HEALTHCARE RECORDS - RETURN

POLICY©

DOCUMENT SUMMARY/KEY POINTS

- To ensure ongoing patient care, patient information documented on approved healthcare forms, must be returned to the Health Information Unit (HIU) at each facility, in a timely manner. The SCHN health care record is electronically generated in eMR, however there are some paper health care forms that have not been transitioned to an electronic format.
- Health information includes information relating to any episode of care: inpatient, non-admitted patient, and correspondence and investigation relation information.
- Inpatient healthcare records must be returned to the Health Information Unit within 48 hours of discharge. Discharges on a weekend can be returned on the Tuesday (to allow for the completion of discharge summaries)
- Emergency/Outpatient health care records must be returned to the Health Information Unit within 24 hours of the patient attending.
- Correspondence and investigation information must be attached to the related discharge and/or clinic attendance prior to return.
- All healthcare record forms MUST be returned to the Health Information Unit with a valid Medical Record Number (MRN) on them.

CHANGE SUMMARY

- Due for mandatory review. Added Section 1.2 Departmental Records.

READ ACKNOWLEDGEMENT

- All staff working in clinical areas and/or where health care records are used are to read and acknowledge they understand the contents of this document.

1 Returning Inpatient Health Care Records

- Administrative officers in charge of returning the paper health care record should ensure Inpatient health care records are returned to the Health Information Unit at your facility **within 48 hours of patient discharge**. Each discharge must have the appropriate front sheet with the correct discharge date and correct ward documented.
- The administrative officer should take reasonable steps to ensure forms relating to the discharge are:
  - Identified with a patient identification label placed on the top right corner of the form.
  - Placed in chronological date order from admission to discharge.
  - Blank forms and carbon copies are removed from the record.
  - All the forms within the patient file belong to the corresponding patient to ensure patient confidentiality.
  - Ensure each patient record has a black/silver clip attached holding the notes together
  - Ensure there are no staples on any documents returned
  - Health records must be hand delivered to the Health Information Unit by the administrative officer, in a confidential black bag to protect patient confidentiality. Black bags are available from Health Information Unit upon request.
- Clinicians should be encouraged to complete front sheet and discharge summaries on the ward before the information is returned to the Health Information Unit.

Note: An arrangement has been made with the Director of Medical Services and Clinical Governance that any discharges that occur on a weekend can be returned on the Tuesday to allow time for the clinicians to complete their documentation requirements.

1.1 Long term patients

Some patients have an extended stay in the Hospital and in these circumstances arrangements have been made with Health Information Unit (HIU) for these notes to be returned to the HIU at the beginning of every month to allow for ease of processing.

1.2 Departmental records

Historically some departments had created and retained separate department records. These are considered to be satellite files and need to be integrated into the eMR. In order to integrate into the eMR, the department needs to contact the Clinical Documentation Co-ordinator in the Health Information Unit to organise options. Depending in the amount of departmental files, records could either be scanned inhouse, or sent to an external scanning vendor approved by the NSW Health for digitisation.

2 Returning Outpatient Health Care Records

- Outpatient health care records must be returned to the Health Information Unit **within 24 hours of the patient attending the clinic**.
- The **Outpatient administrative officer** should take reasonable steps to ensure that any forms relating to the Outpatient attendance has:
  - A patient identification label placed on the top right hand corner of the form.
  - The corresponding clinic name sticker is placed on the form or hand written.
  - The date of attendance is clearly documented on the corresponding form.
  - The name of the treating doctor is clearly documented on the corresponding form.
  - It is NSW Health policy that a new patient requires a referral letter prior to an Outpatient Department appointment being made. Please ensure that these referral letters have a MRN documented on them prior to them being returned to the HIU. Referrals need to be clearly identified as they are prioritised for scanning in the HIU.

3 Returning Emergency Health Care Records

- The **Emergency Administrative officer** should take reasonable steps to ensure any forms relating to the emergency attendance have:
  - A barcoded patient identification label placed on the top right hand corner on all forms
  - Date, time and clinician name entered on any documents generated in ED. Any unused patient identification labels are removed prior to returning information to the medical record department.
  - All forms relating to the attendance collated and clipped together with a black/silver clip.

4 Returning correspondence and investigation information

- Correspondence or loose documents should be attached to the related discharge and/or clinic attendance prior to return where possible.
- Adherence to the above policy ensures patient information can be processed in a timely and efficient manner and readily available for ongoing care.