

## Health Care Records - Documentation and Management

**Summary** The Health Care Records Policy defines the requirements for the documentation and management of health care records across public health organisations in the NSW public health system. The Policy ensures that high standards for documentation and management of health care records are maintained consistent with common law, legislation, ethical and current best practice requirements.

This Policy replaces PD2005\_004, PD2005\_015 and PD2005\_127.

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**Distributed to** Public Health System, Divisions of General Practice, Health Associations Unions, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

**Audience** All NSW Health staff

### Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

## HEALTH CARE RECORDS – DOCUMENTATION AND MANAGEMENT

### PURPOSE

The purpose of this policy is to:

- Define the requirements for the documentation and management of health care records across public health organisations (PHOs) in the NSW public health system.
- Ensure that high standards for documentation and management of health care records are maintained consistent with common law, legislative, ethical and current best practice requirements.

### MANDATORY REQUIREMENTS

Documentation in health care records must provide an accurate description of each patient / client's episodes of care or contact with health care personnel. The policy requires that a health care record is available for every patient / client to assist with assessment and treatment, continuity of care, clinical handover, patient safety and clinical quality improvement, education, research, evaluation, medico-legal, funding and statutory requirements.

Health care record management practices must comply with this policy.

### IMPLEMENTATION

#### Chief Executives are responsible for:

- Establishing mechanisms to ensure compliance with the requirements of this policy.
- Ensuring health care personnel are advised that compliance with this policy is part of their patient / client care responsibilities.
- Ensuring line managers are advised that they are accountable for implementation of this policy.
- Ensuring implementation of a framework for auditing of health care records and reporting of results.
- Ensuring health care records are audited and results reported within the PHO.

#### Facility / service managers are responsible for:

- Ensuring the requirements of this policy are disseminated and implemented in their hospital / department / service.
- Ensuring health care personnel within their facility / service have timely access to paper based and electronic health care records.
- Monitoring compliance with this policy, including health care record audit programs, and acting on the audit results.

#### Health care personnel are responsible for:

- Maintaining their knowledge, documentation and management of health care records consistent with the requirements of this policy.
- Ensuring they are aware of current information about the patient / client under their care including where appropriate reviewing entries in the health record.

## REVISION HISTORY

Version	Approved by	Amendment notes
November 2012 (PD2012_069)	Director-General	This Policy Directive replaces: <i>PD2005_004 Medical Records in Hospitals and Community Care Centres</i> <i>PD2005_015 Medical Records</i> <i>PD2005_127 Records – Principles for Creation, Management , Storage and Disposal of Health Care Records</i>

## ATTACHMENTS

1. Health Care Records – Documentation and Management Standard.

## Health Care Records – Documentation and Management



**Issue date:** December 2012

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## 1 OVERVIEW

### 1.1 Introduction

This standard sets out the requirements for documentation and management for all models of health care records within the NSW public health system. Health care records promote patient safety, continuity of care across time and care settings, and support the transfer of information when the care of a patient / client is transferred eg. at clinical handover, during escalation of care for a deteriorating patient and transfer of a patient / client between settings.

### 1.2 Key definitions

<b>Attending medical practitioner</b>	Visiting Medical Officer or Staff Specialist responsible for the clinical care of the patient for that episode of care.
<b>Approved clinician</b>	A clinician, other than a medical practitioner, approved to order tests eg Nurse Practitioner.
<b>Health care personnel</b>	<p>A person authorised to provide assessment, diagnosis, treatment / care, observation, health evaluation or professional advice or those personnel who have access to the patient / client health care records on behalf of the NSW public health system to facilitate patient / client care.</p> <p>Health care personnel include clinicians (and students) and clinical support staff. Clinicians include registered health practitioners<sup>1</sup> and others including Assistants in Nursing, social workers, dieticians, occupational therapists and Aboriginal Health Workers. Clinical support staff include Health Information Managers, Clinical Governance and Patient Safety staff, ward clerks, health care interpreters and accredited chaplains.</p>
<b>Health care record</b>	<p>The main purpose of a health care record is to provide a means of communication to facilitate the safe care and treatment of a patient / client.</p> <p>A health care record is the primary repository of information including medical and therapeutic treatment and intervention for the health and well being of the patient / client during an episode of care and informs care in future episodes. The health care record is a documented account of a patient / client's history of illness; health care plan/s; health investigation and evaluation; diagnosis; care; treatment; progress and health outcome for each health service intervention or interaction.</p> <p>The health care record may also be used for communication with external health care providers, and statutory and regulatory bodies, in addition to facilitating patient safety improvements; investigation of complaints; planning; audit activities; research (subject to ethics committee approval, as required); education; financial reimbursement and public health. The</p>

