as information (such as results provided by the client/patient's medical doctor or other Health Care Practitioner) becomes available and must be an accurate and complete reflection of the consultation. If the date the record is made differs from the date of the consultation, the date the record is made must be recorded and the date of the consultation noted.

  The time of consultation is to be recorded.

- entries on a clinical record must be made in chronological order.
- clinical records must be legible and understandable and of such a quality that another treating therapist or member of the health care team could read and understand the terminology and abbreviations used and, from the information provided, be equipped to manage the care of the client/patient. The use of generally accepted abbreviations in client/patient case records is satisfactory, but the use of obscure codes and abbreviations should be avoided.
- if documents are scanned to the record, such as external reports, the scanning needs to be undertaken in a way that reproduces the legibility of the original document.
- clinical records must be able to be retrieved promptly when required.
- clinical records must be stored securely and safeguarded against unauthorised access and loss or damage.
- all comments in the clinical record should be respectful of the client/patient and be couched in objective, unemotional language.
- *closing a practice*. This requires the transfer or appropriate management of all client/patient records in accordance with the legislation governing health records in the state or territory in which the person is treated.
- corrections can be made to a clinical record provided the correction is signed by the therapist and the original entry is still visible.
- a treating therapist cannot delegate responsibility for the accuracy of information in the client/patient's clinical record to another person or therapist.

3. Information to be held with the client/patient record

The following information forms part of the clinical record and is to be recorded and maintained, where relevant:

- identifying details of the client/patient, including name, contact details, gender and date of birth (and client/patient's parent or guardian where applicable) in English
- current health history and relevant past health history, including known past treatment by other health professionals, surgery, conditions diagnosed by a medical doctor, allergies and alerts to adverse drug reactions including over the counter and herbal preparations, lifestyle factors such as perceived levels of stress, nutrition factors, alcohol consumption, levels of physical activity, recreational drugs and smoking.
- relevant family health-related history
- relevant social history including cultural background where clinically relevant
- contact details of the person the client/patient wishes to be contacted in an emergency (not necessarily the next of kin); Note: This information needs to be kept up to date and also be kept in English
- clinical details - for each consultation, clear documentation of information relevant to that consultation including the following:
    - the date of the consultation
    - the name of the therapist who conducted the consultation, including a signature where applicable

- the presenting condition
- relevant history
- information about the type of assessments conducted
- relevant clinical findings and observations
- other treatments/therapies being used (including herbal, pharmaceutical, manipulative, dietary, psychological, etc
- treatment principle(s), recommended treatment plan
- all procedures conducted including details of all soft tissue manipulation applications
- details of advice provided
- recommended management plan and, where appropriate, expected process of review;
- other relevant information (e.g. a discussion about possible side effects or alternative forms of treatment)
- details of how the client/patient was monitored and the outcome (progress notes)

- any unusual squeal of treatment or adverse events
- relevant diagnostic data (laboratory, imaging and other investigations) given to the therapist by the client/patient, including accompanying reports
- instructions to and communications with external health service providers including all referrals made or recommended and any letters and reports from other therapists;
- all relevant communication (written or verbal) with or about the client/patient, including telephone or electronic communications
- details of anyone contributing to the client/patient care and records of the client/patient; and
- estimates or quotations of fees.

Skin Penetration and Infection control

Where you use skin penetration techniques during the treatment you must:

Retain a signed copy of the client/patient's informed consent for treatment using skin penetrating techniques and a copy of the information given to the client/patient relating to possible adverse events that may arise due to the use of skin penetrating techniques.

Record any adverse events relating to the application of skin penetration techniques

Ensure that you:

- obey federal, state government and local council skin penetration legislation and protocols;
- handle and dispose of waste material (including 'sharps') in accordance with government guidelines;
- store any instruments or equipment that penetrate the skin or are in contact with body fluid or tissue in a sealed sterile pack in a dry store area. Where the device is non- disposable it

should be cleaned and sterilised in an appropriate manner;

- store any instruments or equipment that make contact with (but do not penetrate) the skin in a dry, contamination free environment. The device/s should be disinfected prior to and cleaned appropriately after use;

- store all other devices or equipment that makes contact with a client/patient in a contamination free environment; and

- maintain a safe and clean environment.

