

Student workbook

**BSBMED303**

**Maintain patient records**

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**TAFE NSW would like to pay our respect and acknowledge Aboriginal and Torres Strait Islander Peoples as the Traditional Custodians of the Land, Rivers and Sea. We acknowledge and pay our respect to the Elders, both past and present of all Nations.**

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|  | **Practice activity**  Learning activities are the tasks and exercises that assist you in gaining a clear understanding of the content in this workbook. It is important for you to undertake these activities, as they will enhance your learning.  Activities can be used to prepare you for assessments. Refer to the assessments before you commence so that you are aware which activities will assist you in completing your assessments. |
|  | **Collaboration**  Whether you discuss your learning in an online forum or in a face-to-face environment discussion allow you to create and consolidate new meaningful knowledge. |
|  | **Self-check**  A self-check is an activity that allows you to assess your own learning progress. It is an opportunity to determine the levels of your learning and to identify areas for improvement. |
|  | **Readings (Required and suggested)**  The required reading is referred to throughout this Student workbook. You will need the required text for readings and activities.  The suggested reading is quoted in the Student workbook; however, you do not need a copy of this text to complete the learning. The suggested reading provides supplementary information that may assist you in completing the unit. |
|  | **Assessment task**  At different stages throughout the workbook after you have completed the readings and activities you will be prompted to complete one or more of your assessment tasks. |
|  | **Video**  Links to videos will be give you a deeper insight into subject matter discussed in this workbook. If you use the student workbook in a digital format you will be able to click on the link to the video. If you are working from a printed version, you will need to look these up using the URL provided. |

Topic 1

Identify and clarify   
own role and   
procedures   
for patient   
recordkeeping

# Topic 1: Identify and clarify own role and procedures for patient recordkeeping

## Introduction

In this topic you will:

* Determine own role and responsibilities within patient recordkeeping system through consultation with relevant personnel or via organisational policy and procedures manual.
* Access documented procedures for patient recordkeeping system and read for understanding.
* Seek clarification with relevant personnel of unclear or ambiguous procedures.

## Determine own role and responsibilities within patient recordkeeping system

### Determining own role and responsibilities

There are a range of factors that will have a bearing on your role and responsibilities in relation to the patient recordkeeping system. There is likely to be some variation depending on the type of medical facility that you are working within. You are advised to access your role description and identify all of the duties associated with patient recordkeeping.

Patient recordkeeping responsibilities may include:

* Keeping and maintaining complete and accurate patient records.
* Maintaining the confidentiality of information.
* Storing, archiving, and transferring medical records in accordance with Australian legislation.
* Updating professional knowledge and implementing recordkeeping practices as necessary.

The duties that you may be expected to perform include:

* Creating patient records.
* Making amendments to existing patient records.
* Ensuring that all of the relevant information is included within patient files.
* Ensuring the appropriate formatting and maintenance of patient records.
* Accessing, storing, and archiving patient records.
* Disclosing records upon the patient’s request.

Further information regarding your role and responsibilities may be obtained from relevant personnel, including:

* Practice manager.
* Reception staff.
* Staff managing patient records.
* External bodies including peak industry organisations.
* Health professionals using the system.
* Partners in the business.

#### Organisational policy and procedures manual

There should be a manual which outlines the policies and procedures which staff members are expected to follow in relation to patient recordkeeping and other aspects of work. This manual may be kept in a paper-based format on your business premises. It may also be accessible via your business website. It would be advisable to ask the supervisor or other senior staff member for help accessing and interpreting the manual. Policies will specify the appropriate means of dealing with issues that are commonly encountered within your medical practice. Procedures will detail the actions that workers are expected to take in accordance with the scope of their role and responsibilities.



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## Activity 1.1: Patient recordkeeping

This activity will provide you with an opportunity to determine your own role and responsibilities within a patient recordkeeping system through consultation with relevant personnel or via an organisational policy and procedures manual.

To complete this activity, you will have access to Pracsoft, a practice management software tool that can be provided to you by your teacher. This software will also be used in your assessments where required.

**Consult relevant personnel or an organisational policy and procedures manual and identify at least five (5) duties that you are expected to perform in relation to the patient recordkeeping system. (Use either Pracsoft or your own example).**

## Access documented procedures for patient recordkeeping system and read for understanding

### Accessing documented procedures

As previously mentioned, your organisation should have procedures in place specifying the actions that staff members are expected to take for successful patient recordkeeping. Such procedures will be included within written policies and accessible in either paper or digital formats. Your medical practice should have a designated administrative record keeping policy which outlines responsibilities and standards in relation to medical record keeping. It should be written in plain and simple terms in order to ensure the understanding of all staff members. Expectations regarding the recording and storage of patient information should be covered. Explanations should be given of any specialist medical terms and abbreviations that are included.

Your organisation may also have a policy and procedures manual, including specifications relating to:

* personnel practices;
* case management procedures;
* workplace health and safety procedures;
* confidentiality;
* referral;
* duty of care;
* coordination/networking with external agencies.

