HEALTH CARE RECORDS MANAGEMENT

POLICY©

DOCUMENT SUMMARY/KEY POINTS

- This document sets out the policy that covers the use and content of SCHN health care records.
- SCHN has an Electronic Medical Record (eMR) as the core clinical records system, with minimal paper documentation like consent forms and external correspondence continuing to exist.
- The appropriate use, privacy and protection requirements of the health record is the same whether electronic or paper format.
- At the end of each patient encounter/visit the paper portion of records will be scanned to enable the entire record to be accessible electronically.
- The eMR incorporates, patient demographics, visit history, orders, results, clinical documentation, medications, observations, discharge summaries, departmental letters/reports and allergy, problem and diagnosis information as well as scanned paper records of internal and external forms.
- There are a number of NSW Health policies that govern the creation, storage, maintenance, security, release and disposal of medical records. This policy must be read in conjunction with these policies, which can be accessed via the links on page 8.
- SCHN ensures compliance with the NSW Health Policy Directive PD2012_069 "Health Care Records Management and Documentation".
- Exceptions to the policy or requests for changes may be made on application to the SCHN Clinical Systems and Data Governance Committee (CSAD) via the chair, or via the Health Information Unit (HIU) Managers.

When accessing either the paper record or any electronic patient systems SCHN clinicians are reminded that they need to abide by the NSW Health Privacy Manual and Access and Amendment to Patient Information by the Patient, Parent, Guardian or other Parties

CHANGE SUMMARY

- Updates based on advances in the eMR
- Updates based on changes in policy and regulations

READ ACKNOWLEDGEMENT

- All staff entering into or retrieving data from the health care record must read and acknowledge they understand the contents of this policy.
- All clinicians responsible for patient care must have access to appropriate training in relevant modules of the eMR so that they can safely and appropriately use the system to access patient records and manage the documentation of care.
- Departmental managers are responsible for ensuring that their staff are familiar with this document and have completed the required training.

POLICY STATEMENT

This policy is to provide staff with information that covers the use and content of health care records, and how to manage risks as they relate to documentation and the electronic medical record.

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1 Definition

The health care record is the documented account of a patient's health and treatment history. A separately identifiable individual health care record is created at the time of a person's first attendance at The Sydney Children's Hospitals Network (SCHN). During each subsequent visit /stay or occasion of service for every person receiving health care from the SCHN, the health care record needs to be updated.

1.1 Purpose of the Health Care Record

There are certain principles that need to be adhered to for the creation of the health care record:

- Confidentiality
- Authenticity and relevance
- Completeness and comprehensiveness
- Responsibility and timeliness for documentation
- Continuity of Care
- Entries should be in chronological sequence where practical
- Entries should be made in the electronic or paper record NOT BOTH
- Patients and families have the right to access and view their medical record within Privacy Guidelines
- Access to records for all staff where appropriate for the delivery of clinical care (not for other uses unless specific patient consent is obtained)
- Durability, storage, security, retention and disposal is in accordance with state policy General Retention and Disposal Authority: Patient Records (GDA17) and Administrative Records (GDA21)

2 SCHN Health Care Record Content

SCHN is committed to the implementation and use of electronic clinical systems which provide accurate and timely access to records. The SCHN Health Care Record may consist of paper-based and electronic documentation. Any paper-based documentation is integrated and available in the electronic Medical Record. Bulk scanning is managed by the Health Information Unit (HIU) at either campus (CHW or SCH). Decentralised importing or uploading of scanned documents is undertaken by administrative staff across SCHN.

Some historical departmental records remain as satellite records and are being integrated over time. Satellite records are not supported as a future state.

There are numerous NSW Health policies that govern the creation, storage, maintenance, security, release, and disposal of medical records. This policy must be read in conjunction with these, which can be accessed via the links at the end of this document.

