6. PATIENT HEALTH INFORMATION MANAGEMENT

6.1 Patient Health Information

Policy

A medical record is a detailed, confidential document compiled by a health professional, over a period of time, on a particular person. Its primary purpose is to

- Identify a person accurately
- Record symptoms and signs
- Support diagnosis
- Justify management decisions
- Record all information fully and accurately including (but not limited to):

    - Medications
    - Allergies
    - Immunisations
    - Medical history
    - Diagnoses
    - Patient treatment and management

This practice has a combination of paper-based and electronic filing system.

Medical records are integral to the provisions of effective ongoing care. This practice has an obligation to maintain records in a form that facilitates this. All significant contacts with the patient, regardless of whether they are face-to-face or via the telephone will be recorded in the patient's medical record. This is to enhance continuity of care.

An alert notification for allergic responses and drug reactions is marked in the patient's medical record.

6.1.1 Creating a New Patient Health Record

Procedure

1. Collect patient details by asking patients to complete the practice's Patient Information Sheet, ***IMC-F2-Patient Information Sheet***
2. Ensure all information has been provided, if not ask the patient to provide missing information. This may be done verbally but should be done quietly and out of earshot of any other patients.
3. Sight the patient's Medicare card and any other concession cards.
4. Take the patient's height and weight, record on the bottom of the Patient Information Sheet.
5. Enter patient information into Best Practice
6. Ensure patient allergies, smoking status, emergency contact details etc. are recorded.
7. Scan Patient Information Sheet, (both sides) to the patient's file.
8. Mark the patient as 'Arrived' only once the Patient Health Record has been created.
9. Ensure the 'New Patient' Best Practice symbol has been used in the appointment book so the doctor is aware the patient is a new patient.

6.1.2 Creating an Entry in a Patient Health Record

Policy

Each time a patient's health record is opened, an entry is created in their record. It is the policy of this practice, that patient health records should only be accessed by authorised staff, and in the process of fulfilling their duties of the job description.

Each entry in a patient's health record should be true and correct, concise, use correct medical terminology, and contain all the necessary patient details and consult information. These entries are considered a legal document, and as well as being used to provide comprehensive and quality care and could be used as evidence in legal proceedings.

Clinical staff and administrative staff, with authorisation, will also access and create an entry in a patient's health record for the purpose of performing administrative procedures, such as scanning documents or reports, updating patient details or documenting a telephone encounter for example.

Procedure

1. Confirm patient identity before opening a patient health record.
2. For administrative staff, ensure contact details and patient demographics are correct and current.
3. For clinical staff, ensure patient allergies, medications, clinical history etc. have been entered and are current. Perform clinical audit where necessary.
4. Document patients consult with accurate and comprehensive notes, including:

    - ✓ patient symptoms,
    - ✓ concerns or issues,
    - ✓ clinical observations and records,
    - ✓ discussions,
    - ✓ treatment,
    - ✓ specialist or allied health referrals,
    - ✓ prescribed medications, and
    - ✓ recommended follow up or investigations.

5. Ensure any 'correspondence out' such as referrals, management plans, health assessments or medical certificates, has the correct patient and clinical details recorded, and have been completed on the preferred practice templates in Best Practice.
6. Document the reason for being in the patient health record.
7. When closing the patient health record, select a diagnosis from the 'reason for visit' menu in the drop-down box.
8. Administrative staff may open patient files for various reasons, and may select reasons such as 'administrative procedure' or 'telephone encounter'
9. Do not use 'free text' to record reason for visit, as the practice's patient data and statistics regarding coded diagnosis will not reflect correct data.

6.2 Receiving Patient Results and Reports

6.3 6.2.1 Receiving Results

Policy

The importance of all incoming pathology results, imaging reports, investigations reports and clinical correspondence, being reviewed by a doctor in a timely manner must not be overestimated.

All actions relating to patient results will be recorded in the patient's health record. The staff member, who telephones or emails the patient, or carried out any other follow-up action, is responsible for recording these details in the patient's health record. All results will be checked and commented on by a doctor. The doctor will record any action taken in the patient's health record.