It will be necessary to read and develop a good understanding of the documented procedures if you are to ensure their successful implementation within the workplace. You are advised to read the procedures in a quiet area free from distractions to ensure that you are able to maintain full concentration. Consider the ways in which the documented procedures relate to the patient recordkeeping duties that you perform on an everyday basis. You might find it easier to process the information if you read out loud. Try and visualise the ways in which you can act upon the documented instructions.

You may have difficulty understanding or relating some of the documented procedures for the work that you carry out. You might worry that other staff members will make negative judgements and doubt your professional capabilities if you ask them for clarification. In actual fact, they are likely to be appreciative and impressed if you approach them. They will be happy that you are keen to fulfil the patient record-keeping responsibilities to the best of your abilities. It might even be possible to arrange assistance and guidance to ensure that you complete record-keeping tasks effectively.

Procedures for the patient recordkeeping system may include:

* Signing and dating entries.
* Taking complete details of patient assessments.
* Consulting and sharing information with patients.
* Securely storing patient records.
* Using abbreviations.
* Making corrections or deleting incorrect entries.
* Disposing of medical records at appropriate times.

The documented procedures should be:

* Written down.
* In accordance with your record keeping policies.
* Clear.
* Accessible to all staff, and
* Clearly state who is responsible for work relating to record keeping procedures.

Source: Administrative record keeping guidelines for health professionals: <http://www.health.gov.au/internet/main/publishing.nsf/Content/admin-record-keeping-book>

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## Activity 1.2: Recordkeeping procedures

This activity will provide you with an opportunity to access documented procedures for a patient recordkeeping system and read for understanding.

**Access and identify at least five (5) procedures which you are expected to follow in relation to patient recordkeeping. (Use either Pracsoft or your own example).**

## Seek clarification with relevant personnel of unclear or ambiguous procedures

### Seeking clarification

It is quite likely that you will encounter some procedures which are unclear and hard to understand. You shouldn’t ignore these types of written procedures or assume that you have the required level of understanding. It will be necessary to consult the supervisor or other relevant personnel for descriptions and clarification. They might identify the need to change the wording or completely replace the confusing written procedures.

Remember that relevant personnel may include:

* Practice manager.
* Health professionals.
* Manager of facility.
* Own supervisor.
* Partners in business.

You will need to ask appropriate questions in order to ensure that you are provided with relevant information about the procedures. Closed questions may be asked when you require basic yes or no answers. However, it would be advisable to ask open questions when you want detailed explanations. You will need to listen actively, maintaining full concentration, and processing any information provided by relevant personnel. It would be worth taking a written note of what is said just in case you forget any details.

You are advised to follow these steps when seeking clarification:

* Admit if you are unsure about what the speaker means.
* Ask for repetition.
* State what the speaker has said as you understand it and check whether this is what they really said (paraphrasing).
* Ask for specific examples.
* Use open, non-directive questions, if appropriate.
* Ask if you have got it right and be prepared to be corrected.

**Source:** Clarifying and clarification: <https://www.skillsyouneed.com/ips/clarification.html>

You may also give summaries of the points made by relevant personnel for the assurance of understanding. This will require you to synthesise and break down any points that have been made and then provide feedback.

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## Activity 1.3: Clarifying unclear procedures

This activity will provide you with an opportunity to seek clarification with relevant personnel of unclear or ambiguous procedures.

**Seek clarification with relevant personnel of any procedures relating to patient recordkeeping that you consider unclear or ambiguous. Use appropriate questioning and active listening methods, taking steps to ensure complete clarification. (Use either Pracsoft or your own example).**

Topic 2

Access patient   
records

# Topic 2: Access patient records

## Introduction

In this topic you will:

* Gain access to patient records to facilitate patient visit.
* Check currency and accuracy of patient demographic and personal details.
* Create new records according to enterprise protocols.
* Check records following patient visits, for practitioners’ instructions related to follow-up action.
* Store patient records according to organisational policy and procedures.

## Gain access to patient records to facilitate patient visit

### Gaining access to patient records

It is important that you are able to gain access to patient records when required. You should identify and act in accordance with organisational policies and procedures related to this process. This will require you to have an understanding of and use the appropriate filing method. Records may be kept in paper, or electronic formats, or a combination of each.

Patient records may be filed in the following orders:

* alphabetical
* numerical
* alphanumeric
* terminal digit
* chronological
* geographical.

The alphabetical ordering of patient files may be based upon the patient’s name or business name. You should be aware that surnames featuring hyphens will be considered as one word. Abbreviations should be considered as written in full. If the numerical filing method is used then each patient will be given a specific number, which will be featured on all of their records. Patient records that are filed chronologically may be ordered depending on the date of creation or last access. Records may also be kept alphabetically in accordance with the geographic location of the patient’s address or where their care is to be provided.