Progress Notes

The level of detail required in a client/patient case record may vary according to the nature of the presenting condition and whether it is an initial or subsequent consultation. For example, in the case of subsequent visits for an ongoing condition, information recorded in earlier consultations need not be repeated, unless there are relevant changes.

Progress details and treatment must however be recorded clearly.

Records not in English

MAA recognises the cultural diversity of MAA accredited member therapists and the cultural diversity of their clients/patients.

For the purposes of client/patient safety and clear communication between client/patient and therapist it may be necessary to make recordings in the language of the therapist and the client/patient.

The requirement of legislation and adherence to Health Funds Terms and Conditions is that all client/patient records are to be recorded in *English*.

Where records are maintained in a language other than English, should a copy of a client/patient's records be requested by the client/patient, or required by an authorised third party, it is the responsibility of the MAA accredited member therapist to provide at their own expense an English translation of the client/patient's records.

4. Requests for reports or records

MAA accredited member therapists have a professional and legal responsibility to:

- provide a report of the client/patient's treatment and progress to another health care practitioner where requested by the client/patient

- upon request by the client/patient, provide access to and or copies of records relevant to the client/patient.

- upon request by a Health Fund direction

- upon request by a court order or otherwise as compelled by law

5. Accounting records

MAA accredited member therapists have a professional and legal responsibility to maintain accurate, legible contemporaneous accounting records of each visit.

As a minimum, each accounting record must be labelled with the client/patient's identifying details and:

- the date of each service;
- itemised fees charged; and
- details of all payments including the date of the payment.

An itemised receipt must be issued for each payment, indicating:

- the date of payment,
- name of the remedial therapist who provided the service,
- address where the service was provided, with
- contact telephone number,
- name of the client/patient who received the treatment,
- date of service,
- all treatment(s) provided, with
- charge(s).

6. Electronic records

Electronically held records must meet the same requirements as non-electronically held records with the following additional considerations:

Records should be password protected to ensure that only the MAA accredited member therapist and authorised support staff can access the records. Protective pass-codes should be used and updated on a regular basis including when a staff member ceases employment.

Client/patient records should not be sent by email unless there is protection, such as encryption, from potential unauthorised access. No individual should be permitted to access or use the practice computer(s) other than the MAA accredited member therapist and authorised staff members.

Client/patient access to their records held on computer can be provided via a direct print-out of the record.

Adequate backup systems to protect client/patient records are essential and must provide a guarantee of the ability to restore up-to-date information in the event of power loss or system or computer failure.

7. Confidentiality

MAA accredited member therapists have a legal and ethical responsibility to keep client/patient information confidential. Obligations are set out in a number of State and Commonwealth laws.

The principles enshrined in these laws should inform MAA accredited member therapists' record keeping in terms of: collection, use, disclosure, disposal and transfer of information, as well as in relation to the quality and security of the information and the mechanisms by which access to information is given.

MAA accredited member therapists must inform themselves regarding relevant laws and standards and ensure compliance.

MAA accredited member therapists have the responsibility to ensure that all staff members with access to client/patient records are properly instructed in maintaining client/patient record confidentiality. The legislative requirements apply to all individuals who handle client/patient information.

MAA accredited member therapists' aims are to comply with the Information Privacy Act 2000 Version No.022 as at the 1st August 2011 and the Health Records Act 2001 Version No. 022 as at the 1st July 2010 as well as the Commonwealth Privacy Act 1988 - C2013C00231 as at the 12th April 2013 and to implement practices and procedures to ensure compliance.

MAA accredited member therapists are to observe the following privacy principles:

Collection of information
MAA accredited member therapists will only collect information that is relevant. At the time of collection, MAA accredited member therapists will provide a written statement why they need the information requested, what purposes they use this information for and whom they regularly disclose this information to. Information will also be provided about the client/patient's right to access and, if appropriate, correct information the MAA accredited member therapist hold about them. Information that is collected will be held securely to prevent any security breaches. Information that is collected will be processed in order to meet the individual needs of the client/patient.

Use and Disclosure
MAA accredited member therapists will not divulge any personal or health information to a third party for any reason other than the primary purpose for its collection or for purposes specified in their privacy notice or with the consent of the individual or as required by law.

MAA accredited member therapists value their clients/patients and will respect the privacy of their personal and health information.

Data Quality
MAA accredited member therapists will take all reasonable steps to ensure the information that is collected is complete, accurate and current.