<sup>1</sup> Health practitioners registered under the following National Boards - Chiropractic, Dental, Medical, Nursing and Midwifery, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry and Psychology – are required to comply with the health care records section of their relevant code of conduct/guidelines/competency standards. On 1 July 2012 the following healthcare personnel will be represented by a national registration board – Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners, and occupational therapists <http://www.ahpra.gov.au/>.

	<p>record may become an important piece of evidence in protecting the legal interests of the patient / client, health care personnel, other personnel or PHO.</p> <p>The health care record may be paper, electronic form or in both. Where a health care record exists in both paper and electronic form this is referred to as a hybrid record. Where PHOs maintain a hybrid record health care personnel must at all times have access to information that is included in each part.</p> <p>This policy applies to health care records that are the property of, and maintained by, PHOs, including health care records of private patients seen in the PHO. The policy does not apply to records that may be maintained by patients / clients and records that may be maintained by clinicians in respect of private patients seen in private rooms.</p>
<b>Must</b>	Indicates a mandatory action required by a NSW Health policy directive, law or industrial instrument
<b>Medical Practitioner</b>	A person registered under the Health Practitioner Regulation National Law (NSW) in the medical profession.
<b>Public health organisation (PHO)</b>	<ul style="list-style-type: none"> <li>a) Local health district</li> <li>b) Statutory health corporation that provides patient / client services,</li> <li>c) Affiliated health organisation in respect of its recognised establishment or recognised service that provides patient / client services, or</li> <li>d) Ambulance Service of NSW.</li> </ul>
<b>Should</b>	Indicates an action that ought to be followed unless there are justifiable reasons for taking a different course of action.

### 1.3 Privacy and confidentiality

All information in a patient / client’s health care record is confidential and subject to prevailing privacy laws and policies. Health care records contain health information which is protected under legislation.<sup>2</sup> The requirements of the legislation, including the Privacy Principles, are explained in plain English in the NSW Health Privacy Manual.<sup>3</sup> Health care personnel should only access a health care record and use or disclose information contained in the record when it is directly related to their duties and is essential for the fulfilment of those duties, or as provided for under relevant legislation.

### 1.4 Auditing

Health care records across all settings and clinical areas must be audited for compliance with this policy. PHOs must establish a framework and schedule for auditing of records and approve and designate audit tools and processes.

<sup>2</sup> Health Records and Information Privacy Act 2002 <http://www.legislation.nsw.gov.au/maintop/view/inforce/act+71+2002+cd+0+N>,  
<sup>3</sup> PD2005\_593 Privacy Manual (Version 2) – NSW Health [http://www.health.nsw.gov.au/policies/pd/2005/PD2005\\_593.html](http://www.health.nsw.gov.au/policies/pd/2005/PD2005_593.html)

Clinical audits of documentation in health care records should involve a team based approach with the clinical team consisting of medical practitioners, nurses, midwives, allied health practitioners and other health care personnel, as appropriate.

Health care record audit results should be:

- a) Provided to relevant clinical areas and health care personnel.
- b) Included in PHO performance reports.
- c) Referred to PHO quality committees to facilitate quality improvement.

## 1.5 Education

PHOs must establish a framework for the development and delivery of suitable education on documentation and management of health care records. All health care personnel who document or manage health care records must be provided with appropriate orientation and ongoing education on the documentation and management of health care records.