You may need to obtain the authorisation of a supervisor or other senior staff member in order to access the patient records. They might provide you with passwords which will need to be entered to access files kept in digital form. Such passwords may need to be actively remembered, rather than noted for the assurance of patient privacy and confidentiality. It might also be necessary to obtain keys for opening cabinets where patient files are kept. You should take care over the security of the keys and ensure that they are returned as soon as possible after use. Every effort must be made to ensure that the patient records remain secure and that they aren’t lost or damaged.

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## Activity 2.1: Patient records

This activity will provide you with an opportunity to gain access to patient records to facilitate patient visit.

**Access relevant patient records in order to facilitate the visit of a patient to your medical practice. Use Pracsoft to access a patient’s record.**

**Use space below for any notes you wish to make.**

## Check currency and accuracy of patient demographic

### Checking currency and accuracy

It is important to ensure that patient records are both current and accurate, making updates as necessary. You will need to maintain contact with patients, checking and prompting them to update their details accordingly. Such updates may be made during visits to your medical practice in consultation with administrative staff. You may also be expected to make phone calls and maintain digital contact with the patients. They may have the option of updating their information via the practice website. You may need to access files in paper and digital formats in order to ensure that the details are correct.

Patient demographic and personal details may include:

* date of birth
* gender
* ethnicity
* patient address
* contact number
* identifying number
* emergency contact information
* allergies and medical information.

Details of the patient’s health information may also need to be recorded.

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## Activity 2.2: Currency and accuracy of patient details

This activity will provide you with an opportunity to check the currency and accuracy of patient demographic and personal details.

**Using Pracsoft, check the details of at least three (3) patients registered with a medical practice in relation to the currency and accuracy of personal details. Highlight any amendments that are required. Record these in the box below.**

## Create new records according to enterprise protocols

### Creating new records

You should be aware that there are a wide variety of patient records which may be created in paper/electronic formats, or a combination of both. Such records should be created as soon as possible after the provision of patient information. It will be necessary to specify the date of medical consultation or patient interaction if records are produced at later dates.

The records should include different types of information and be securely stored using appropriate methods. Access to the records should facilitate the continued provision of patient-centred treatment and care.

The types of medical records that may be created include:

* Clinical notes.
* Investigations.
* Letters from other doctors and healthcare providers.
* Photographs.

All medical records will ideally be:

**Complete**—you will be expected to include all of the relevant details in relation to the patient.

**Consistent**—you should ensure that aspects such as formatting and medical language are used consistently within the records.

**Legible**—you should take care and ensure that any handwritten notes are clear and easy to read.

**Accurate**—you should ensure the accuracy of any information about the patient.

**Relevant**—you should ensure that information is relevant to the patient and the services provided by your medical care centre.

**Accessible**—you should ensure that records can be accessed by authorised personnel, no matter whether they are stored in paper or digital formats.

**Timely**—you should ensure that patient information is recorded as soon as possible for the assurance of accuracy and make updates as necessary.

There isn’t a generally accepted rule about the types of information that should be included within medical records. However, the Australian Medical Insurance Group have specified these minimum requirements:

* Contact details, including emergency contact and other demographic information.
* A current health summary.
* Medical history.
* Consultation notes including all face to face consultations (those conducted in the practice, at home, or in nursing homes or hospitals):
  + including the presenting problem, possible diagnosis and a management plan
  + use of a system such as SOAP (Symptoms, Observations, Assessment and Plan) may aid consistency.
* All advice given to a patient, including that provided by practice staff.
* All attempts to contact a patient regarding:
  + appointments
  + follow up
  + billing
  + treatment.
* Consent for treatment (see further information below).
* Financial consent.
* Consultation notes for all Telehealth sessions.
* All non-face to face communications (those conducted via telephone, email, online or SMS).
* Documentation about procedures performed.
* Diagnostic related investigations, results, reports, and follow-up.
* Any clinical images, diagrams, videos of the patient, and a record of consent for the same.
* Correspondence received and sent.
* Referrals.
* Prescriptions.
* Completed documentation forms: including worker’s compensation certificates, sick certificates, immunisation exemption forms, fitness to drive, fly, dive or pilot (seafaring), insurance applications and requests for access to records.

According to the Medical Board of Australia’s Good Medical Practice: A code of conduct for doctors in Australia and the Health Practitioner (New South Wales) Regulation 2010 medical records should include:

* Information relevant to diagnosis and treatment, e.g. history, physical examination (including relevant negative findings), mental state, results of any tests, allergies.
* Clinical opinion.
* Plan of treatment.
* Any medication prescribed.
* Information, warnings, or advice given to the patient in relation to any proposed medical treatment.
* Details of significant discussions or correspondence including telephone calls and copies of referral letters, reports, and test results.
* Any follow-up instructions given to the patient.
* Details of any medical treatment, including any medical or surgical procedure:
  + date of the treatment
  + nature of the treatment
  + name of any person who gave or performed the treatment
  + type of anaesthetic, if any
  + any tissues sent to pathology
  + results or findings made in relation to the treatment
  + any written consent provided by the patient for the treatment.