If a client/patient, wishes to access or update their personal or health information the MAA accredited member therapists will provide all reasonable assistance with this.

Data Security
MAA accredited member therapists will take all reasonable steps to ensure that information is protected from misuse, unauthorised access, modification or disclosure. All information not required will be destroyed in accordance with privacy legislation or as required by other legislation.

Openness
MAA accredited member therapists will take all reasonable steps to provide their clients/patients with details of their personal and health information being held within the client/patient's records upon request.

MAA accredited member therapists will advise their clients/patients of the type of information they possess, the purpose for it being held, the method of collection, use and disclosure of the information as well as their client/patient's rights to access and amend this information.

Access and Correction
MAA accredited member therapists will give their clients'/patients' access to their personal or health information at no charge upon request. All requested information will be provided within 30 days from receipt of the request. All information that is not accurate will be amended within 5 days of receiving a written request to do so.

Informal access to records is usually available. .

MAA accredited member therapists seek to have accurate records so information needed to update these records such as current contact details will be made on request.

Unique identifiers
Sometimes MAA accredited member therapists have to collect unique identifiers such as Health Fund Membership numbers. If MAA accredited member therapists do need this information the purposes for collecting these numbers will be explained to clients/patients.

MAA accredited member therapists will not use these unique identifiers for any other purposes than those for which they were collected.

If MAA accredited member therapists ascribe a unique identifier to an individual for internal recording use this will not be shared with any other body or person without the consent of the client/patient.

Anonymity
MAA accredited member therapists will give their clients/patients the option of not identifying themselves when entering transactions with them wherever it is lawful and practicable.

Transborder data flows
MAA accredited member therapists will not transfer personal information to a person outside of Australia unless that person or body is legally obliged to protect the individual's privacy under equivalent or higher privacy legislation as themselves. In most circumstances the transborder transfer of personal or health information that MAA accredited member therapists hold about a client/patient will only be transferred with that client/patient's consent.

Sensitive Information
MAA accredited member therapists will only collect sensitive information about a client/patient with consent of the client/patient or if required by law.

"Sensitive information" – information or an opinion about an individual's:

a) racial or ethnic origin	b) political opinions	c) membership of a political association
d) religious belief or affiliations	e) sexual preferences	f) criminal record
g) membership of a trade union	h) membership of a professional or trade association	

MAA accredited member therapists will only contract with and supply personal or health information with persons, organisations or businesses who agree to adhere to their privacy policy and all relevant privacy legislation.

References

1. *Privacy and health records legislation:* Useful information regarding privacy and health records legislation can be found at www.privacy.gov.au. Third party access is subject to the provisions of the relevant privacy and health records legislation.

2. Health Fund Terms and Conditions

3. Private Health Insurance (Accreditation) Rules 2011 as amended 3rd January 2013.

4. Kangan Institute Centre for Better Living- Sport Fitness and Natural Therapies: Student Clinic – 'Standards of Practice Guidelines Management of client/patient records'

5. Max Therapy Institute: Student Clinic – 'Standards of Practice Guidelines Management of client/patient records'

6. AMMI Bio-Therapy – workplace policies and procedures

7. Forrester, K. Griffiths, D. Essentials of Law for Health Professionals 2003 Mosby Elsevier Australia ISBN: 1-875897-66-6

8. Health Training Package HLT07: HLT40312 Certificate IV in Massage Therapy Practice; HLT50307 Diploma of Remedial Massage. Accredited Course: 21920VIC Advanced Diploma of Remedial Massage (Myotherapy)

9. MAA recommended Textbooks:
   Textbook of Remedial Massage. Sandra Grace & Mark Deal. 1st Edition Churchill Livingstone/ELSEVIER. ISBN: 9780729539692

   Massage Therapy – Principles and Practice. Susan G. Salvo 4th Edition Saunders ISBN**:** 9781437719772

   Foundations of Massage. Casanelia, L. Selfox, D. Green, L. 3rd Edition ISBN-10: 0729538699 ISBN-13: 978-0729538695

   Clinical Massage Therapy – Understanding, Assessing and Treating over 70 Conditions. Rattray, F & Ludwig. L. 1st Edition. Talus Incorporated Toronto, Ontario. Canada ISBN: 0-9698177-1-1

10. Osteopathy Board of Australia – Guidelines on clinical records

11. Chiropractic Board of Australia – Guidelines for clinical record keeping

12. Chinese Medicine Board of Australia – Patient records guidelines

13. MAA Code of Conduct

14. MAA Constitution

Appendix A:

MAA recommended definitions for Health Fund Provider status:

AHRG: **Massage Therapy** is the manipulation of the soft tissue of whole body areas to bring about generalised improvements in health, such as relaxation or improved sleep, or specific physical benefits, such as relief of muscular aches and pains.

