

# DESTRUCTION OF SCANNED HEALTH CARE RECORDS POLICY®

## DOCUMENT SUMMARY/KEY POINTS

- This document outlines how the SCHN Health Information Services comply with guidelines for disposing of paper health care records after document imaging (or scanning).
- This policy ensures compliances with the State Records General Disposal Authority: Imaged Records (GA 45)
- Ensures compliances with Australian Standards Health Records: Part 2: Digitized (scanned) health record system requirements.

## CHANGE SUMMARY

- SCHN version was due for review. Updated to include eMR information for the Network.
- Updated to include SCHN Auditing for the Network

## READ ACKNOWLEDGEMENT

- SCHN Health Information Unit Management Team and the SCHN Health Information (Medical Records) Administrative Officers and NETS Clinical Information & Quality Manager and the NETS Clinical Information Administrative Officers must read and acknowledge they understand the contents of this policy.

|                        |  |   |
|------------------------|--|---|
| <b>Approved by:</b>    | SCHN Policy, Procedure and Guideline Committee |   |
| <b>Date Effective:</b> | 1 <sup>st</sup> October 2023                   | <b>Review Period:</b> 3 years           |
| <b>Team Leader:</b>    | Manager  | <b>Area/Dept:</b> Medical Records, SCHN |

## Background

SCHN health records strategy aims to ensure a single patient view of records in a reliable and accessible electronic medical record across the Network.

The Sydney Children's Hospital Network comprising of Children's Hospital at Westmead (CHW), Sydney Children's Hospital, Randwick, Bear Cottage, Children's Court Clinic and the Newborn and Paediatric Emergency Transport Service (NETS) scans any paper health care records using the Clinical Record Information System (CRIS) or directly into eMR via uploading clinical documents.

This means that when 'loose' sheet paper health care records are returned to the Health Information Unit (HIU) and Clinical Information Office (CIO) at NETS in bulk, they are put through the document imaging processes making all information part of the patient's Electronic Medical Record (eMR). Patient Documents can also be uploaded directly by administrative staff across SCHN into the patients eMR using the upload clinical notes functionality. Once uploaded into the systems, the paper records can be destroyed confidentially.

Access to any scanned SCHN health records is through the SCHN eMR and for NETS scanned records pre 2017 is via Alchemy. Work is being undertaken to integrate the older scanned NETS records into eMR.

## Document Imaging Process (scanning via CRIS)

Documents are imaged into the Clinical Record Information System (CRIS) at the end of each encounter by the Health Information Unit (HIU) and CIO at NETS. The HIU undertakes bulk scanning of documents.

Document Imaging Processes involve 3 procedures:

1. prepping (ensuring all documents are ready to be fed into the scanner)
2. scanning (quality checking documents once they have been scanned)
3. indexing (itemising each document or health care form for ease of review).

Final process after set quality checks includes the secure destruction of these records.

Health Care Records documents that have been scanned are available to view by authorised staff through the SCHN eMR. Scanned records are considered a true record and can be retained as an alternate to the paper form, allowing the original paper record to be destroyed.

## Uploading scanned documents via eMR

Documents can be uploaded directly into the eMR at any point of an admission or outpatient visit by administration or clinical staff throughout the network.

Direct uploading Processes include 3 steps:

1. scan and save the document to the PC
2. using eMR open the patient's correct MRN and encounter
3. upload the document using the scan icon on clinical notes
4. Destroy the scanned copy that is saved on the PC

## Compliance with State Records General Retention and Disposal

### Authority: Imaged Records (GA 45)

The "General Retention and Disposal Authority: Imaged Records"<sup>1</sup> (GA45) issued by State Records provides authorisation for the destruction of patient/client records that have been copied into a digital format. The Authority provides authorisation for the destruction of the original health care records that have been imaged provided that the following conditions have been met:

- **All requirements for retaining originals have been assessed and fulfilled.**

*Notes that have been scanned are available in an electronic format which is retained permanently by SCHN. This is supported by NSW Ministry of Health and the Evidence Act (1995) which states that it "does not preclude electronic records being used as evidence unless their veracity can be questioned, making electronic records legally acceptable. This is also supported in the Authority<sup>1</sup> which states, "Where an original State record is legally destroyed, the imaged copy becomes the official State record".*

- **Copies are made which are authentic, complete and accessible.**

*SCHN meets the requirements set out in the Authority<sup>1</sup>:*

| To be:     | ...an image copy must be   |
|------------|--|
| Authentic  | the product of routine, authorised copying and registration processes                        |
| Complete   | an accurate, legible reproduction of the original, in its entirety                           |
| Accessible | Available and readable to all those with a right to access it, for as long as it is required |

- **Copies are kept for the authorised retention period, and**

*As outlined in the Authority<sup>1</sup>, "where an original State record is legally destroyed, the image copy becomes the official State record". The electronic copy of the records will be retained for the full retention period required for paediatric medical records with appropriate measures to ensure their accessibility over time.*

- **5% of originals are kept for quality control purposes.**
  - Regular quality checks are performed by the SCHN Document Imaging Team on documents which are scanned and committed to CRIS during the prep, scan and indexing process.
  - SCHN Document Imaging Team monitor the CRIS Quality Assurance log daily.
  - One health care document is passed through the 3 processes (prep, scan and index).
  - SCHN Document Imaging managers carry out weekly audits on random batches of inpatient and outpatient documents.
- Original health care record notes will not be released by the Health Information Unit once they have been imaged and available in the eMR. For medico legal requests the imaged health care record will be extracted and made available via electronic format/paper format as requested.

**SCHN can currently confirm that:**

SCHN complies with the processes as described in

[Original or source records that have been copied \(GA45\)](#)

[General Retention and Disposal Authority: GDA17](#)

## **Destruction of SCHN Health Care Records**

Imaged Health Care Records are confidentially destroyed in accordance with the *Health Records and Information Privacy Act 2002* and State Records' guidelines. Destruction of the original documents occurs post imaging. The notes are destroyed following strict protocols such as the destruction of health care records occurs by placing the records into secured locked confidential bins which are then collected by an NSW Health Destruction services vendor and a destruction certificate is provided for SCHN record.

All documents are available in the SCHN eMR or directly through the scanning system CRIS. CRIS can be electronically tracked via extensive audit reports that are available in the Native CRIS application. Audit reports can be requested from the SCHN Health Information Service Manager.

## **Auditing Original SCHN Health Care Records**

In line with NSW State Records destruction authorities, 5% of scanned records are audited each month. Auditing health care records occur by randomly selecting different document types scanned into the eMR by different Document Imaging employees. The audit ensures the document has been scanned into the correct MRN, correct date, the document is clear and readable, and is an exact replica of the original document. These audits are carried out by the SCHN Clinical Documentation Coordinator in the HIU and reports can be requested.

## Bibliography

1. NSW State Records Original or source records that have been copied [[GA45](#)]  
<https://staterecords.nsw.gov.au/recordkeeping/guidance-and-resources/original-or-source-records-have-been-copied-ga45>
2. NSW State Records General Retention and Disposal Authority [[GDA17](#)]  
<chrome-extension://efaidnbmnnnibpcajpcqlclefindmkaj/https://staterecords.nsw.gov.au/sites/default/files/2023-05/GDA17%202019%20version%20%28updated%20July%202020%29.pdfhtmlfile/Shell/Open/Command>

### **Copyright notice and disclaimer:**

The use of this document outside Sydney Children's Hospitals Network (SCHN), or its reproduction in whole or in part, is subject to acknowledgement that it is the property of SCHN. SCHN has done everything practicable to make this document accurate, up-to-date and in accordance with accepted legislation and standards at the date of publication. SCHN is not responsible for consequences arising from the use of this document outside SCHN. A current version of this document is only available electronically from the Hospitals. If this document is printed, it is only valid on the date of printing.