General requirements as to content and form of records include:

* A record must include sufficient information concerning a patient’s treatment to allow another medical practitioner to continue appropriately managing the patient’s care.
* All entries must be accurate statements of fact or statements of clinical judgement. Personal (non-medical) opinions should not be included.
* Only abbreviations or expressions which are generally understood in the medical community should be used.
* Each entry must identify the person who made the entry and the time and date it was made.
* A record may be made and kept in a computer database or other electronic form but only if it is capable of being reproduced, e.g. printed on paper.
* A medical practitioner or medical corporation must not alter a record in a way that obliterates, obscures, or renders illegible information that is already contained in the record.

The following items should appear on every page of an NSW Health record, or on each screen of an electronic record (with the exception of pop-up screens where the identifying details remain visible behind):

* Unique identifier (e.g., Unique Patient Identifier, Medical Record Number).
* Patient / client’s family name and given name/s.
* Date of birth (or gestational age / age if date of birth is estimated).
* Sex. The exception is Obstetrix records where sex of the mother is not recorded.

**Source:** Health care records - documentation and management: <http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_069.pdf>

According to the Australian RACGP, practices need to have an effective system whereby a patient’s health information is stored in a dedicated patient health record. Health records need to include: the patient’s contact and other demographic information, medical history, consultation notes (including care outside normal opening hours and home visits), letters received from hospitals or consultants, other clinical correspondence, investigations or referrals, and results. Besides clinical information, the patient health record may also contain other relevant information pertaining to the patient such as any WorkCover or insurance information or relevant legal reports.

It is critical that patient health records are legible so that another practitioner could take over the care of the patient if necessary. Not only does written information need to be legible (able to be read and understood), if the practice scans documents such as external reports, the scanning needs to be undertaken in a way that reproduces the legibility of the original document.

**Source:** Standards for general practices: <https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition/standards-for-general-practices-5th-ed>

### Using coding systems

Clinical coding systems are used for the purpose of enhancing accessibility and maintaining patient records. The use of such codes may prove helpful in relation to the sharing of medical information and collaboration among the care network. Recognisable codes should be integrated to highlight specific types of medical information which can be searched by clinical practitioners.

Most clinical information systems will contain a nationally recognised medical vocabulary, coding system or classification system (eg SNOMED CT-AU, the World Organization of Family Doctors’ International Classification of Primary Care [ICPC]) to record patient information. These allow clinicians to use structured data entry (eg dropdown menus and picklists) to enter diagnoses, prescriptions, pathology and other diagnostic results. This information is automatically coded and classified by the software so that all patient records contain standardised information.

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## Activity 2.3: New records

This activity will provide you with an opportunity to create new records according to enterprise protocols.

**In Pracsoft, create a new record for a patient registered with your medical practice in accordance with enterprise protocols.**

## Check records following patient visits

### Checking records

It will be necessary to check patient records after visits to the medical practice for practitioners’ instructions related to follow-up action. The practitioners are likely to have obtained new information and carried out assessments during scheduled appointments with the patients. They should use their professional judgement to specify the steps that must be taken for progression in the patient’s care and treatment. Recommendations and requirements relating to follow-up action should be clearly highlighted within the patient’s medical record.

Practitioners' instructions may include:

* Scanning/filing documents in records.
* Referral to another health professional (make appointment, fax referral).
* Making further appointments with health professionals within the facility.
* Informing patient of requirements for follow-up tests or medical procedures.
* Providing information sheet as per doctor instructions.
* Hospital admission and pre-op documentation.
* Community transport/taxi.

It is important for the patient records to be readily accessible to authorised personnel. You should be able to obtain the relevant information relatively quickly and in easily understandable formats. It will be necessary to use specific vocabulary and active listening and questioning techniques to confirm understanding of the medical information. You should make specific reference to terms and codes that are used by staff members in your medical practice. It would be worth jotting down any points that are made for reference when required.



Figure Info folder image.

The following measures should be in place to facilitate access to information:

* A file movement register so you know where files are at all times.
* A system in place to ensure records are stored securely.
* Labelling and numbering conventions for files that all staff understand, and
* An archived record system that is clearly defined and allows staff to find archived records easily.

Source: Administrative record keeping guidelines for health professionals: <http://www.health.gov.au/internet/main/publishing.nsf/content/admin-record-keeping-book>

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## Activity 2.4: Checking instructions

This activity will provide you with an opportunity to check records following patient visits, for practitioners’ instructions related to follow-up action.

**Conduct a check of a patient’s medical record after a visit to your practice and identify any instructions related to follow-up action made by the practitioner using Pracsoft.**

Use the space below for any notes you wish to make.

