BSBMED303
Maintain patient records
Learner Guide
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SECTION 1 – ELEMENT 1 IDENTIFY AND CLARIFY OWN ROLE AND PROCEDURES FOR PATIENT RECORDKEEPING

Effective record keeping benefits all medical practices. It improves the efficient day-to-day operation of your practice; helps record and maintain your patient information and enables transparent reporting.

There are other benefits related to effective record keeping. These include maintaining the security of confidential clinical files, supporting staff to do their work more effectively, improving staff retention, and enhanced business continuity.

Having adequate administrative records may also assist if you are ever asked to participate in an Australian Taxation audit, Medicare compliance audit or for accreditation purposes. It is important to understand that record keeping obligations differ depending on the purpose of the records. You may also not be aware that neglecting record maintenance may increase the risk of receiving an incorrect Medicare payment or mean that you are not able to provide adequate evidence to substantiate claims. All record management systems with an organisation must comply with State and Federal Acts and legal requirements in order to fulfil the needs and requirements of business operations.

Recordkeeping acts and legislation include:

- Public Records Office Retention and Disposal Authority PROS 07/01
- Public Records Office Standard PROS 97/003 (Destruction Of Public Records)
- Regulations made under those Acts and international standard for records management ISO 15489
- Document Destruction Act 2006
- Legislation : Privacy and Confidentiality

Queensland legislation which provides privacy and confidentiality protections for personal information include:

- Information Privacy Act 2009
- Information Privacy Regulation 2009
- Hospital and Health Boards Act 2011
- Hospital and Health Boards Regulation 2012

Applications for access and/or amendment of personal information may be sought under:

- Information Privacy Act 2009
- Information Privacy Regulation 2009
- Right to Information Act 2009
- Right to Information Regulation 2009

Ensuring your practice has an administrative record keeping policy in place enables staff to access information your practice requires easily, supports the operations of the practice and assists with meeting any compliance requirements.
Policies should be:

- written down and accessible to all staff
- descriptive about the responsibilities that all staff have for managing records—this might include, but is not limited to, Medicare records
- inclusive of email and other electronic records, and
- descriptive of possible outcomes for incorrect claiming of Medicare services or Medicare fraud

To improve administrative record keeping, most organisations have policies that help staff understand their responsibilities in relation to record keeping, sets the standards they operate by and sets out how to achieve and maintain this standard. Having a set standard gives staff a goal and sets out the types of records that should be kept and how to store those documents. As a result, staff will be more content in their position, improving practice staff retention. Setting regular review dates and involving staff in the review process, are part of the evaluation process for quality assurance processes.

What is a patient record?

A record is any document or other source of information compiled, recorded or stored in written form or on film, or by electronic process, or in any other manner or by other means. Records are created for the production of evidence of individual and corporate performance.

This includes:

- Hand-written medical records
- Electronic medical records
- Correspondence to and from the medical practitioner to third parties (patient, specialists, health funds, etc.)
- Pathology and radiology reports
- Documents provided to the patient (e.g. photographs, literature, pamphlets, video tapes)
- Diary records
- Accounting and financial records
- Test results
- Documented procedures
- Copies of certificates documenting issues (e.g. Workers Compensation, Centrelink, insurance claim forms).

A medical record is compiled in such a manner that meets the need of the clinician and facilitates ease of access to information. An alert notification (sticker) must be displayed on the front cover of the medical record where a client has any of the following: an allergic response, a drug reaction, significant infectious diseases or pathogens, immune deficiencies, blood disorders, repeated aggression or other behavioural issues. An alert sticker is a flag only.

As a practitioner you are provided with the support and resources you need to do adequately complete all patient records effectively. Organisations will have processes in place for:

- developing clear policies and procedures
• providing staff with opportunities to network with peak bodies and other medical practices so they can share ideas about administrative record keeping
• involving staff in monitoring and improving administrative record keeping systems so they feel accountable for the systems
• providing clear lines of accountability and responsibility
• including record keeping responsibilities in job descriptions, including clear expectations, and
• having a staff code of conduct that includes expected behaviours and legal responsibilities
SECTION 2 - ELEMENT 2 ACCESS PATIENT RECORDS

Record management systems need to meet the requirements of legislation and fulfil the needs and requirements of the organisations business and legal operations, accountability requirements and community expectations.

A system may be paper based (such as index cards as used in a library), or may be a computer system, such as an electronic records management application.

Health information management professionals traditionally perform data and information warehousing functions (e.g., purging) utilizing all media including paper, images, optical disk, computer disk, microfilm, and CD-ROM. These warehouses or resources from which to retrieve, store, and maintain data and information include, but are not limited to, application-specific databases, diagnostic biomedical devices, master patient indexes, and patient medical records and health information.

Types of record systems

Filing systems and record management processes

Filing is one of the most important tasks in the management of information. If records are not kept and filed so that they can be retrieved easily, efficiently and effectively when required, then those records have limited use.