The content and delivery of education programs should be informed by health care record audits. The results of such audits should be used to target problem areas relating to particular health care personnel groups or facets of documentation and management.

Specific education must be conducted for the introduction of any new complex health care record forms and for changes in documentation models.



## 2 DOCUMENTATION

### 2.1 Identification on every page / screen<sup>4</sup>

The following items must appear **on every page of the health care record**, or on each screen of an electronic record (with the exception of pop up screens where the identifying details remain visible behind):

- a) Unique identifier (eg. Unique Patient Identifier, Medical Record Number).
- b) Patient / client's family name and given name/s.
- c) Date of birth (or gestational age / age if date of birth is estimated).
- d) Sex. The exception is ObstetriX records where sex of the mother is not recorded.

### 2.2 Standards for documentation<sup>5</sup>

Documentation in health care records must comply with the following:

- a) Be clear and accurate.
- b) Legible and in English.
- c) Use approved abbreviations and symbols.
- d) Written in dark ink that is readily reproducible, legible, and difficult to erase and write over for paper based records.
- e) Time of entry (using a 24-hour clock – hhmm).
- f) Date of entry (using ddmmyy or ddmmyyyy).
- g) Signed by the author, and include their printed name and designation. In a computerised system, this will require the use of an appropriate identification system eg. electronic signature.
- h) Entries by students involved in the care and treatment of a patient / client must be co-signed by the student's supervising clinician.<sup>6</sup>
- i) Entries by different professional groups are integrated ie. there are not separate sections for each professional group.
- j) Be accurate statements of clinical interactions between the patient / client and their significant others, and the health service relating to assessment; diagnosis; care planning; management / care / treatment/ services provided and response / outcomes; professional advice sought and provided; observation/s taken and results.
- k) Be sufficiently clear, structured and detailed to enable other members of the health care team to assume care of the patient / client or to provide ongoing service at any time.
- l) Written in an objective way and not include demeaning or derogatory remarks.

<sup>4</sup> PD2009\_072 State Health Forms [http://www.health.nsw.gov.au/policies/pd/2009/PD2009\\_072.html](http://www.health.nsw.gov.au/policies/pd/2009/PD2009_072.html)

<sup>5</sup> Each registered health practitioner is required to comply with the health care records section of the code of conduct / guidelines / competency standards under their relevant National Board

<sup>6</sup> PD2005\_548 Student Training and Rights of Patients [http://www.health.nsw.gov.au/policies/pd/2005/PD2005\\_548.html](http://www.health.nsw.gov.au/policies/pd/2005/PD2005_548.html) and GL2005\_034 Reports – Countersigning Enrolled Nurse, Trainee Enrolled Nurse or Assistant in Nursing Patient Care [http://www.health.nsw.gov.au/policies/GL/2005/GL2005\\_034.html](http://www.health.nsw.gov.au/policies/GL/2005/GL2005_034.html)

- m) Distinguish between what was observed or performed, what was reported by others as happening and / or professional opinion.
- n) Made at the time of an event or as soon as possible afterwards. The time of writing must be distinguished from the time of an incident, event or observation being reported.
- o) Sequential - where lines are left between entries they must be ruled across to indicate they are not left for later entries and to reflect the sequential and contemporaneous nature of all entries.
- p) Be relevant to that patient / client.
- q) Only include personal information about other people when relevant and necessary for the care and treatment of the patient / client.
- r) **Addendum** – if an entry omits details any additional details must be documented next to the heading ‘Addendum’, including the date and time of the omitted event and the date and time of the addendum.

For hardcopy records, addendums must be appropriately integrated within the record and not documented on additional papers and / or attached to existing forms.

- s) **Written in error** - all errors are must be appropriately corrected.

No alteration and correction of records is to render information in the records illegible.

An original incorrect entry must remain readable ie. do not overwrite incorrect entries, do not use correction fluid. An accepted method of correction is to draw a line through the incorrect entry or ‘strikethrough’ text in electronic records; document “written in error”, followed by the author’s printed name, signature, designation and date / time of correction.