## Store patient records according to organisational policy and procedures

### Storing patient records

From a legal perspective, it will be necessary to keep patients’ medical records so long as they may be required for reference in the event of litigation. This will depend on the medical legislation which applies within your state or territory of Australia. If there have been complaints or adverse medical outcomes, then the patient records should be kept indefinitely or until authorisation for disposal is given. Indefinite storage periods will also apply in the event of death or the issuing of patient claims for damages.

According to legislation which applies to New South Wales and the Australian Capital Territory, the periods of storage should be as follows:

* **An adult**: seven years from the date of last entry.
* **A child:** until the age of 25 years.

**Source:** “*Health Records and Information Privacy Act 2002 No 71*” NSW Government: <https://www.legislation.nsw.gov.au/#/view/act/2002/71/part4/div2/sec25>

*The Privacy Act 1988* (APP11 – Security of personal information) stipulates that medical practices/practitioners have an obligation to ensure that there are safeguards in place to protect a patient’s health information. It is a legal requirement to keep patient records either within lockable storage or secure access areas when not in use. All paper-based medical records should be filed as soon as possible after use, and there shouldn’t be any risk of casual inspection.

The Australian Privacy Principles stipulates that:

* Records should be stored in such a way that information is protected from misuse, interference and loss; and from unauthorised access, modification or disclosure; and that;
* The entity must take such steps as are reasonable to permanently destroy or de-identify the information, securely and confidentially, when it is no longer required.

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. 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.

**Source:** “Health care records - documentation and management” NSW Government: <http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_069.pdf>

Ways of ensuring the security of information include:

* Implementing computer system safeguards, including password protection, with regular changes to passwords
* Ensuring that there is a backup facility (preferably offsite) for all electronic information
* Ensuring that there is lockable physical security for paper records
* Ensuring that the information is transferred securely, i.e. not transmitting health information via non-secure email
* Monitoring information systems to check and evaluate the data security.

**Source:** “Medical records” MDA National: <https://www.mdanational.com.au/~/media/Files/MDAN-Corp/Medico-Legal/Medical-Records.pdf?la=en> (Accessed on 02/07/2019).

Your medical practice should:

* Keep all records (not just clinical records) secure.
* Ensure that only the appropriate staff have access to these records.
* Keep records storage areas clean and clear of clutter.
* Make sure staff understand policies on storage, damage, and alteration of records and take the appropriate action if a breach occurs.
* Check records regularly for unauthorised alteration or deliberate damage.
* Make sure all staff are aware of the consequences of fraud.
* Make sure all staff are aware that records are checked for accuracy, and all suspected cases of Medicare fraud are reported.
* Have a disaster recovery plan in place, in case of the loss or destruction of records.
* Make sure all electronic records are backed-up and that the integrity of the back-up data is also checked.

**Source:** “Administrative record keeping guidelines for health professionals” Australian Government: <http://www.health.gov.au/internet/main/publishing.nsf/content/admin-record-keeping-book> (Accessed on 30/07/2018).

It would be advisable to consult staff on a regular basis about the use of storage systems and any improvements that could be made by your medical practice. You should also keep a log of security breaches for the identification of necessary improvements.

Specific care must be taken over the storage of medical records in electronic formats. Computer files should be protected by passwords, which may only be shared with authorised personnel. Such staff members should save and securely exit applications to ensure that patient details don’t remain visible on the screen. Screensavers and passwords may be used to minimise the risk of observations by unauthorised personnel and other individuals.

Your medical practice should have established policies in place outlining the appropriate means of restricting access to digital files.

The following requirements should be met:

* Having a written policy on the levels of access that exist for the various roles within your practice.
* Having policies that outline how unauthorised access will be managed.
* Giving staff an individual password that they must use at all times.
* Changing staff passwords regularly.
* Ensuring passwords are not shared and are kept secure.
* Ensuring access to files is checked by using the audit capabilities of your practice software.

The disposal of records will be necessary in some instances (where such records have been kept for specific periods of time or are no longer required). However, care must be taken over the disposal of records to ensure that the patient details remain private and confidential. They should be completely destroyed, so that there is no chance that they can be read or reconstructed. Paper records should be disposed of using methods such as shredding, pulping, and burning.

### My Health Record

Healthcare organisations must have written security practice policies in place in order to participate in the My Health Record system.

Healthcare organisation must comply with the following legislation:

* *My Health Records Act 2012*
* *My Health Records Rule 2016*
* *My Health Records Regulation 2012*
* *Healthcare Identifiers Act 2010 (HI Act)*

The HI Act requires that an organisation take reasonable steps to protect healthcare identifiers from misuse and loss and unauthorised access, modification and disclosure.

The My Health Records Rule sets out the security requirements that participating organisations must comply with to be eligible for registration and to remain registered under the My Health Record system. Non-compliance can result in cancellation of participation and other penalties.

**Source:** “Security practices and policies checklist” Australian Government:

<https://www.myhealthrecord.gov.au/for-healthcare-professionals/howtos/security-practices-and-policies-checklist> (Accessed on 02/07/2019).

