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 is committed to the adoption of the Electronic Medical Record (eMR) as the core clinical records system, progressively moving away from paper documentation.
- The SCHN Health Care Records are currently in a Hybrid State; a record that exists in both paper and electronic systems. Where Clinicians need to work with both paper and electronic parts of the record, all personnel must have a clear understanding of what is contained in each part.
- 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 PowerChart, Patient Management, scheduling systems, as well as scanned paper records, internal and external forms and includes: patient demographics, visit history, orders, results, specialty documentation, Emergency Department and inpatient discharge summaries, departmental letters/reports and allergy and problem information. Linked systems include ED, ICU, surgical and radiology among others.
- There are a number of NSW Ministry of 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 Health Care Records Governance Committee (HCRC) via the chair, or via the Health Information Unit (HIU) Managers.
- This policy document is reviewed annually via the HCRC

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 if **at CHW Access and Amendment to Patient Information by the Patient, Parent, Guardian or Other Parties.**

CHANGE SUMMARY

- Minor review to add section 5.4 as agreed by the SCHN Health Care Records Governance Committee.

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 PowerChart and other 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 Hospital 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 version of the 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 & Disposal Authority-Imaged Records GdA36, NSW Health Information Bulletin IB2009_064)

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 consists of paper-based and electronic notes. The paper-based notes are scanned and integrated into the electronic Medical Record. Scanning is managed by the Health Information Unit (HIU) at either campus (CHW or SCH). There are a variety of contributing systems that form the electronic Medical Record (eMR) across the Network: PowerChart, Health-e-Care, FirstNet, Surginet, PathNet and Critical Care Information System (CCIS). All of these are collectively referred to as the eMR. 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 Department of 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 Content

- PowerChart is the computer application used as the foundation view of eMR across SCHN and is the user interface for clinical staff to access patient information in the electronically stored medical record.
- Each patient's health care record is available online, and various displays regarding the patient's status are visible in the summary page. The functionality of PowerChart is progressively being expanded and improved with the long term intention to replace paper documentation.
- Some of the current information available through PowerChart includes:
  - Patient Demographics (including next of kin information and GP contacts)
  - Patient summaries
  - Visit Lists (ED, Inpatient and Outpatient visits)
  - Inpatient Discharge Summaries
  - Laboratory and Medical Imaging Orders and Results
  - Emergency Department Summaries at CHW and ED documentation at Sydney Children's Hospital (SCH)
  - Perioperative documentation at SCH
  - Outpatient Letters
  - Outpatient Scheduling
  - Departmental Letters
  - Growth Charts
  - Specialty documentation (variable to sites)
  - Imaged Documents viewable via an interface with the Clinical Record Information System (CRIS). CRIS is the repository of scanned paper medical records.
- PowerChart enables clinicians to view lists of current patients, which can be grouped by location, team or other criteria.
- Where functions are available in PowerChart they should not be replicated on paper except when providing service in downtimes.
- No electronically available records will be printed for internal use, but can be printed on request for other agencies, contact the HIU for assistance.

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.

3.1 Ordering tests

- All requests for pathology and imaging tests for inpatients must be placed electronically via PowerChart. Only when PowerChart is unavailable, a paper request form may be completed and forwarded to the laboratory or medical imaging. *(There are exceptions to this in the outpatient setting there are some exceptions to imaging, and pathology external tests at this time.)* **At CHW**, more information about ordering test can be found at:
  - Pathology Tests: Ordering, Tracking and Result Viewing – CHW policy

3.2 Result Review

- The results of any patient can be viewed in PowerChart.
- Inpatient results will not be printed
- Outpatient results are printed and sent to the requestor; however this is being phased out.
- To enable monitoring of results, the PowerChart *Message Centre* notifies clinical staff of new results from investigations that they have ordered.