The method of arrangement of the medical records will affect the ease of filing, maintenance of records and retrieval of records.

Medical Record Standards and a numerical filing system for the storage of medical records.

Terminal Digit Filing

Two coloured coded number stickers are placed on the protruding right hand side of the back of the medical record cover. This allows for all charts where the terminal two digits are the same, to be filed together. This coordination of colour reduces the misfiling of records, and aids the ready identification of files that have been misplaced. More specific file location within the colour grouping is by the third last digit, which is to be written above the 2 coloured stickers.
The objective of Medical Record Standards is to improve the quality of health care by facilitating communication between health care professionals in addition to allowing for ease in recording, storage, access, filing and retrieval of information. Methods and systems for recording medical information must be authorised by the organisation.

Alphabetical Filing

With alphabetical filing, medical records are organized using the last and first name. This makes it easy for you to locate medical records for appointments. This filing system expedites the information retrieval process but lacks confidentiality; a patient can be easily identified this way, but the name must be visible to do so.

Straight Numeric Filing

A numeric system files medical records in chronological order. There are three types of straight numeric filing systems used in storing medical records: the unit numbering system, the serial unit numbering system, and the serial numbering system. In the serial numbering system, every patient receives a new number every time he is treated at the hospital. If you visit the hospital five times, you get five different medical record numbers. Unlike the serial numbering filing system, with serial unit numbering despite receiving a new medical record number, your previous records are brought forward and filed by the number that was issued to you latest. As for the unit numbering system, you are assigned one medical number during your first visit, which is applicable in all subsequent treatments and visits. The straight numeric filing method increases client confidentiality and makes it easier to retrieve information. Another advantage is that office personnel can be easily trained on its usage.

Middle-Digit Filing

In this type of medical filing system, numbers are grouped in pairs just like with terminal-digit filing. However, in this case, primary numbers are formed by the two digit numbers in the middle of six consecutive numbers while secondary numbers are the first two numbers in the same order of six numbers. Tertiary numbers are made up of the last two digits. The disadvantage of this type of filing is that it is more complicated and therefore personnel requires more training time. Furthermore, it cannot be used in cases where numbers are higher than six.

Middle Digit Filing

Middle digit filing is a variation of terminal digit filing. It assigns digits on the right side of the series as tertiary. But the middle and left digits are referred to as primary and secondary respectively. The advantage of this system compared to others is that colour coding can be easily applied. The disadvantage is that as a patient, your numbers are only limited to six digits for easy division into primary, secondary and tertiary digits.

Subject Filing System

The subject filing system organizes a patient’s records on the basis of subject area, such as insurer’s or patient’s information. The advantage of this type of medical filing is that everything related to a particular subject is grouped together in a single location. The disadvantage is that it is hard to decide on the location for filing the information. This is because some information fits in more than one subject area or none.
The responsibilities for current and non-current records management within an organisation must include that the records are:

1. Stored in a suitable, secure environment
2. Documented and indexed
3. Sentenced according the appropriate guidelines
4. All costs associated with compliance and for ongoing management and retrieval are to be met by the organisation

**Roles and responsibilities for record keeping**

When personnel are employed by a health organisation it is imperative that their roles and responsibilities for managing the patient record keeping system are communicated

Employees must receive the appropriate patient record systems training in order to support the delivery of quality and safe treatment and care to the patient and to ensure that the health record provides a concise and accurate account and be able to be used in a court of law.

WHS responsibilities lie in the day to day management of all health and safety issues including the roles and responsibilities for patient record keeping by making sure all workers’ health and safety is being maintained by:

- Training for new workers in manual handling techniques
- Training for all workers when new equipment or work practices are introduced.
- Use storage techniques-wall brackets, shelving- to reduce holding, carrying, lifting, etc.;

**Documentation guidelines**

The health record is a legal document and good professional record keeping that accurately reflects clinical practice is your obligation.

- Legibility is essential
- Documentation must be in blue or black pen
- Do not use ‘whiteout’ in any circumstance
- If an error is made put a line through the error and write the correct information above, below or after the error

- Each page within a health record must contain a patient/consumer label name and unit record (UR) number for identification.
- Be brief, factual and to the point and take care not to confuse quantity with quality.
- Every entry within a health record must include the date, time, signature, printed name and designation.
- Do not use non-standard abbreviations.
- “Post it” notes or other ‘message notes’ must not be used.
• Spaces must not be left between entries.
• Document actions and observations accurately. Document the information in an objective, non-judgemental manner with the assumption that the patient/consumer or carer may read it.
• Recording must be an accurate, concise, timely account of events relative to the ongoing evaluation of the patient’s condition and expected outcomes.
• If the entry is late (recorded out of sequence note this clearly in the health record).
• Record observations, events and interventions promptly or as soon as possible after they occur.
• Under no circumstances must an entry be made on behalf of another person.
• In you are not the primary source of the information in the entry ensure that this primary source is clearly identified and recorded.

