Reliable Record Keeping

# Frequently Asked Questions

The purpose of this FAQ is to provide you with helpful tips on how to adopt professional and reliable record keeping practices.

## 1. What is a record?

In the NDIS context, the Terms of Business defines “records” as including **“documents, information and data stored by any means and all copies and extracts of the same”.** As such, electronic or handwritten notes and recordings (audio and visual) are all formal records.

A record provides evidence of actions or decisions about a participant and the delivery of services and supports and is used to capture information that is necessary or useful and to be relied on in the future (rather than just as a reference).

## 2. Why are good record keeping practices important?

Keeping reliable records is important to ensure that the information contained within them can be relied upon in the future in supporting participants and delivery services. In order to achieve the purposes for which records are created, they need to be made in such a way that ensures they are credible and contain sufficient information to assist.

In the NDIS context, records can be created for the following important purposes:

* Tracking and organising the delivery of supports and services
* Communication between workers, the support team, the participant and their representative for the purposes of continuity of care
* For use in support planning and assessments and to support future plan reviews
* To feed into administration (invoicing, claims, rosters etc)
* For use in legal proceedings and complaints to ensure facts are available to respond accurately and provide evidence
* To ensure compliance with the legal obligations of a provider under the NDIS Rules

If records are created and they do not assist with the purposes above, they can cause poor outcomes for participants, limit the ability of a provider to meet the participant’s needs and answer complaints or claims and impact a provider’s compliance.

## 3. Who is responsible for good record keeping?

Ultimately, it is the provider who is responsible under the NDIS Act to ensure records are kept in accordance with the NDIS Rules but workers play a role by complying with the provider’s policies and practices.

## 4. What are the legal obligations in relation to records?

* There are three key sources of legal obligations specific to record keeping under the NDIS. These are laid out in the Terms of Business, NDIS Act and the supporting Rules. Your employer is required to have policies and practices in place in order to comply with these legal obligations.
* It will be part of your employment agreement to following these policies and practices.
* Workers also have a duty of care to take reasonable care when delivering supports or providing a service and making records about those supports and services. This includes:
* That you record relevant, necessary and need-to-know information; and
* That you comply with all reporting and documentation requirements set out in your employer’s policies and practices.

## 5. Who are records created for?

There is a range of people who might see the records created including:

* Other workers
* The provider/employer
* Health practitioners and others providing supports and services to the participant for continuity of care
* Insurers and lawyers
* Participants/representatives/informal supports
* The NDIA and NDIS Commission
* Investigators and official bodies like the police
* Other regulators like state and territory Departments and the Australian Health Practitioner Regulatory Agency

The records you create now could be viewed by any of these people while the record is kept. They might have cause to review the record for a number of reasons including:

* When adding entries (for example, other support workers, a carer)
* When reviewing delivery of services (eg when a change of circumstances occurs) or conducting a plan review
* During a compliance review or audit
* When requesting disclosure or access through the Commonwealth Privacy Act 1988 or State and Territory privacy or health records laws
* When logging a reportable incident; they might need to look at the record you created
* In the event of a claim or complaint against a service provider or worker
* By court order or request from the Coroners Court
* Under Freedom of Information requests to regulators or from the NDIA

It is therefore unlikely that a record you create won’t be reviewed or considered in future. It is therefore important to remember who you are writing for and ensuring what you write is appropriate for the circumstances in which it might be looked at in the future.

## 6. What should be recorded?

Typically you will need to record information about participants and the supports/services they are receiving such as:

* The support and services that were delivered, those that were not delivered or unable to be delivered and why.
* The date, times, places of the supports delivered
* How the participant directed the provision of supports – what was requested, declined, postponed, and anything discussed between you and the participant about the supports
* Any specific communications, comments or concerns about the supports raised by the participant, their family/carers or that you observed, that relates to the quality of the supports provided
* How the participant is tracking against the goals in their plan – even where there is no change
* Any choice and control discussions and outcomes eg, if during a service, a resident declined to take their medication
* General health, wellbeing and mood of the participant including circumstances when there are no change or reactions
* Any difficulties or issues you experienced or observed in delivering the supports to the participants
* Any situations involving exposure to harm or danger to the participant or others (including yourself), including about the conduct or behaviour of the participant or another person, the physical environment, or a change in the participant’s needs and circumstances

## 7. What should not be recorded?

When recording information about participants and the support and services delivered you should avoid recording:

* Your personal opinions of the participant or their families and other service providers
* Information that is irrelevant to care or service delivery
* Criticisms or complaints about others such as other support workers, the participants or their support networks
* Inappropriate or emotive language (unless you are directly quoting)

## 8. What are the key features of good record keeping?

* The information contained in the record needs to be **relevant** having regard to the purpose and function of that record
* The record needs be created in a **timely** manner – that is at the time of or shortly after the information becomes known
* The record needs to be **accurate** and provide **adequate** information to enable other readers or users of the record to understand the information that the record captures and to respond appropriately to the information it contains
* The record needs to be **clear** and **legible** –easily understood by other readers and users
* As a record is a professional account of information relevant to the duties you are undertaking, it needs to be **fair** and **objective** to ensure the record is relevant, accurate and adequate for its purpose

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