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## Activity 2.5: Storing records

This activity will provide you with an opportunity to store patient records according to organisational policy and procedures.

**In the Pracsoft tool, store at least one paper-based and one digital record in accordance with the policies and procedures that apply to your organisation. Ensure that the records are stored in such a way as to maximise security and minimise the risk of privacy infringements.**

Topic 3

Help maintain   
records

# Topic 3: Help maintain records

## Introduction

In this topic you will:

* Make required checks of patient records.
* Carry out archiving of patient records as required.
* Transfer patient records to another health facility upon appropriate request for patient information.

## Make required checks of patient records

### Checking patient records

It will be necessary to conduct regular checks of patient records to ensure that appropriate standards of organisation are being maintained and updates are being made accordingly.

Checks of patient files may include:

* Checking on a pre-determined cycle.
* Checking on specified dates.
* Ensuring files are tidy, neat, and correct.
* Ensuring files are stored in correct order (alphabetical, numerical, or alphanumeric).

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## Activity 3.1: Checking patient records

This activity will provide you with an opportunity to make required checks of patient records.

**Identify three (3) tasks that apply to the checking of patient records.**

## Carry out archiving of patient records as required

### Archiving of patient records

Your organisation may specify the need to archive some patient files so that they can be accessed at later dates as required. You should take particular care over the storage of such files. Storage areas should be free of chemical contamination, dust free, vermin-free, and protected against fire and flood.

It may not be practical or possible to keep all of the patient records within your medical practice. However, you are advised to keep records that are related to treatment for serious medical conditions and other important matters. You should only destroy medical records if you are entirely confident that they will not be required for any purpose related to your medical practice.

Archiving may include:

* Archiving on direction and under supervision.
* File storage using appropriate archiving options such as boxes, external storage facility, electronic scanning and imaging.
* Identification of files for archiving.
* Removal of files from system.

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## Activity 3.2: Archiving records

This activity will provide you with an opportunity to carry out archiving of patient records as required.

**Archive at least two (2) patient records in accordance with organisational requirements. Ensure that appropriate methods of storage are used, and access is restricted to authorised personnel. Use the Pracsoft tool to complete this activity.**

## Transfer patient records to another health facility

### Transferring patient records

It might be necessary to transfer a patient’s records to another health facility in order to ensure the appropriate provision of ongoing health care. However, the referring practice should send a copy in the first instance and retain the original file until seven years has passed since the last appointment. It will be important to ensure the security of any records that are transferred to other practices Registered mail and courier are considered the most appropriate delivery options. Medical records that are sent via email will ideally be encrypted for the prevention of unauthorised access. Any records that are kept on CD’s or USB sticks should be protected with secure passwords. The costs of the transfer should be paid for by the patient.

You might have to process requests for transferring patient records to medical facilities in other countries. It will be necessary to obtain the patient’s authorisation for the disclosure of information to facilities in countries which don’t have the same privacy principles as are applied in Australia.

In some instances, the health records will be so large and complex that the transfer process will be somewhat impractical. However, the original health care provider may create a summary containing all of the important information for transfer upon the patient’s request. It may be considered necessary to provide details of tests and medical investigations that have taken place. The new practitioner should be provided with as much relevant information as possible to ensure the provision of patient-centred treatment and care.

Appropriate request for patient information refers to:

* Legitimate request for patient information agreed to by patient and for purposes of furthering treatment regime with another health facility and within legislative requirements including:
  + approval by relevant health practitioner
  + Freedom of Information Act
  + organisational policy and procedures
  + Privacy Act.

The Australian Medical Association guidelines for doctors on providing patient access to medical records specify that:

* Patients have a right to be informed about all personal information held about them by an organisation that provides health services, and they generally have a right to access that information.
* It is recommended that, if in providing access, doctors permit a patient to view and/or copy a medical record concerning themselves, this should take place in the presence of the doctor so that the doctor is able to explain the record to the patient. The doctor may also wish to record any explanations and interpretations and make a copy of these available to the patient. This should avoid any misinterpretation which might occur with unsupervised access.
* Except in circumstances of a medical emergency, or where there is a serious and imminent threat of harm to the patient or another person, and as required by law, medical records should not, without the patient's express written consent, be released to persons other than the patient and other members of the treating team. Where appropriate, the consent of the patient's legally appointed guardian or attorney may be sufficient.
* Information from the medical records of deceased persons cannot be released other than according to statutory requirement, under legal compulsion, or with the consent of the executor or appointed administrator of the deceased person's estate.

**Source:** “Guidelines for doctors on providing patient access to medical records” AMA: <https://ama.com.au/sites/default/files/documents/AMA_Position_Statement_on_Guidelines_for_Doctors_on_Providing_Patient_Access_to_Medical_Records_1997__Revised_2002.pdf> (Accessed on 30/07/2018).