3 Contents of the Health Care Record

- Cerner Millennium is the suite of applications used as the eMR across SCHN.
- South East Sydney Local Health District Patient Administration System (SESI iPM) is also used to update patient demographics at SCH.
- Each patient's health care record is accessible electronically through a range of devices internal and external to SCHN to support patient care across multiple facilities.
- Some of the current information available through the eMR includes:
  - Patient Demographics (including patient contact information and GP contacts)
  - Visit Lists (Emergency Department, Inpatient and Outpatient visits)
  - Patient tracking (Tracking boards, patient lists, dashboards, portals, metrics)
  - Medication management (including Chemotherapy protocols)
  - Clinical documentation (progress notes, departmental documentation)
  - Discharge Summaries (Inpatient and Emergency Department)
  - Laboratory and Medical Imaging Orders and Results
  - Messaging capability (result endorsement, documentation review and simple messaging between clinicians)
  - Vital signs and observations
  - Perioperative documentation
  - Outpatient Letters
  - Outpatient Scheduling
  - Departmental Letters
  - Growth Charts
  - Diets
  - Referrals
  - Scanned paper documentation
- Where functions are available in eMR they should not be replicated on paper except when providing service in downtimes.
- Printing of electronically available records should be minimised for discharge summaries, transfer summaries and management plans. Other requests for printed records should be made to the Health Information Unit.
- Results, documents interfaced and downtime 247 from other internal and external 3rd party clinical and diagnostic systems.

Clinicians responsible for the care of patients need to access the eMR and other relevant supporting paper documents to get a complete view of the patient's history and treatment during the current episode. At the end of every episode, paper records will be scanned.

4 Compliance with NSW Health Policy Directive PD2012_069

Refer to NSW Ministry of Health Policy Directive PD2012_069 "Healthcare Records – Documentation and Management for more information.

- Health Care Records must be kept confidential, current, accurate, complete and readily available for patient care.
- With the integration of eMR, all staff have a responsibility to remain updated in terms of any enhancements to the information available within the eMR and other clinical information systems.

All SCHN health care records are scanned and made available for viewing in the eMR. Disposal conditions of these records is prescribed within the Destruction of Scanned Health Care Records policy.

- The admitting medical officer in charge of the patient's care should take reasonable steps to ensure that an adequate health care record is maintained for each patient.
    - *Where this duty is delegated to another practitioner, (e.g. Registrar or Resident Medical Officer), the medical practitioner in charge of the patient's care remains responsible for ensuring that the delegated duty is performed.*

  Every patient has a SCHN Health Care Record created and may have several Medical Record Numbers (MRN) in accordance with the NSW Health Client Registration Policy SCHN Client registration policy
- Where a patient is seen in a departmental or outreach setting it is the responsibility of the treating health professional to ensure a Medical Record Number is issued at the time of the patient's attendance.
- Documentation created in the departmental or outreach setting by SCHN providers should be made available to the SCHN record either via direct eMR input or paper records returned to the HIU for scanning.
- All Health care providers MUST use the medical record to document and communicate all aspects of care. Documentation must be in accordance with the NSW MoH Policy Directive PD2012_069 Healthcare Records - Documentation and Management.
- The Health Care record must be sufficiently detailed to allow care delivery to be monitored and evaluated.
- The NSW Health Patient Discharge Documentation guideline outlines the documentation required when discharging admitted patients from an NSW Health public hospital.

Discharge summaries are completed within 48hours of discharge.

- SCHN requires a single integrated medical record to be maintained by the SCHN Directorate of Strategy and Innovation. In some circumstances (and with the prior approval of the SCHN HIU Manager) where departmental satellite records exist, cross references in the respective hospital record should be made.
    - In accordance with NSQHS Standard Edition 2 on a single integrated medical record, it is required that all departments will liaise with the HIU Manager to ensure that departmental records are integrated into the eMR.
- Health records are regularly evaluated to ensure they meet medico-legal requirement professional standards and are benchmarked across other health facilities.

5 Principles/Guidelines

5.1 Copy and paste in the eMR

- To ensure correct, current and relevant information is documented, as a general principal users should not copy and paste between parts of the eMR. Tagging needs to be used (see 5.2 below).
- Copy and pasting is limited to when users need to bring new clinical information into the eMR, from other documents or emails.
- Staff are to comply with Department based policies on documentation in the medical record.