This practice has a recall system to ensure that patient results have been actioned according to urgency and priority, and a reminder system to ensure any clinical recommendations are followed up. Please refer to ***Section 5.17 – Recall and Reminder Systems*** for further information about this policy.

Procedure

Paper-Based

1. Open the mail and sort based on procedures recorded in ***Section 3.5 – Handling Incoming Mail.***
2. Imprint urgent results with a stamp that details:
    - Date received
    - Initials of the staff member who received the result.
    - Initials of the doctor
    - Follow-up action required by staff
3. Do not file test results until the above information is completed, and the doctor has been advised of the urgent results.
4. If the results are urgent and the doctor is not at the practice, contact the Practice Principal regarding the urgent results.
5. Complete any follow up action requested by the Practice Principal
6. Document all follow up actions in the patient's file
7. Scan urgent results once actioned, and advised to do so by the doctor, to the patient's file
8. If the results are not urgent, scan to the patient file using the bulk scanner application.
9. All results, letters, reports etc. must be scanned to the doctor's inbox.
10. Document any actions in the patient's file.
11. Place results in basket reserved for documents to be shredded.

Electronic

1. Results are automatically transmitted periodically throughout the day via Medical Objects, a secure software application for receiving patient results electronically.
2. All results received electronically via Medica Objects will be delivered to the doctor's inbox automatically through the practice software.
3. The doctor will check his inbox regularly throughout the day and assign results to the patient's file with the appropriate follow up action, if any.

Fax

1. Results are received periodically throughout the day via fax.
2. Imprint urgent results with a stamp that details:
    - Date received
    - Initials of the staff member who received the result.
    - Initials of the doctor
    - Follow-up action required by staff
3. Do not file test results until the above information is completed, and the doctor has been advised of the urgent results.
4. If the results are urgent and the doctor is not at the practice, contact the Practice Principal regarding the urgent results.
5. Complete any follow up action requested by the Practice Principal.
6. Document all follow up actions in the patient's file.
7. Scan urgent results once actioned, and advised to do so by the doctor, to the patient's file.
8. If the results are not urgent, scan to the patient file using the bulk scanner application.
9. All results, reports, letters etc. must be scanned to the doctor's inbox.

10. Document any action in the patient's file.
11. Place results in basket reserved for documents to be shredded

6.2.2 Receiving Urgent Results Outside of Normal Opening Hours

Policy

Patients are regularly referred for diagnostic services and testing. All results are required to be managed according to urgency and priority, including those that are deemed to be seriously abnormal or life-threatening. It is the policy of this practice that the referring doctor is to be contacted should there be seriously abnormal or life -threatening results concerning a patient when the results have been received outside of normal opening hours.

Procedure

1. Regular diagnostic service providers will be given the doctors after hours contact number, with the doctor's permission.
2. Regular diagnostic and testing service providers would be defined as local services, such as I-Med Radiology Emerald, CQ Radiology Emerald, QML Pathology Emerald etc.
3. In the instance that the doctor cannot be contacted outside of normal opening hours regarding urgent results, the patient should be directed to the hospital.
4. The Practice Manager should be contacted if the patient requires urgent medical attention and have left the vicinity of a hospital or local emergency services.
5. The Practice Manager may be able to provide alternate contact details for the patient, such as next of kin or emergency contact.
6. The doctor should follow up with the patient as soon as possible and document any action in the patient's health record.

GP 2.2 ➢ E

6.2.3 Receiving Reports

Policy

Any patient reports received from health care providers, such as specialists and allied health professionals, will be checked and recorded according to the procedure in ***Section 6.2.1 Receiving Results***.

The importance of all incoming patient reports being reviewed by a doctor in a timely manner must not be overestimated. The doctor must be advised of all urgent reports

Procedure

See procedures for paper based (mail), electronic and faxed results, in 6.2.1.

6.3 Retention of Records and Archiving

Policy

Medical records will be kept for a minimum of 7 years (or until the patient is 25 years of age, if a child) following the last year that the patient attended the practice.

Records for the last 4 years are kept in *Active* storage, which is located within our database. Records of patients, who have not presented to the practice for more than 4 Years are located in *Inactive* storage which is located within our database.