For electronic records the history of audited changes must be retained and the replacement note linked to the note flagged as “written in error”. This provides the viewer with both the erroneous record and the corrected record.

## 2.3 Documentation by medical practitioners

Documentation by medical practitioners must include the following:

- a) Medical history, evidence of physical examination.
- b) Diagnosis/es (as a minimum a provisional diagnosis), investigations, treatment, procedures / interventions and progress for each treatment episode.  
A principal diagnosis must be reported for every episode of admitted patient care.
- c) Medical management plan.
- d) Where an invasive procedure is performed and / or an anaesthetic is administered, a record of the procedure including completion of all required procedural checklists. Where a general anaesthetic is administered, a record of examination by a medical practitioner prior to the procedure is also required.
- e) Comprehensive completion of all patient / client care forms.
- f) A copy of certificates, such as Sick and Workers Compensation Certificates, provided to patients / clients must be retained in the patient / client’s health care record.

### 2.3.1 Attending Medical Practitioner

The Attending Medical Practitioner (AMP) is responsible for the clinical care of the patient / client for that episode of care and is responsible for ensuring that adequate standards of medical documentation are maintained for each patient / client under their care.

When documentation is delegated to a medical practitioner e.g. Intern, Resident, Registrar, the AMP remains responsible for ensuring documentation is completed to an appropriate standard that would satisfy their professional obligations.

The AMP should review the preceding medical entries and make a written entry in the health care record (print name, signature, designation and date/time) to confirm they have been read at the same time as they are reviewing the medical management plan for the patient / client to ensure it remains current and clinically appropriate, consistent with the AMP's duty of care to the patient / client.

## 2.4 Documentation by nurses and midwives

Documentation by nurses and midwives must include the following:

- a) Care / treatment plan, including risk assessments with associated interventions.
- b) Comprehensive completion of all patient / client care forms.
- c) Any significant change in the patient / client's status with the onset of new signs and symptoms recorded.
- d) If a change in the patient / client's status has been reported to the responsible medical practitioner documentation of the name of the medical practitioner and the date and time that the change was reported to him / her.
- e) Documentation of medication orders received verbally, by telephone / electronic communication including the prescriber's name, designation and date / time.

## 2.5 Frequency of documentation

The frequency of documentation entries should conform to the following as minimum requirements.

### 2.5.1 Acute Care Patient / clients

- a) Registered Nurse / Midwife, Enrolled / Endorsed Nurse should make an entry in the patient / client's health care record a minimum of once a shift. An entry by an Assistant in Nursing should **not** be the only entry for a shift.

Entries should reflect in a timely way the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient / client's condition and/or treatment should be documented as these occur.

- b) Medical practitioners should make an entry in the health care record at the time of events, or as soon as possible afterwards, including when reviewing the patient / client.<sup>7</sup>
- c) Other health care personnel should make entries to reflect their level of assessment and intervention consistent with the medical management plan.

<sup>7</sup> Medical Board of Australia. Good Medical Practice: A Code of Conduct <http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx>

### 2.5.2 Long Stay or Residential Patients / Clients

Depending on the health care setting and the length of stay (or expected length of stay) of the patient / client, health care personnel should make an entry at least weekly in the health care record particularly when warranted by the patient's medical condition or frailty.

Additional entries should be made to reflect changes in the patient / client status, condition and/or treatment or care plan as these occur.

### 2.5.3 Non-Admitted Patient / Clients

An entry must be made in the health care record for each patient / client attendance (including video conference sessions) and for failures to attend.

Entries should reflect the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient / client's condition and/or treatment should be documented.

Attendance of individual patient / clients at sessions of a formal multiple session group program should be noted. Such attendances may be documented in an attendance register or scheduling system rather than the patient / client's health care record. Where a patient / client receives specific individual care or treatment in addition to the group session interaction, this care or treatment should be documented in their health care record.