AHRG: **Remedial Therapy** is the systematic assessment and treatment of the muscles, tendons, ligaments and connective tissues of the body to assist in rehabilitation, pain and injury management. It is performed to create favourable conditions for the body to return to normal health after injury and is defined by the premises that the treatment can reasonably reverse certain physical effects a patient may be presenting. A range of manual therapy techniques may be employed in treatment, such s deep connective tissue massage, Trigger Point Therapy, Muscle Energy Techniques, direct and indirect Myofascial Techniques, and Neuromuscular Facilitation, (as well as techniques ranging from Swedish to specialised massage for athletes, babies and pregnant women. Specialists may also practice Shiatsu Techniques to achieve improvement throughout the body. Aromatherapy and wholistic approaches such as Kinesology may also be used).

ARHG: **Myotherapy** is the treatment of myofascial pain, injury and dysfunction affecting movement and mobility.

Appendix B:

CODE OF CONDUCT

Objective

The objective of the Massage Association of Australia's (MAA) Code of Conduct is to provide its practitioners with a basis for professional and self reflection, and evaluation on ethical conduct. This document defines and identifies acceptable behaviour, promotes high standards of practice, and establishes a framework for professional behaviour and responsibilities.

The MAA is a professional organisation and has an obligation to its members, the general public and the industry as a whole.

The Public Interest

- Members shall ensure that within their chosen fields they have appropriate knowledge and understanding of relevant legislation; Federal, State, Territory and local council laws and regulations; and that they comply with such requirements.

- Members shall in their professional practice have regard to basic human rights, compassion and respect for others and shall avoid any actions that adversely affect such rights.

Duty of Client Care

- Members shall practice within the boundaries of their qualification/s and shall cause no harm to clients either of a physical or emotional nature.

- Members shall carry out treatment with due care and diligence in accordance with the requirements of the client and will treat according to the client's informed consent.

- Where a client is unable to give informed consent for any reason (for example medical condition, psychological state of mind, age), informed consent must be obtained from the client's legal guardian.

- When treating minors (under 16 years of age) the client must be accompanied for treatment by a parent or guardian and have permission for any treatment.

- Uphold client confidentiality.

- Members must maintain accurate clinical records in a secured environment, for the duration necessary to meet legal requirements.

- Members must recognise their professional limitations and be prepared to refer a client to other health service practitioners as appropriate.

- Members shall not engage in services that are sexual in nature with the client.

Duty to the Profession

- Members shall uphold the reputation of the profession and shall seek to improve professional standards through participation in personal development and will avoid any action, which will adversely affect the good standing of the MAA.

- Members shall seek to advance public knowledge and to counter false or misleading statements, which are detrimental to the profession.

- Members shall act with integrity toward fellow therapists/practitioners and to members of other professions with whom they are concerned in a professional capacity.

Professional Competence and Integrity

- Members shall maintain professional skills to represent themselves at a professional standard, seeking to continue or maintain personal and professional development skills.
- Members shall accept professional responsibility for their work.
- Members shall not lay claim to any level of competence which they do not possess, or provide services which are not within their professional competence.

Advertising

- Members must not advertise in a false, misleading or deceptive manner.
- Members must not abuse the trust or exploit the lack of knowledge of consumers.
- Members must not make claims of treatments that cannot be substantiated.
- Members must not encourage excessive or inappropriate use of services.

Privacy

- Members will abide by the requirements of Federal, State and Territory privacy and patient record law.
- Members shall honour the information given by a client in the therapeutic relationship.
- Members shall ensure that there will be no wrongful disclosure, either directly or indirectly, of personal information.
- Records must be securely stored, archived, passed on or disposed of in accordance with Federal, State and Territory record law.
- The client has a right to be adequately informed as to their treatment plan and have access to their information as far as the law permits.