The ***Message Centre*** within eMR will be implemented across SCHN by September 2014

- In order to receive the notification, the clinician must first log onto PowerChart.
- Allows results to be forwarded to other interested parties and allows for comments to be added to the results.
- Results are able to be reviewed and signed electronically to ensure compliance with the NSW Ministry of Health Policy Directive PD2012_069 "Health Care Records – Documentation and Management"
- Clinical staff will need to regularly access the Message Centre to check results and mark them as viewed.
- **Critical or urgent results** will continue to be notified by phone as per existing Laboratory and Medical Imaging Department policies.
- Results that have not been viewed in the *In-box* will be **automatically removed after a period of 3 months**.
- All results remain permanently available for viewing through the PowerChart.

While the Message Centre is designed to assist clinical staff in the systematic checking of results, none of its functions replace the overall responsibility of clinical staff and units to make themselves aware of and act on test results for their patients.

4 Compliance with NSW MoH 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 progression towards an integrated eMR, all staff have a responsibility to stay abreast of the enhancements to the information available within PowerChart and other clinical information systems.
- All SCHN health care records are scanned and made available for viewing via PowerChart. Disposal conditions of these records is prescribed within the SCHN 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 Health Care Record created with a unique Medical Record Number (MRN) in accordance with the SCH Patient Registration & CHW Registration of Patients on Patient Management System Procedure.
- 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, by contacting the HIU (in accordance with the SCH Patient Registration & CHW Registration of Patients on Patient Management System Procedure).
- 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.
- 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.
- SCHN requires a single integrated medical record to be maintained by the HIU and eMR Unit. In some circumstances (and with the prior approval of the HIU Manager) where departmental satellite records exist, cross references in the respective hospital record tracking system should be made.
    - In accordance with EQuIPNational Standards on a single integrated medical record, it is required that all departments will liaise with the HIU Manager to ensure that departmental records are merged into the main record through the This will mean Departmental records will be scanned and 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 principle users are not encouraged to copy and paste between parts of the eMR, however this function is often used to bring new clinical information into the eMR, e.g. from other documents or emails.
- Staff are to comply with Department or Facility based policies on documentation in the medical record.
- Where copying and pasting is known to be required and appropriate e.g. adding radiology reports to discharge summaries, training is required to reinforce that care must be taken to ensure that any copy and pasted information is attached to the correct patient file. As part of their initial PowerChart training staff will be shown how and when to appropriately copy and paste in the eMR.

5.2 Responsibility for corrections in the Record eMR:

- The Health Information Managers (HIM) of each facility should be contacted when an error is identified.
- The HIM will access the eMR documentation error and use the guide below to identify and contact the appropriate person to correct error. This may include seeking assistance from the eMR team to help with correcting the record.
- Guidance regarding who has responsibility for correcting errors identified in the eMR is as follows.

5.2.1 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.

5.2.2 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 HIU at either campus.

5.3 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 PAS Trainer.
  - Have completed training in the relevant clinical modules.
  - 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 Health Care Records Governance Committee 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.

5.4 Documentation by Administrative Staff

  - The SCHN Health Care Records Goverance Committee 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 designation and name. There wil be limited ability to document in certain parts of the medical record and these will all require to be approved by the Health Records Governance Committee.

5.5 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 **safe guards 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/Post script *"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 PowerChart 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 for inclusion in the eMR: email schn-hiu@health.nsw.gov.au

5.6 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;

  (a) to photograph patients solely for the purpose of clinical management with the full consent of the patient or carer;

  (b) as soon as practical to have the photograph imported into the eMR, and **deleted** from their personal device;

  (c) not to divulge any personal health information or photographs from their phone/device;

  (d) 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;

  (e) 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;

  (f) 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;

  (g) 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.

(h) 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

5.7 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.'

The **paper based medical record** where personal health information including, assessment, findings at examination, treatment plans initiated following assessment and diagnostic results, medication charts, and other related clinical information may be documented in the first instance on paper and filed in the medical 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*** filed into the medical record.
- The date of writing in the medical 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.
- Different reports have different date titles such as "Verified", "Confirmed by" or "Date document completed and it is this date and not the "printed on" date, which 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 both formats of the health record.