## 2.6 Alerts and allergies

Clinicians must flag issues that require particular attention or pose a threat to the patient / client, staff or others including:

- a) Allergies / sensitivities or adverse reactions, and the known consequence.
- b) Infection prevention and control risks.
- c) Behaviour issues that may pose a risk to themselves or others.
- d) Child protection / well being matters including
  - i. alerts and flags for High Risk Birth Alerts or prenatal reports
  - ii. children at risk of significant harm
  - iii. where NSW Police or the Department of Family and Community Services have issued a general alert to a PHO.
- e) Where patients / clients have similar names and other demographic details.

PHOs must implement systems for the identification of such alerts and allergies. If a label is used on the outside folder of a paper based health care record this does not negate the need for documentation in the health care record of the alert / allergy, and known consequence.

Any such issue should be 'flagged' or recorded conspicuously on appropriate forms, screens or locations within the health care record. Where alerts relate to behaviour issues or child protection matters the alert should be discreet to ensure the privacy and safety of the patient / client, staff or others.

These flags, especially where codes or abbreviations are used, must be apparent to and easily understood by health care personnel; must not be ambiguous; and should be standardised within the PHO.

A flag should be reviewed at each admission. When alerts and allergies are no longer current this must be reflected in the health care record and inactivated where possible.

## 2.7 Labels

Non-permanent adhesive labels should be avoided. Where considered essential the label must be relevant to the patient / client and placed so that all parts of the health care record are able to be read and patient / client privacy maintained. State approved labels must be used.

## 2.8 Tests – requests and results

The health care record must document pathology, radiology and other tests ordered, the indication and the result.

When tests are ordered the name of the ordering medical practitioner / approved clinician and their contact number must be clearly printed (if written) or entered (if computerised) on the request form.

Pathology, radiology and other test results must be followed up and reviewed with notation as to action required. The results must be endorsed by the receiving medical practitioner / approved clinician, with endorsement involving the name, signature, designation of the medical practitioner / approved clinician, and date / time.

PHOs must develop local procedures, including steps to be taken, when:

- a) Relevant details on the request form are incomplete or illegible.
- b) The ordering medical practitioner / approved clinician is not on duty or contactable.

**Critical/unexpected/abnormal results** should be documented in the patient / client's health care record by the responsible medical practitioner / approved clinician as soon as practicable and any resultant change in care / treatment plans documented.

## 2.9 Patient / client clinical incidents

All actual clinical incidents must be documented in the patient / client's health care record.<sup>8</sup>

Staff must document in the health care record.

- a) Incident Information Management System (IIMS) identification number.
- b) Clinically relevant information about the incident.
- c) Interactions related to open disclosure processes.<sup>9</sup>

## 2.10 Complaints

Complaint records are not to be kept with the patient's health care record.<sup>10</sup>

## 2.11 Emergency Department records

Emergency Department records must include the following:

<sup>8</sup> PD2006\_030 Incident Management Policy [http://www.health.nsw.gov.au/policies/pd/2007/PD2007\\_061.html](http://www.health.nsw.gov.au/policies/pd/2007/PD2007_061.html)

<sup>9</sup> PD2007\_040 Open Disclosure [http://www.health.nsw.gov.au/policies/pd/2007/PD2007\\_040.html](http://www.health.nsw.gov.au/policies/pd/2007/PD2007_040.html)

<sup>10</sup> Complaint Management Policy (section 7.9) [http://www.health.nsw.gov.au/policies/pd/2006/PD2006\\_073.html](http://www.health.nsw.gov.au/policies/pd/2006/PD2006_073.html)

- a) Date and time triaged including triage score.
- b) Presenting problem and triage assessment.
- c) Date and time seen by a medical practitioner, other clinicians such as a Clinical Initiatives Nurse, Nurse Practitioner, nursing, midwifery and allied health staff.
- d) Medical, nursing, midwifery and allied health assessment.
- e) Pathology, radiology and other tests ordered. Pathology, radiology and other test results must be followed up and reviewed with notation as to action required.
- f) Description of critical / unexpected / abnormal pathology, radiology and other test results. If the patient / client has left the Emergency Department and not been admitted, document the steps taken to contact the patient / client or their carer if the test results indicate that urgent treatment / care is required.
- g) Details of treatment.
- h) Follow up treatment where applicable.
- i) Transfer of care date and time, destination (eg. home, other level of health care) method and whether accompanied.