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## Activity 3.3: Tranfer patient records

This activity will provide you with an opportunity to transfer patient records to another health facility upon appropriate request for patient information.

**Using Pracsoft, make a transfer of patient records to another facility upon the appropriate request for patient information. Ensure that appropriate amounts of information are included and take steps for the assurance of privacy and confidentiality.**

Topic 4

Monitor and review   
own role

# Topic 4: Monitor and review own role

## Introduction

In this topic you will:

* Monitor and review own role and responsibilities in maintaining patient records to identify opportunities for improvements to system and own work practices.
* Make recommendations to relevant personnel for improvements to the established procedures and processes for maintaining patient records.

## Monitor and review own role and responsibilities in maintaining patient records

### Monitoring and reviewing own role and responsibilities

As previously mentioned, you should have a good understanding of your role and responsibilities in relation to patient recordkeeping. You should know which types of information needs to be obtained from patients, which storage methods should be used, and for how long the information needs to be kept in accordance with organisational requirements and legislation. It will be necessary to monitor and review the performance of your record-keeping duties for the identification of improvements to the system and your own work practices. It is also advisable to conduct regular audits of administrative record keeping processes that apply within your organisation.

Your medical practice should:

* Use record keeping performance indicators as part of your staff performance reviews, so staff know what is expected of them.
* Have a process for reporting and presenting the outcomes of internal audits to staff, where appropriate.
* Ensure internal audit findings are used to improve administrative record keeping standards within your practice, and
* Use internal audit findings to set future record keeping goals for your practice.

**Source:** Administrative record keeping guidelines for health professionals: <http://www.health.gov.au/internet/main/publishing.nsf/content/admin-record-keeping-book>

The act of monitoring and reviewing your own role and responsibilities is known as reflective practice. It involves considering the duties that have been performed and actions taken for the effective identification of improvements. You are advised to reflect, not just on your own professional performance, but also that of colleagues within your organisation. It should be possible to build upon your own strengths and learn lessons from others.

Possible improvements to system and work practices include:

* Ensuring that medical records are clear and complete.
* Identifying and correcting spelling mistakes.
* Ensuring the accuracy of personal details within patient records.
* Ensuring the legibility of handwritten records.
* Updating records as soon as possible upon the collection of patient information.
* Minimising the use of technical language and jargon for increased understanding.
* Improving the privacy and confidentiality of patient information.
* Ensuring compliance with relevant legislation.

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## Activity 4.1: Review roles and responsibilities

This activity will provide you with an opportunity to monitor and review own role and responsibilities in maintaining patient records to identify opportunities for improvements to system and own work practices.

**Engage in reflective practice and organise an audit of administrative record keeping processes for the identification of opportunities for improvements to system and own work practices. Provide details of any possible improvements that are identified.**

## Make recommendations to relevant personnel for improvements to the established procedures and processes for maintaining patient records

### Making recommendations

It is likely that you will identify a range of possible improvements to the established procedures and processes for the maintenance of patient records. However, such improvements may only be implemented if you are able to successfully persuade relevant personnel that they are required. You will first need to identify the personnel who are able to authorise and action changes necessary for improvement in the area of medical recordkeeping.

As previously mentioned, relevant personnel may include:

* Practice manager.
* Health professionals.
* Manager of facility.
* Own supervisor.
* Partners in business.

You should consider the most appropriate means of engaging such personnel in discussions about the need for workplace changes. If you believe that relatively minor adjustments are all that is necessary, then you may take the opportunity to make suggestions during informal everyday discussions. However, you may consider making particularly significant recommendations during scheduled workplace discussions and meetings.

There are a number of factors that should be considered in relation to the process of making workplace recommendations. You should think carefully about what you are going to say and who you are going to address with the recommendations. It would be worth creating a written outline which you can refer to for the purpose of ensuring that all of the relevant points are covered. There should be enough time to outline your points in sufficient depth and allow the relevant personnel to give feedback. You are advised to draw upon specific examples and positive effects of implementing your recommended changes. It will be necessary to speak in plain and simple terms, providing other staff members with clarification as necessary.

Recommendations may be made in accordance with the best practice performance cycle:

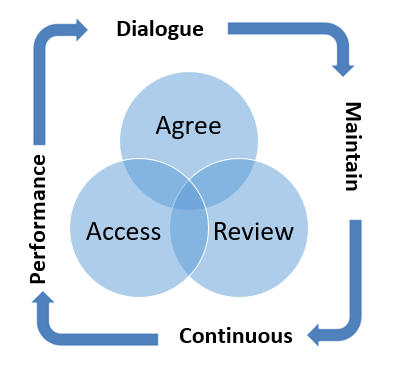


Figure Best practice performance cycle.

**Source:** Adapted from “The art of feedback: giving, seeking and receiving feedback” ACT Government: <http://www.cmd.act.gov.au/__data/assets/pdf_file/0003/463728/art_feedback.pdf> (Accessed on 30/07/2018).