Every 6 months, a record review is conducted for active records not accessed. These records are removed from *active file* and stored in the *inactive file* area. Patient's accounts records are reviewed after each end of financial year. After 7 years if an adult, or 25 years if a child, following the last occasion in which a patient presented for a consultation, the medical record will be deleted from our database.

All records are safeguarded against unauthorised access.

6.3.1 Destruction of Medical Records

Procedure

This practice disposes of confidential medical records and materials utilising the in-house cross-cut shredder.

6.4 Transfer of Medical Records

6.4.1 Transfer of Medical Records to Another Practice

Policy

Transfer of medical records from this practice can occur in the following instances:

1. When a patient asks for their medical record to be transferred to another practice.
2. For medico-legal reasons, e.g., record is subpoenaed to court.
3. Patient presents for consultation at our branch practice. The record is requested from that branch via fax.
4. Where an individual medical record report is requested from another source.

When a patient asks for their medical record to be transferred to another practice, written consent must be obtained from the patient prior to the transfer. Upon consent, this practice will forward a photocopy or summary report to the requesting organisation only after a fee has been paid.

Procedure

1. Prior to forwarding a copy or summary of the medical record to the requesting organisation, ensure that the patient provides the practice with a signed document indicating their consent.
2. If a photocopy or computer printout of the medical record, stamp or record "COPY" on each page.
3. Prior to sending the request, scan the patients request consent to the patient's file.
4. Once payment is received send the medical record photocopy or summary to the requesting organisation via post.
5. Prior to sending the request, photocopy the letter and attach with the patient's consent to their medical record.

6.4.2 Transfer from Another Practice

Policy

At times, it is necessary for a doctor to become familiar with a new patient's medical history via their medical record from a previous practice. If a copy or summary of a medical record is required, written patient consent is essential before the transfer of records proceeds.

Procedure

1. Ask the patient to sign a form indicating consent for their previous practice to forward a copy or summary of their medical record.
2. Fax/Email a letter to the previous practice requesting that they provide a copy or summary of the patient's medical record and enclose the original copy of the patient's consent.
3. Prior to sending the request, scan the consent from the patient and attach it to the patient's new medical record.

6.5 Accessing Personal Health Information

Policy

At times, patients may request personal health information. It is the policy of this practice that any patient wishing to obtain personal health information, such as reports, specialist letters, or results etc., may do so by requesting the information in writing where possible, or when logistics do not allow, verbally.
A patients' identity must be confirmed before any personal health information is provided, to ensure patient privacy and confidentiality is maintained.

Procedure

1. Use at least three patient identifiers to confirm identity of patient requesting records
2. Patient must complete a request for personal health information, ***IMC-F9-Request for Personal Health Information***
3. Patients should note what information they wish to obtain and how they would like to receive the records, (view in person, email, pick up in person etc.)
4. The request form will need to be signed by the patient.
5. If the request includes the doctor's consultation notes or results not previously given to the patient, then the request will need to be authorised by the doctor, who will consent to what information can be provided.
6. Health information should be provided as per request.
7. Scan request to patient file
8. Document action taken.

For parents wishing to obtain personal health information for a child, the child must be under 14 years of age and there must not be any current court rulings in place regarding custody arrangements. Children over the age of 14 years can request their personal health information themselves or consent to a parent etc. accessing their health information through My Health Record system.

6.6 Administration of Privacy Legislation

Policy

The practice manager is our privacy officer who implements and monitors adherence to all privacy legislation in this practice.

The privacy officer acts as liaison for all privacy issues and patient requests for access to their personal health information. If staff have any queries concerning privacy law, they are to refer to the privacy officer.

Procedure

The practice manager attends information and training sessions with regard to Privacy Legislation laws and trains staff and implements new policy and procedures in the practice when deemed appropriate

6.7 Notifiable Diseases

Policy

Under Infectious Diseases Act - Health (Infectious Diseases) Regulations in Sections 146, 390 and 391 of the Health Act 1958, medical practitioners are to report infectious diseases as specified. Notifications of cases are made to the Central Public Health Unit.