## 2.12 Anaesthetic reports

Anaesthetic reports must include the following:

- a) Pre-operative assessment, including patient anaesthetic history.
- b) Risk-rating eg. American Society of Anaesthesiologists (ASA) score.
- c) Date and time anaesthetic commenced and completed.
- d) Anaesthesia information and management ie. medications, gases, type of anaesthetic.
- e) NSW safety checklists including patient assessment and equipment checklists consistent with Australian and New Zealand College of Anaesthetists requirements.
- f) Operative note / monitor results.
- g) Post-operative notes / orders.

## 2.13 Operation / procedure reports

Operation / procedure reports must include the following:

- a) Date of operation / procedure.
- b) Pre-operative and post-operative diagnosis.
- c) Indication for operation / procedure.
- d) Procedure safety checklist.
- e) Surgical operation / procedure performed.
- f) Personnel involved in performing the operation / procedure.
- g) Outline of the method of surgery / procedure.
- h) Product / device inserted and batch number.

- i) Changes to, or deviations from, the planned operation / procedure, including any adverse events that occurred.
- j) Operative / procedural findings.
- k) Tissue removed.
- l) Pathology ordered on specimens.
- m) Post-operative orders.

## 2.14 Telephone / electronic consultation with patient / clients

When clinical information is provided to a patient / client, or their carer / guardian / advocate, the consultation must be documented in the health care record. The identification of the caller must be documented.

Where the caller is not the patient / client, or their carer / guardian / advocate obtain consent from the patient / client, or their carer / guardian / advocate prior to the consultation. Document the

- a) Caller's name,
- b) Relationship to the patient / client, and
- c) That the patient / client, or their carer / guardian / advocate has consented to the caller seeking clinical information about the patient / client

in the patient / client's health care record.

## 2.15 Telephone / electronic consultation between clinicians

Where a clinician involved in the care and treatment of a patient / client formally consults another clinician, via telephone / electronic means, about the patient / client and the consulted clinician provides advice, direction or action, that advice, direction or action must be documented in the health care record by the clinician seeking the advice. The name and designation of the consulted clinician, and the date / time of the consultation must also be documented as soon as practical following consultation with the other clinician and in a manner as to ensure continuity of care for patients.

## 2.16 Leave taken by patients / clients

Any leave taken by the patient / client should be documented in their health care record with the date / time the patient / client left and returned. The patient / client should be assessed before proceeding on leave and the outcome of that assessment documented in the health care record, together with the documented approval of the AMP noting the assessment.

## 2.17 Leaving against medical advice

A patient/client who decides to leave the health service/program against medical advice must be asked to sign a form to that effect with the form filed in the patient/client's health care record. If the patient/client refuses to sign the form this must be documented in the health care record, including any advice provided.

Examples of advice that could be provided to the patient/client include:

- a) The medical consequences of the patient's decision, including the potential consequences of no treatment
- b) The provision or offering of an outpatient management plan and follow-up that is acceptable and relevant to the patient
- c) Under what circumstances the patient should return, including an assurance that they can elect to receive treatment again without any prejudice.



## 3 MANAGEMENT

### 3.1 Responsibility and accountability

The Chief Executive of the PHO must comply with the State Records Act and its regulation in respect of health care records.<sup>11</sup>

Responsibility for the maintenance of appropriate health care records must be included in the terms and conditions of appointment (including position descriptions) for all health care personnel as defined in this policy.

Documentation must be included as a standing item in annual performance reviews of clinicians. Failure to maintain adequate health care records will be managed in accordance with current NSW Health policies and guidelines for managing potential misconduct.

### 3.2 Individual health care record

An individual health care record with a unique identifier (eg unique patient identifier, medical record number) must be created for each patient / client who receives health care. Every live or still born baby must be allocated a unique identifier that is different to the mother.

