

Adopted 24 November 2011

Scope of policy

This document conveys the expectations of the Optometry Board of Australia (the Board) with regard to health records created and maintained by optometrists.

Background

The Board has developed a *Code of Conduct*¹ to assist and support optometrists to deliver effective health services within an ethical framework.

Section 7.4 of this Code refers to health records, and it lists key points of good practice in maintaining clear and accurate health records as listed below:

- Keeping accurate, up-to-date and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management in a form that can be interpreted by another optometrist.
- Ensuring records are held securely and are not subject to unauthorised access.
- Ensuring records show respect for patients and do not include demeaning or derogatory remarks.
- d) Ensuring records are sufficient to facilitate continuity of care.
- e) Making records at the time of events or as soon as possible afterwards.
- Recognising the rights of patients to access information contained in their records and facilitating that access.
- g) Facilitating the transfer of health information promptly when requested by the patient.

These points provide an overview of the Board's expectations. There are also obligations for optometrists in relation to health records under relevant state and territory legislation and the *Privacy Act 1988* (Cth).

The Board, in providing guidance to optometrists, will from time-to-time draw on references published by other professional bodies.

Policy

As well as the relevant sections of the Board's *Code of Conduct*, the Board expects all optometrists to adhere to the Clinical guidelines for record keeping published by the Optometrist Association of Australia at www.optometrists.asn.au/RecordKeepingGuidelines/tabid/1012/language/en-AU/Default.aspx.