Procedure

It is the responsibility of the treating doctor or nominated person to notify the Central Public Health Unit of any communicable diseases.

6.8 Medical Students

Policy

From time to time, the doctors at this practice may take on a supervising role for medical students as part of their studies. Patients may not wish to have their personal health information used for education purposes. This practice respects the patient's right to privacy and where possible will use de-identified data for case studies. Patients will be informed of impending medical students participating in practice activities, with a sign displayed in the waiting room. Medical students will be supervised

The supervising doctor will inform each patient prior to their consultation that a medical student is present and ask the patient's permission for the student to observe their consultation. Patients are given the option to decline the medical student's presence.

It is the policy of this practice that any participating medical students will complete essential Blackwater Health Care Centre forms, such as ***IMC-F16-Confidentiality Agreement***, ***IMC-F28-Confidential Personal Information***, ***IMC-F29-Employee Induction Checklist*** and ***IMC-F58-Med Student Timesheet***.

6.9 Research and Quality Program

Policy

Where it is desired to publish material related to clinical work or for practice continuous quality improvement activities, the anonymity of patients is to be preserved. Research requests are to be approved by the practice principal.

The patient must consent to any specific data collection for research purposes. If the data is required by or in accordance with rules established for accreditation by RACGP or other diligent professional health agencies, then data will be de-identified where possible, with related obligations of confidentiality upon health professionals engaging in these activities.

6.10 Disease Registers (For Public Health Purposes)

Policy

For cervical screening, CARDIAB, breast screen and other disease specific registers consent is required from the patient to use their personal health information for this purpose. The patient is given the opportunity to decline inclusion in these types of registers.

6.11 Subpoena, Court Order, Search Warrant and Coroner

Policy

Information will be released if a subpoena, court order, search warrant or coroner is received. If the doctor is concerned about confidentiality issues, he/she may decide to challenge it in court if sufficient evidence amounts to possible breach in confidentiality.

Procedure

1. Inform the patient's doctor and practice principal.
2. Retrieve the patient's medical record from the filing area.
3. Record the date of court case in the patient's medical record.
4. Make a copy of the record.
5. Retain the copy in file and mark as a duplicate on each page with reason for the copy noted inside.
6. Sometimes a staff member is required to take the medical record to court. Telephone the relevant solicitor or Clerk of courts and try to arrange a confidential courier to transport the record in, as an alternative.
7. Telephone closer to the day requested, if a staff member must take the record physically to court, to ensure the date is correct and the case is still on.
8. Return the record to the practice after the review by the court unless otherwise instructed by the court.

6.12. Relatives and Friends

Policy

No information is to be released unless the patient has authorised another person to be given access if they have the legal right and a signed authority.

Separate records are advised for all family members but especially for children whose parents have separated, and care must be taken that sensitive demographic information about either partner is not recorded on the demographic component of the record.

6.13 Police and Lawyers

Policy

Police and lawyers must obtain a signed patient consent (or subpoena, court order or search warrant) for release of information. The request is directed to the doctor. Where only a signed patient request is obtained the doctor is not legally obliged to release information.

6.14 Insurance Company and Social Welfare Agency

Policy

No information will be given without express written consent from the patient. All enquires must be directed to the patient's doctor. Release of information is an issue between the patient and the doctor.

6.15 Employers

Policy

If the patient has signed a consent to release information for a pre-employment assessment, or similar report, the request should be directed to the doctor who will respond with the required information.

Otherwise, no information is to be released. When in doubt always refer the request to the doctor. Patients may seek access via privacy law.

6.16 Emergencies

Policy

Where immediate treatment is necessary to preserve a life or prevent serious injury, all attempts are made to gain the patient's consent. This may not be possible in all cases prior to administering emergency care.

6.17 Informed Consent

Policy

Our doctors inform their patients of the purpose, benefit and risks of proposed treatment or investigations. We believe that patients need to receive sufficient information to allow them to make informed decisions about their care.

Information is clear and given in a form that is easy to understand, whether it be verbally, in a diagram with explanation, brochure, other handout/leaflet or poster e.g., available in our waiting room.