Where multiple patient identifiers exist for the same patient / client within a PHO there must be processes established for their reconciliation and linkage, with the ability to audit those processes.

A reference notation should be placed on the health care record to identify any relevant other documents that relate to the patient's health care. Index or patient administration systems must reference the existence of satellite / decentralised health care records that address a specific issue and that are kept separate from the principal health care record. Due to the nature of the information contained in sexual assault records these must be maintained separately from the principal health care record and be kept secure at all times; as should child protection / wellbeing and genetics records.

Staff screening and vaccination records are considered as personnel rather than health care records and must be maintained separately.

### 3.3 Access

Health care records should be available at the point of care or service delivery. Health care records must not be removed from the campus unless prior arrangements have been made with the PHO eg. required for a home visit, required under subpoena.

Health care records are only accessible to:<sup>12</sup>

- a) Health care personnel currently providing care / treatment to the patient / client.
- b) Staff involved in patient safety, the investigation of complaints, audit activities or research (subject to ethics committee approval, as required).

<sup>11</sup> State Records Act 1998 <http://www.legislation.nsw.gov.au/maintop/view/inforce/act+17+1998+cd+0+N>  
State Records Regulation 2010 <http://www.legislation.nsw.gov.au/maintop/view/inforce/subordleg+450+2010+cd+0+N>

<sup>12</sup> PD2005\_593 Privacy Manual (Version 2) – NSW Health [http://www.health.nsw.gov.au/policies/pd/2005/PD2005\\_593.html](http://www.health.nsw.gov.au/policies/pd/2005/PD2005_593.html), Health Records and Information Privacy Act 2002 <http://www.legislation.nsw.gov.au/maintop/view/inforce/act+71+2002+cd+0+N>, Government Information (Public Access) Act 2009 <http://www.legislation.nsw.gov.au/maintop/view/inforce/act+52+2009+cd+0+N>

- c) Staff involved in urgent public health investigations for protecting public/population health, consistent with relevant legislation.<sup>13</sup>
- d) Patient / client to whom the record relates, or their authorised agent, based on a case by case basis in accordance with health service release of information policies and privacy laws.
- e) Other personnel / organisations / individuals in accordance with a court subpoena, statutory authority, valid search warrant, coronial summons, or other lawful order authorised by legislation, common law or NSW Health policy.

All requests for information, that is contained in a patient / client's health care record, from a third / external party should be handled by appropriately qualified and experienced health care personnel, such as Health Information Managers, due to the sensitive nature of health care records; the special terminology used within them; and regulatory requirements around access to, and disclosure of, information.

### 3.4 Ownership

The health care record is the property of the PHO providing care, and not individual health care personnel or the patient / client.

Where shared care models or arrangements exist for clinicians to treat private patient / clients within PHO facilities / settings, responsibility for the management of those health care records must be included in the terms of the arrangement between the PHO and the clinician.

### 3.5 Retention and durability

Health care records must be maintained in a retrievable and readable state for their minimum required retention period.<sup>14</sup>

Entries should not fade, be erased or deleted over time. The use of thermal papers, which fade over time, should be restricted to those clinical documents where no other suitable paper or electronic medium is available e.g. electrocardiographs, cardiococographs.

Electronic records must be accessible over time, regardless of software or hardware changes, capable of being reproduced on paper where appropriate, and have regular adequate backups.

### 3.6 Storage and security

The Health Records and Information Privacy Act 2002 establishes statutory requirements for the storage and security of health care records, which are also included in the NSW Health Privacy Manual. A summary of these requirements is provided below. However, the Privacy Manual should be consulted for further detail in this area.

Personal health information, including healthcare records, must have appropriate security safeguards in place to prevent unauthorised use, disclosure, loss or other misuse. For example, all records containing personal health information should be kept in lockable storage or secure access areas when not in use.