Disciplinary Procedures

This Code sets out certain basic principles that are intended to help members maintain the highest standards of professional conduct. All members must accept professional, legal and ethical responsibilities in order to protect themselves and the public's interest.

Should a case arise where a member is in breach of the Code of Conduct, MAA has the right to cancel a practitioner's membership or take other action in accordance with Section 11 of the Constitution.

Further information can be found in the MAA's Constitution and in the Complaints, Disputes and Disciplinary Procedures.

Appendix C:

Therapist - Client Record Self-Evaluation

The following list can be used for self-evaluation of your client records to identify strengths and weaknesses in record-keeping practices and documentation.

Client record Keeping Activity	Always	Needs Improvement	Not applicable
My record keeping system allows for ready retrieval of an individual patient file			
My records are legible			
An abbreviation Legend is available and is the abbreviation Legend commonly used by all Health Professionals			
My Records are written in English			
My Records are written in another language other than English but also with English translation			
The client/patient's identity is clearly evident on each component of the file			
A signed Consent for Treatment Form forms part of the Record			
Each client/patient file clearly shows full name, address, date of birth, gender			
The date of each visit is recorded			
The family history, functional inquiry & past history (including significant negative observations) is recorded & maintained			
Allergies are clearly documented			
An updated list of current medications (including 'over the counter', vitamins and herbal preparations is recorded in the file			
Lifestyle factors such as smoking, special diets, exercise, alcohol consumption and recreational drugs are recorded			
A "cumulative client profile" relating to each client is present & fully maintained			
The Presenting Condition (chief complaint) is clearly stated			
The duration of symptoms is noted			
An adequate description of the symptoms is present			
Positive physical findings are recorded			
Significant negative physical findings are recorded			
Records of external laboratory tests & other investigations are included with the Records			
A signed Consent to Release Confidential Information is evident in the case of a need for Referral			
All Letters of referral are maintained within the Record			

Requests from the Client/Patient for consultation with Other Health Care Practitioners are documented			
The Assessment of signs and symptoms is recorded			
The treatment plan and/or treatment is recorded			
Doses (number of required treatments) & duration (length of each treatment) of prescribed remedies are noted			
Progress notes relating to the management of clients suffering from chronic conditions are made			
There is documented evidence that periodic general assessments are being made			
There is evidence that adjustments to the Treatment Plan are being made to match the progress of the periodic general assessments			
There is documented evidence that health maintenance is periodically discussed (topics such as smoking, alcohol consumption, obesity, lifestyles etc.)			
There is evidence that the therapist periodically reviews the list of prescribed drugs, supplements, remedies etc. being taken by client/patients suffering from multiple or chronic conditions			
In the event that more than one therapist is making entries in the client file, is each therapist identifiable?			
Information about possible negative outcomes of treatment given to the Client/Patient is recorded			
Evidence of information about the benefits and negative aspects of Dry Needling treatment given to the Client/Patient is recorded			
A specific Signed Consent for Dry Needling Treatment Form is retained in the records			
Evidence of Client/Patients non-compliance with therapist recommendations and the course of action taken to assist the Client/Patient to become compliant is maintained in the records			
Documented evidence of specific activity given to the Client/Patient to carry out between visits is maintained in the records			
Phone conversations and any home visits are documented in the Client/Patients records			
If a transfer of Client Records is requested all written requests, fees charged and obligations are recorded in the records			
When Client/Patient records are requested by Health Funds or MAA for Annual Audit purposes they meet the requirements of Health Fund Legislation minimum requirements as laid out by each Health Fund Terms and Conditions of Recognition/Registration as a Health Fund Provider and the Terms and Conditions of continuing MAA Membership			

Appendix D:

DISPOSAL OF CLINIC CLIENT/PATIENT HEALTH RECORDS

Client records must be kept for at least seven (7) years after the client treatment or care ceases in the case of adult clients. Client records for children (under 18 years of age) must be kept until the client reaches the age of 25 years.

The destruction of client records before seven years after cessation of treatment could be construed as a breach of duty of care or a breach of an implied term of the practitioner/client contract.

Under National Privacy Principles guidelines, appropriate measures must be undertaken by the therapist to ensure the confidentiality, security and preservation of records and access to information.