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).
- 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** and filed in the hard copy medical record; or in the relevant fields in the eMR.
- Contemporaneous notes made on hard copy records *will be scanned* as part of the medical record
- The fact that a diagnostic results 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.
- 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 medical record. A letter sent back to the referring clinician in not deemed to be a sufficient record of consultation.

6 Privacy and Confidentiality

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.

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 Ministry of Health **Privacy website** at http://www.health.nsw.gov.au/pages/privacy.aspx

Inappropriate use or viewing of records can result in termination. A leaflet for Staff outlining their privacy obligations can be accessed via the Privacy Intranet Site.

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**: http://chw.schn.health.nsw.gov.au/o/documents/policies/policies/2006-8304.pdf
  - ***Government Information (Public Access)*** [GIPA] ***Act 2009*** (NSW): http://www.ipc.nsw.gov.au/privacy/gipa_act.html
  - Access to Electronic Healthcare Records (eMR) for Research, Improvement Activity or Case Studies Policy and Procedure (currently under review)
  - **Opioid Dependence – Sharing of Information between NSW Health and DoCS for Child Protection Purposes Policy**: http://chw.schn.health.nsw.gov.au/o/documents/policies/policies/2007-8053.pdf
  - SCHN "**Keep Them Safe**" – Child Protection intranet site: http://chw.schn.health.nsw.gov.au/ou/child_protection/resources/keep_them_safe/

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:

- **Access and amendment to patient information by the patient, parent, guardian or other parties:** http://chw.schn.health.nsw.gov.au/o/documents/policies/policies/2006-8304.pdf
- **GIPA website:** http://www.ipc.nsw.gov.au/privacy/gipa_act.html

8 Key Performances indicators

- All 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 and eliminated by 2016.
- Turnaround times(from return of notes to the HIU) for:
  - ED scanning is within 8 hours
  - OPD within 24 hours
- Admissions within 48 hours
- All clinical staff will be trained in the use of the eMR

9 Related Policies and Bibliography

1. Communications: Use and Management of Misuse of NSW MoH Communication Systems (PD2009_076): http://chw.schn.health.nsw.gov.au/o/documents/policies/policies/2006-8323.pdf
2. Healthcare Records – Documentation and Management (PD2012_069): http://chw.schn.health.nsw.gov.au/o/documents/policies/policies/2013-9048.pdf
3. Access and Amendment to Patient Information by the Patient, Parent, Guardian or Other Parties: http://chw.schn.health.nsw.gov.au/o/documents/policies/policies/2006-8304.pdf
4. Accessing PowerChart (eMR) by Researchers or others involved in Improvement Activities or Case Studies (under review)
5. Access to Electronic Copies of Imaged Documents by Staff for Research Purposes: (under review)
6. Privacy Manual Version 2: http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_593.pdf
7. Destruction of Scanned Health Care Records: http://chw.schn.health.nsw.gov.au/o/documents/policies/policies/2014-9019.pdf
8. Pathology Tests: Ordering, Tracking and Result Viewing – CHW: http://chw.schn.health.nsw.gov.au/o/documents/policies/procedures/2007-8059.pdf
9. Registration of Patients on Patient Management System – CHW policy: http://chw.schn.health.nsw.gov.au/o/documents/policies/procedures/2007-8020.pdf
10. SCH Patient Registration policy: http://seslhnweb/iPM/Training_UserGuides/Guides/PatientRegistrationVersionAPAC2_1.pdf
11. NSW Health Client Registration Standard: http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_094.pdf
12. Medical Records Return – CHW policy; http://chw.schn.health.nsw.gov.au/o/documents/policies/policies/2006-8164.pdf
13. NSW Health Patient Matters Manual: http://www.health.nsw.gov.au/policies/manuals/Pages/patient-matters-manual.aspx
14. NSW Health Records - Principles for Creation, Release, Storage and Disposal of Health Care Records: http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_127.pdf
15. EQuIPNational Accreditation Guidelines (accessed via Clinical Governance Unit Intranet site > Resources> Accreditation > EQuIPNational Resources)