<sup>13</sup> Public Health Act <http://www.legislation.nsw.gov.au/>

<sup>14</sup> Patient Matters Manual ([http://www.health.nsw.gov.au/policies/manuals/patient\\_matters.asp](http://www.health.nsw.gov.au/policies/manuals/patient_matters.asp)) and patient / client records requirements at State Records (<http://www.records.nsw.gov.au/recordkeeping/government-recordkeeping-manual/rules/general-retention-and-disposal-authorities/general-retention-and-disposal-authorities-1/?searchterm=GDA>)

Control over the movement of paper based health care records is important. A tracking system is required to facilitate prompt retrieval to support patient / client care and treatment and to preserve privacy.

A secure physical and electronic environment should be maintained for all data held on computer systems by the use of authorised passwords, screen savers and audit trails. If left unattended, no personal health information should be left on the screen. Screen savers and passwords should be used where possible to reduce the chance of casual observation. Consideration may be given to providing staff with different levels of access to electronic records where appropriate (i.e. full, partial or no access).

Details of the roles and responsibilities of staff, including system administrators and IT technical and support staff, concerning the protection of health care records held on electronic information systems are given in the NSW Health Electronic Information Security Policy [http://www0.health.nsw.gov.au/policies/pd/2008/PD2008\\_052.html](http://www0.health.nsw.gov.au/policies/pd/2008/PD2008_052.html).

### 3.7 Disposal<sup>15</sup>

Health care records, both paper based and electronic, must be disposed of in a manner that will preserve the privacy and confidentiality of any information they contain.

Disposal of data records should be done in such a way as to render them unreadable and leave them in a form from which they cannot be reconstructed in whole or in part.

Paper records containing personal health information should be disposed of by shredding, pulping or burning. Where large volumes of paper are involved, specialised services for the safe disposal of confidential material should be employed.

The disposal of health care records must be documented in the PHO's Patient Administration System and undertaken in accordance with the relevant State General Disposal Authority.

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<sup>15</sup> Patient Matters Manual ([http://www.health.nsw.gov.au/policies/manuals/patient\\_matters.asp](http://www.health.nsw.gov.au/policies/manuals/patient_matters.asp)) and patient / client records requirements at State Records (<http://www.records.nsw.gov.au/recordkeeping/government-recordkeeping-manual/rules/general-retention-and-disposal-authorities/general-retention-and-disposal-authorities-1/?searchterm=GDA>)

## 4 IMPLEMENTATION SELF ASSESSMENT CHECKLIST

An Implementation Self Assessment Checklist is provided to support implementation of this policy.

Requirement:	Self Assessment:			
	Nil	In development	Partial implementation	Mature

### A. STRATEGIC FUNDAMENTALS

PHO has documented processes to manage health care records

PHO uses an approved abbreviation list

There are resources and support to implement the Health Care Records policy and regular monitoring of progress by a responsible officer

Key performance indicators are developed to monitor and measure implementation of the Health Care Records policy in the PHO

Examples of performance measures:

1. Patient identification is on every page of the health care record or on each screen of the electronic record.
2. Handwritten entries are legible to a reader other than the author.

### B. INTEGRATION INTO NORMAL BUSINESS SYSTEMS

Responsibility and accountability for documentation and management of health care records is clearly stated in position descriptions and incorporated into performance review for all relevant health care personnel.

The design, approval and implementation of health care records forms (including electronic systems) is consistent with state policies and procedures.

Requirement:

Self Assessment:

Nil	In development	Partial implementation	Mature
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**C. ORGANISATIONAL IMPLEMENTATION**

A schedule is in place for auditing of health care records across clinical settings. This should include both record completeness and clinical audits.

All clinical areas are audited for compliance with the Health Care Record policy according to the schedule noted above.

Results and analysis of health care record audits are provided to clinicians and managers, and are used to inform remedial quality improvement activities.

Results and analysis of health care record audits are used to inform education on clinical documentation.

There is a process for recognition of excellence in the documentation and management of health care records.

Health care records key performance indicators are monitored at ward / unit, hospital / service and PHO level and benchmarked with appropriate peers.