5.2 Tagging in the eMR

- Clinicians may use the Tag function in Documentation to copy information from other clinicians' notes providing that it is still current and applicable to the patient. The advantage of Tagging information is that it clearly shows the original document source of the text in a footnote.
- Learning.kids Tagging text in Documentation

5.3 Responsibility for corrections in the Record eMR:

- If an error is made, the user will need to log a Digital Helpdesk request
- Health Information Managers (HIM) will be notified of the request.
- The HIM will access the eMR documentation and review the error.
- In the instance a document needs to be removed from a patients file, the HIM will review the documentation, and will assess if approval to “hide” the document will only be granted. The condition that needs to be met are:
    - The document was written in the wrong patient’s eMR.
    - The document contains sensitive information.
    - The document contains personal staff member information.

- Guidance regarding who has responsibility for correcting errors identified in the eMR is as follows.

5.3.1 Clinical Documentation:

- If the clinician who made the error is still working in the SCHN, responsibility to correct the documentation remains with that clinician.
- If the clinician is no longer employed by the SCHN, responsibility falls with the Head of the Department.
- If a request for amendment has been made under Health Records Information Privacy Act (HRIPA), Privacy Information Personal Protection Act (PIPPA) or Government Information Privacy Act (GIPA) the responsibility for determining if correction or amendment should occur, falls with the Director of Clinical Governance (DCG) of the SCHN or their delegate. If the amendment is agreed to by the DCG (or delegate) then the amendment should be made by the Head of the Department.
- If a request for amendment has been made under HRIPA, PIPPA or GIPA, and the Director of Clinical Governance (or delegate) disagrees with the request for amendments, the individual has the right under legislation to have their own statement attached to their record. The SCHN cannot refuse the statement submitted. In such cases the statement will be scanned into the patient's eMR.

5.3.2 Administrative Documentation:

- Where client registration details have been identified as incorrect or require updating then as per the client registration policy, the Campus where the patient is being treated currently should update the details in their respective Person Management systems.
- Written requests received to correct/change/update registration details are to be managed by the Patient Administration System (PAS) Team in HIU at either campus.

5.4 Transcription of the data on behalf of the treating clinician

- Transcription on behalf of the treating clinician by non-clinical staff may occur under certain circumstances (e.g., after eMR downtime, or under agreed planned care documented elsewhere) **provided that**:
    - The staff doing the transcription have successfully completed an accredited medical terminology or equivalent course.
    - Have completed basic Person Management training with the SCHN Application Training and Support Unit
    - Have completed training in the relevant eMR function.
    - Have maintained skills by entering data on a regular basis.
    - The Clinical Director/Department Head who has authorised the transcription of data into the eMR on behalf of the treating clinician has established processes to ensure the quality of the transcribed data is verified for example by periodic auditing.

- Approval is to be sought from the SCHN Clinical Systems and Data Governance Committee (CSAD) in cases where the treating clinicians wish other staff to transcribe information into the eMR on their behalf that vary from the guidelines outlined above.
- Where a clinical diagnosis has not been recorded in the medical record the medical record should be reviewed by a clinician.

5.5 Documentation by Administrative Staff

The SCHN Clinical Systems and Data Governance Committee (CASD) has approved administrative staff to document into the electronic medical records and capture health information that has been exchanged as part of the information collection process. Examples include administrative staff calling patients about fasting requirements. Any entry in the eMR completed by administrative staff will be easily identifiable as such with the staff name. Administrative staff are only able to access certain documents within the eMR based on their designation.

5.6 Email communication between clinicians and patients

- Email is sometimes used by clinicians as a means of therapeutic communication with patients. If clinical communication to patients using a work email address occurs, the following **safeguards should be in place**:
  - There should be a pre/postscript contained in all emails stating that they will only be read during work hours and that for urgent health related matter, the patient should contact relevant health care provider (GP, ED, Community after-hours team etc.).