Disposal of clinic client records must be carried out in a secure manner in order to protect client confidential information, such as by shredding or using a secure document disposal service.

Related Legislation: http://www.health.vic.gov.au/healthrecords/

Overview

The Health Records Act 2001 (the Act) created a framework to protect the privacy of individuals' health information. It regulates the collection and handling of health information. The Act:

- gives individuals a legally enforceable right of access to health information about them that is contained in records held in Victoria by the private sector; and
- establishes Health Privacy Principles (HPPs) that will apply to health information collected and handled in Victoria by the Victorian public sector and the private sector.

The access regime and the HPPs are designed to protect privacy and promote patient autonomy, whilst also ensuring safe and effective service delivery, and the continued improvement of health services. The HPPs generally apply to:

- all personal information collected in providing a health, mental health, disability, aged care or palliative care service; and
- all health information held by other organisations.

Complaints about interferences with privacy (breaches of Part 5 of the Act or an HPP) are handled by the Health Services Commissioner.

Who must comply with the Health Records Act?

The Act applies to the health, disability and aged care information handled by a wide range of public and private sector organisations. This includes health service providers, and also other organisations that handle such information. For example:

- bodies such as companies, incorporated associations, unincorporated associations, Local Government, Victorian Government agencies and Departments, public hospitals and other public bodies (such as Victoria

Police); and
- sole practitioners, partnerships, Members of Parliament, and trustees.

The Health Privacy Principles (HPPs) in the Act apply to health information that is handled in Victoria. The Act will apply in two main ways.

1. Does the organisation provide a health, disability or aged care service?

When an organisation provides a health, disability or aged care service, the HPPs apply to all identifying personal information originally collected by the organisation in the course of providing that service. All such information is "health information". Such a provider is referred to in the Act as a "health service provider".

This will include personal information collected to provide services by:

- medical practitioners (general practitioners and specialists);
- dentists;
- mental health providers;
- allied health service providers;
- complementary health service providers;
- nursing services;
- private and public hospitals;
- community health centres;
- pharmacists dispensing drugs;
- day procedure centres;
- pathology services;
- supported residential services;
- aged care providers (including nursing homes and hostels, and other service providers);
- palliative care providers;
- disability service providers; and
- other organisations (such as public and private schools, the Victorian Department of Health and other Government agencies or public bodies), but only in those situations where the personal information is collected to provide a health, disability or aged care service.

2. Personal information collected in other situations

The HPPs will apply to the collection, use and handling of identifying personal information that is defined as "health information" under the Act. This will include:

- information or opinion about the physical or mental health, or disability, of an individual;
- an individual's expressed preferences about the future provision of health, disability or aged care services to him or her;
- the nature of health, disability or aged care services that have been, or are to be, provided to an individual;
- information originally collected in the course of providing a health, disability or aged care service to an individual;

- personal information collected in connection with the donation of human tissue;
- genetic information that is or could be predictive of the health of an individual or their descendants.

Any organisation that handles this kind of identifying health information is subject to the HPPs, unless an exemption under the Act applies. The exemptions under the Act are very limited.

The Act applies regardless of the size of the business or organisation. There is no "small business" exemption.

Organisations that are subject to the Act, when they handle health information, include:

- Victorian Government Departments and public bodies established under Victorian law;
- universities;
- researchers;
- blood and tissue banks;
- public and private sector employers (eg. in relation to their employees' personnel records);
- kindergartens and crèches;
- counsellors;
- insurers and superannuation organisations;
- gymnasiums;
- any other organisation that holds health information or health reports concerning its clients or customers

Inquiries about the Act

Further information is also available from the Office of the Health Services Commissioner athttp://www.health.vic.gov.au/hsc/

The Commissioner's office can be contacted on (03) 8601 5200 or toll free on 1800 136 066.

How to view the Act

The **Health Records Act** is available on the Victorian Legislation and Parliamentary Documents website athttp://www.legislation.vic.gov.au

http://www.records.nsw.gov.au/recordkeeping/government-recordkeeping-manual/rules/general-retention-and-disposal-authorities/public-health-services-patient-client-records-gda/part-1-the-general-retention-and-disposal

http://www.alrc.gov.au/publications/28.%20Data%20Security/information-destruction-and-retention-requirements

(Through ALRC, MAA Members are requested to keep abreast of new Australia-wide and state requirements)