The Sydney children's Hospitals Network
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HEALTHCARE RECORDS - RETURN

POLICY©

DOCUMENT SUMMARY/KEY POINTS

- To ensure ongoing patient care, patient information must be returned to the Health Information Unit (HIU) in a timely manner. The health care record comprises all hard copies of health related information generated about a patient. This includes: 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 and/or front sheets)
- **Emergency/Outpatient medical record** must be returned to the Health Information Unit **within 24 hours of the patient attending the clinic**.
- 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 - minor changes made throughout the policy.

READ ACKNOWLEDGEMENT

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

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1 Returning Inpatient Health Care Records

- The administrative officer in charge of returning the health care record should ensure Inpatient health care records are returned to the Health Information Unit **within 48 hours of patient discharge**. Each discharge must have the appropriate front sheet with the correct discharge date and correct ward separation.
- 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 strict form numerical order and are 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 are in correct order and belong to the corresponding patient to ensure patient confidentiality.
  - Ensure each patient record has a black/silver clip attached for each patient separately.
- 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 Clinical Governance and Medical Administration 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.

- Discharges 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.

> **Process at SCH:** For Loose Admissions discharges SCH Clinical Support Administrators are to create an LA document type in PDT tracking. All returned LA's and CMR's then need to be tracked to *Returns* prior to the file returning to HIU. Please refer to PDT for tracking procedure http://seslhnweb/iPM/Training_User/UserGuides.asp

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.

This Policy/Procedure may be varied, withdrawn or replaced at any time. Compliance with this Policy/Procedure is mandatory.

2 Returning Outpatient/Emergency 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 Clerk** 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 documented on the corresponding form.
  - For brand new patients only, a single entry must be made per page for scanning and indexing purposes. A barcode patient identification label must be placed on each form.
  - It is policy that a new patient requires a referral letter prior to an Outpatient Department appointment being made. Please ensure that these referral forms have a MRN documented on them prior to them being returned to the HIU.
- The **Emergency Clerk** should take reasonable steps to ensure any forms relating to the emergency attendance have:
  - All forms must have a barcoded patient identification label placed on the top right hand corner
  - Date, time and clinician name entered on the assessment sheet.
  - Any unused patient identification labels are removed prior to returning information to the medical record department.
  - All forms relating to the discharge collated together.

3 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.

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