    SCHN suggested Pre/Postscript *"Emails will only be reviewed and actioned during business hours (8.30am-5pm). For any urgent health related matters, patients are directed to contact their relevant Health Care Provider or present at their nearest ED".*
  - If the clinician is on leave, the out of office message should state that they cannot guarantee that any email will be read and responded to within a particular timeframe. Therefore, any urgent clinical matters should be referred to the clinician on-call for the specialty, the emergency department, or the GP as appropriate.
  - If, *a patient* sends an email that contains clinically relevant information to a clinician this information should be treated as correspondence from the patient and scanned into the eMR.
  - Phone/Communication note form in eMR allows for the documentation of content from an email to be included as part of the patient's eMR.
  - Electronic correspondence should be forwarded to schn-hiu@health.nsw.gov.au for inclusion in the eMR.
  - A messaging system is also available via the Cartula Health App between the clinician and parent/carer when parent/carers download the app. See the My Health Memory app on SCHN website.

- Parents/carers can also upload documentation into the app to assist with the patient care.
- A document interface also allows sending of information to the parent/carer to the app as an alternative to email.

5.7 Photography

If a photograph of a patient is required during treatment the **clinical photographer** should be requested. If the urgency or location of photographs required make this impractical, clinicians may photograph patients with the following in place:

- The clinician undertakes:
  - to photograph patients solely for the purpose of clinical management with the full consent of the patient or carer.
  - as soon as practical to have the photograph imported into the eMR, and **deleted** from their personal device.
  - not to divulge any personal health information or photographs from their phone/device.
  - not to copy, retain, store or transfer the information or photographs, or part thereof, other than for the purposes of the provision of data to the patient's medical record.
  - to immediately destroy upon completion of the provision of the reports any copy, representation, image or impression of the photographs made or held by or on any record storage device of the clinician.
  - ensure that their device is secured with a password and remote deletion to ensure against loss, unauthorised access, use, modification or disclosure and any other misuse.
  - if sending the photograph via unsecured messaging for urgent assistance there must be no identifiers on the photograph, and anything that could identify the patient should be obscured.
  - not to further use the photograph for education teaching or any other purpose without explicit signed consent, a copy of which must be retained in the record.
- Electronically transferred images to be included in the eMR should be forwarded to schn-hiu@health.nsw.gov.au

Refer to the SCHN Clinical Images, Photography, Video and Audio recordings of Paediatric Patients policy.

5.8 Health Record Content

The health record must include a record by the medical practitioner of the history, examination, investigation, diagnosis, treatment, adverse events and progress for each treatment episode. A record must be made for the provision of each medical treatment or other medical service or consultation. The record must be contemporaneous or entered as soon as practicable after events.

'Health care personnel who provide a service, assessment, diagnosis, management and/or professional advice are responsible for legibly documenting and dating activity in the person's health record.'

- All entries will be dated, and time stamped and signed by the individual clinician (it is not sufficient to only record the Team name, although that can be included)
- The paper copy record may also include correspondence and external results. Correspondence includes referral letters from the GPs and external clinician, copies of notes from other facilities, request copies of clinical information and consultant's outpatient letters back to GPs.
- External results include all diagnostic reports, such as pathology reports and x-ray reports from external providers. These ***will be*** scanned into the medical record.
- The date of documenting in the health care record will be taken as evidence of contemporaneous record keeping. The health information collected, stored and used in the eMR meets requirements for retention and security and can be accessed by clinicians across the network.
- The date of document creation and not the "printed on" date is to be taken as evidence of contemporaneous record keeping.

To obtain a complete and accurate view of the current status of a patient, staff must access the electronic health record including scanned documents.

Printed information derived from the eMR is not regarded as part of the paper medical record and will not be filed in the medical record; the eMR is considered the source of truth when duplication is evident.

Clinical information held in the eMR will be printed for legal requests such as subpoenas or when lawfully authorised for release or external review where necessary.