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## Activity 4.2: Recommendations

This activity will provide you with an opportunity to make recommendations to relevant personnel for improvements to the established procedures and processes for maintaining patient records.

**Think back to the activities in your student workbook that used the Pracsoft tool.**

**What improvements do you think you could make to processes and procedures covered in these activities?**

**Discuss in pairs or small groups your ideas.**

# Appendices

## Legislation

### Legislation, Legislative Instruments and Standing Orders

**n.d. information taken from Australian Government - Legislation, policies, standards and advice**

<http://www.naa.gov.au/information-management/information-governance/legislation-standards/index.aspx>

#### *Privacy Act 1988*

This Act regulates the handling of personal information about individuals. This includes its collection, use, storage and disclosure.

The Act contains 13 [Australian Privacy Principles](http://www.oaic.gov.au/privacy/privacy-act/australian-privacy-principles) (APPs) which outlines how personal information is handled, used and managed. APP 11 contains provisions for the destruction or de-identification of personal information. APP 10 outlines the need to keep accurate, up-to-date and complete personal information.

**Relevant website:** <http://www.comlaw.gov.au/Details/C2015C00089>

The Australian Privacy Principles cover:

* The open and transparent management of personal information including having a privacy policy.
* An individual having the option of transacting anonymously or using a pseudonym where practicable.
* The collection of solicited personal information and receipt of unsolicited personal information including giving notice about collection.
* How personal information can be used and disclosed (including overseas).
* Maintaining the quality of personal information.
* Keeping personal information secure.
* Right for individuals to access and correct their personal information.

Australian Privacy Principles: <https://www.oaic.gov.au/privacy-law/privacy-act/australian-privacy-principles>

#### *Health Records and Information Privacy Act 2002*

The purpose of the Act is to promote fair and responsible handling of health information.

**Relevant website:** <https://www.legislation.nsw.gov.au/#/view/act/2002/71>

#### *My Health Records Act 2012*

The Act provides for the establishment and operation of the My Health Record system to provide individuals and their healthcare providers with access to their key health information online where and when they need it.

#### Relevant website: <https://www.legislation.gov.au/Details/C2017C00313>

#### *Freedom of Information Act 1982*

This Act provides a legally enforceable right of access to government-held documents, other than exempt documents. It enables individuals to request access to documents about themselves or other documents, such as documents concerning policy development and government decision-making and to seek amendment or annotation of personal records. It applies to Australian Government ministers and most agencies. The Act specifies which agencies and categories of documents are exempt.

Part II of the Act establishes an information publication scheme (IPS) for agencies. Agencies are required to publish a plan detailing the information they propose to publish under the scheme and how and to whom it publishes that information. Agencies must publish 10 categories of information including the agency’s structure, functions, operational information and citizen engagement arrangements. Agencies are required to publish a disclosure log, which is a register of information released in response to FOI requests (subject to limited exceptions).

**Relevant website:** <http://www.comlaw.gov.au/Series/C2004A02562>

#### *Archives Act 1983*

This Act empowers the National Archives of Australia to oversee recordkeeping practices in the Australian Government and to set recordkeeping requirements for Commonwealth records (Section 2A).

Under the Act, agencies are responsible for the:

* Destruction, transfer, or alteration of Commonwealth records (section 24), subject to Archives’ authorisation.
* Transfer of archival resources of the Commonwealth into Archives’ care (section 27).
* Following of records management standards and other obligations set by the Archives.

The Act also establishes a right of public access to non-exempt Commonwealth records in the 'open access period' (transitioning from 30 years to 20 years over the period 2011 to 2021 under amendments to the Act passed in 2010).

Different open access periods exist for:

* Cabinet notebooks (transitioning from 50 years to 30 years over the period 2011 to 2021).
* Records containing Census information (99 years).

**Relevant website:** <http://www.comlaw.gov.au/Series/C2004A02796>

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# References

These suggested references are for further reading:

#### Websites

##### Guidelines for client records:

<http://www.pacfa.org.au/wp-content/uploads/2014/12/Guidelines-for-Client-Records.pdf>

##### Administrative record keeping guidelines for health professionals:

<http://www.health.gov.au/internet/main/publishing.nsf/content/admin-record-keeping-book>

##### Health care records—documentation and management:

<http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_069.pdf>

##### Following policy and procedures:

<http://etraining.communitydoor.org.au/mod/page/view.php?id=63>

##### Medical records:

<http://www.avant.org.au/resources/start-a-practice/practice-operations/systems-and-procedures/medical-records/>

##### Privacy and health record resource handbook:

<https://ama.com.au/article/privacy-and-health-record-resource-handbook-medical-practitioners-private-sector>

##### Patient health records:

<https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition/standards-for-general-practices-5th-ed>

##### Transfer of medical records—a guide:

<https://ama.com.au/tas/transfer-medical-records-guide>

*All references accessed on and correct as of 11/04/2017, unless other otherwise stated.*