Doctors take into consideration the patient's ethnicity and principal language spoken. Steps are taken to ensure an interpreter is utilised where necessary and at the patient's request. Issues of personality, personal fears and expectations, beliefs and values are also considered.

There is no coercion by our doctors. Our patients can choose to reject their doctor's advice or seek a second opinion. Doctors also inform patients of potential additional costs and out of pocket expenses for treatments and investigations, prior to them being carried out, whether they would be done on site or referred to medical specialists.

Patients are asked to be open and should be able to feel free to discuss all health issues and proposed treatments, without the fear of reprisals.

Patient consent is obtained for the following:

- Operative procedures on-site (written consent)
- Patient's personal health information sought for research projects (written consent)
- Clinical training program (written consent)
- Third party observation or participation in patient consultation (written consent)

The Privacy Act states that consent may be 'express' or 'implied'.

- Express Consent – clear and unmistakably states, obtained in writing, orally or in any clear other form where consent is clearly communicated.
- Implied Consent – e.g., patient presents to doctor, discloses health information and this is written down by the doctor/entered on computer during the consultation, e.g., doctor collects specimen and sends it to pathology, reason to consider that the patient is giving implied consent to passing necessary information to the laboratory.

6.17.1 Consent Forms

Policy

'Consent to Operative Treatment' Form is used by the doctor for patient consent to on-site procedures. The doctor explains the form to the patient and completes it with the patient signature.

Procedure

Doctors inform patients of the following issues concerning treatment and investigations:

- Possible nature of illness/disease
- Proposed approach to investigation, diagnosis and treatment including describing if it is conventional or experimental, common side effects and the clinician undertaking the procedure/treatment
- Purpose, importance, benefits and risks
- Other options
- Length of procedure/treatment
- Approximate indication of costs involved including out of pocket expenses
- Degree of uncertainty of a) any diagnosis found and b) therapeutic outcome
- Potential result of not undertaking the specified procedure/treatment or any other treatments

6.18 Computer

Policy

It is the policy of this practice that data held on the practice's computer system is secured to prevent unauthorised access, exploitation and loss of data.

Staff members, temporary staff and contractors that require access to the practice's systems are required to sign confidentiality agreements before commencing work.

Electronically held data will be protected from exploitation by organisations that may sell the data for commercial purposes. Disks, faxes and computer printouts are positioned or stored out of sight when not in use.

Computer equipment is in physically secure areas within the practice.

6.19 E-mail

Policy

Patient information is only sent via e-mail if it is securely encrypted according to industry and best practice standards. Refer to Section ***3.1 Email Correspondence, Internet Usage and social media*** in our ***Communication Policy*** for more details.

6.20 Facsimile

Policy

The following procedure is to be strictly adhered to, due to the medico-legal nature of our patient information:

- When faxing patient information, the fax number and identification of the recipient must be confirmed before transmitting.
- Ask the person requesting the fax to ensure that someone authorised is standing by to receive the fax at that fax machine.
- Record "Confidential" on the fax coversheet.
- Check the number dialled before pressing 'SEND'.
- Keep transmission report produced by the fax as evidence that the fax was sent. Also confirm the correct fax number on the report.

6.21 Corrections in Medical Record

Policy

A patient may ask to have their personal health information amended if he/she considers that is not up to date, accurate and complete. Our practice will try to correct this information. Corrections are attached to the original health record.

Where there is a disagreement about whether the information is indeed correct, our practice attaches a statement to the original record outlining the patients' claims.

It is the policy of this practice that identified errors are not permanently removed. It will be noted in the record that the information has been deemed incorrect, incomplete or not up to date, add changes to correct the information and initialled and dated by the author with an explanatory note beside or below the original item. Thus, the reason for the incorrect entry is clearly documented with the new entry underneath or in the next available position. The new entry is signed or initialled and dated.

Procedure

If an error occurs in writing, within the medical record:

1. A new entry will be recorded directly underneath the incorrect entry, stating there was an error in the above entry.
2. Document the error by opening the correct patient file → select the 'Amend' tab in the patient's file.
3. Record correct information.
4. Close the patient file and document reason for accessing the file.