The following principles apply to medical records and contemporaneous notes:

- A note is any documentation which is made about clinical decisions, treatment, advice, or actions for the immediate or ongoing care of the patient.
- Documentation in the health record is to occur at the time of, or as soon as practicable following the provision of care, observation, assessment, diagnosis, review of results, management /treatment, professional advice, or any other matter of worthy note, including documentation of incidents relating to the patient.
- As far as possible, documentation should be in chronological date order, with all entries dated and signed by the clinician (including a printed last name and title).
- Discharge summaries are a government requirement and must be completed within 48 hours of the patients discharge.
- The fact that a diagnostic result exists, whether it is in printed or electronic form is not sufficient evidence that a clinical decision has been made or clinical treatment or action has been initiated using the information.
- When clinical treatment or action is initiated in response to either hard copy printed results or electronically stored results, a contemporaneous note must be documented by the clinician in the **progress notes**. Contemporaneous notes made on hard copy records *will be scanned* as part of the medical record.
- Results sign off should occur in the eMR. Clinical results which are printed from eMR, and which have been initiated or signed by a clinician but without additional notation will be destroyed by the Health Information Unit in accordance with the SCHN Destruction of Health Care Records Policy.
- Contemporaneous notes promote a continuity of a person's care across service and time boundaries and when required as evidence of patient care are essential for protecting the legal interest of the patient, hospital or service, Area Health Service, and clinical staff.
- Records of consultation should be recorded, signed and dated in the health care record.

6 Privacy and Confidentiality of Health Information

SCHN staff and employees are bound by the Health Privacy Principles which underpin privacy legislation in NSW.

In using the eMR or paper record, clinicians are reminded that they need to abide by the. NSW Health Privacy Manual for Health Information .

The confidentiality of the patient is protected by security safeguards. For example, access to patient information is determined by the role of the user. Clinicians have open access and administration staff have limited access. If you do not have the necessary authority to view a patient's data, it is not displayed for your logon. For patient privacy reasons, only those who need to view or enter information for patient records are permitted to do so.

It is important to ONLY use your personal username and password for access to patient medical records. All employees of NSW Health sign confidentiality agreements on commencement of their employment stating that information and access to medical records will only be during their course of work. An audit runs periodically and can be produced on request, which shows every staff member who has accessed a patient's medical record. Further information about Information Privacy please refer to the NSW Health **Privacy website**.

Inappropriate use or viewing of records can result in termination. A leaflet for SCHN staff outlining their privacy obligations can be reviewed for additional information.

7 Access to SCHN Health Care Records

Patient information can **ONLY** be accessed in accordance with NSW Privacy Legislation

7.1 Internal and/or External Health Professionals or other Agencies

- Health Professionals or other accredited agencies can access patient information. The following linked documents provide detailed guidelines on accessing information under different circumstances.
    - **Access and amendment to patient information by the patient, parent, guardian or other parties** Access and Amendment to Patient Information by the Patient, Parent, Guardian or other Parties
    - ***Government Information (Public Access)*** [GIPA] ***Act 2009*** (NSW): https://www.ipc.nsw.gov.au/
    - SCHN Access to Electronic Healthcare Records for Improvement Activity or Case Study Purposes procedure.
    - SCHN "**Keep Them Safe**" – Child Protection intranet site: https://intranet.schn.health.nsw.gov.au/child-protection-and-wellbeing.

7.2 Consumer Access: Patient and/or Parent or Guardian

Documented guidelines are available for consumers on how to access their medical record. Refer to the following documents:

- SCHN Access and Amendment to Patient Information by the Patient, Parent, Guardian or other Parties policy.
- **GIPA website:** https://www.ipc.nsw.gov.au/

8 SCHN Key Performance indicators

- All paper records will be returned to the Health Information Unit (HIU) by the next working day
- All records will be retrievable electronically
- Satellite records will be diminished over time.
- Turnaround times (from return of notes to the HIU) for:
  - ED scanning is within 8 hours
  - OPD within 24 hours
  - Inpatients within 48 hours
- All clinical staff will be trained in the use of the eMR