**Progress notes**

One of the most widely recommended methods for documenting a particular client encounter is the Subjective Objective Assessment Plan (SOAP) format. This format is widely used in medical practices, allied health practices and natural medicine practices and many versions of clinical software uses a SOAP format for documenting client encounters.

There are many advantages including encouraging comprehensive records, reducing unnecessary documentation, assisting in the organisation of the notes, saving time, and facilitating rapid and easy retrieval of information from the record.

Practitioners should consider the following points when documenting their client encounters:

**Subjective Data (S)**

• Presenting complaint, including the severity and duration of symptoms;
• Whether this is a new concern or an ongoing/recurring problem;
• Changes in the client’s progress or health status since the last visit;
• Past medical history of the client and their family, where relevant to the presenting problem;
• Salient negative responses.

**Objective Data (O)**

• Relevant vital signs;
• Physical examination appropriate to the presenting complaint;
• Positive physical findings;
• Significant negative physical findings as they relate to the problem.

**Assessment (A)**

• Patient risk factors, if appropriate;
• Ongoing/recurring health concerns, if appropriate;
- Review of medications, if appropriate;
- Review of laboratory and procedure results, if available;
- Review of consultation reports, if available;
- Diagnosis, differential diagnosis, or problem statement in order of probability and reflective of the presenting complaint.

**Plan (P)**

- Discussion of treatment options;
- Tests or procedures ordered and explanation of significant complications, if relevant;
- Consultation requests including the reason for the referral, if relevant;
- New medications/remedies/supplements ordered and/or medication repeats including dosage, frequency, duration and an explanation of potentially serious adverse effects;
- Any other patient advice or client education (e.g., diet or exercise instructions, contraceptive advice);
- Follow-up and future considerations;
- Specific concerns regarding the client including client refusal to comply with your suggestions.
SECTION 3 – ELEMENT 3 HELP MAINTAIN RECORDS

Making checks of patient records

Checking patient records and following your organisations information sharing policies and procedures demonstrates a strong focus on risk management. Policies and procedures will identify and guide protocols for dealing with normal results, abnormal results (urgent and non-urgent) and important tests/referrals and will give details of how tests and results are communicated to patients.

‘Follow up’ can mean:

- following up the information – following up on tests and results that are expected but have not yet been received by the practice
- following up the patient – tracing the patient to discuss the report, test or results after they have been received by the practice and reviewed, or tracing the patient if the patient did not take a test as expected

‘Recall’ means:

- a system to make sure patients receive further medical advice on matters of clinical significance

‘Clinical significance’ is determined by:

- the probability that the patient will be harmed if further medical advice is not obtained
- the likely seriousness of the harm

‘Follow up system’ is required to ensure that:

- all received test results and clinical correspondence (e.g. reports from other healthcare providers) relating to a patient’s clinical care are reviewed
- clinically significant tests and results are followed up
- patients are made aware of the seriousness of not attending for follow up
- patients are made aware of who is responsible for communicating with whom about results and when this is to occur

There may be considerable risk in not following up clinically significant tests and results.

Reliance on patient memory or motivation alone does not reduce the need for an effective follow up system in the practice. Patients may not follow the recommendations for tests provided by the practice because of their particular circumstances, fear, ignorance, personality, expectations, beliefs, cultural background or a range of other factors. The practice needs to have systems to identify and respond to situations where a particular patient may not understand or comply with their responsibilities to go through with a test or to follow up the results with the practice. General practitioners in the practice need to reflect on which patients, tests and results justify a suspicion or concern. The practice needs to have a system that will allow practitioners to take action to address their concerns. These concerns could be based on suspicion that the information from a test is likely to be clinically significant, or that the patient might not have the test performed.
In cases where a practitioner suspects that the results will be clinically significant, the practice needs to create additional safeguards to ensure that potentially clinically significant information does not get ‘lost in the system’. One approach is by obtaining a clearly expressed agreement from the patient (which is documented by the practitioner) that the patient is responsible for having the recommended tests performed and/or getting the results. However, this alone might not be sufficient for follow up in all circumstances. The practice needs to have a system that protects against the failure of both the practitioner and the patient remembering to follow up on tests or results. These systems need to allow for more intensive follow up action if required by the circumstances.

The nature and extent of responsibility for following up tests and results will depend on what is reasonable in all of the circumstances. Overall, the following factors are important in determining if something is clinically significant and therefore requires follow up:

- the probability that the patient will be harmed if adequate follow up does not occur
- the likely seriousness of the harm
- the burden of taking steps to avoid the risk of harm

The clinical significance of a test or result needs to be considered in the overall context of the patient’s history and presenting problems. Clinically significant results do not necessarily only mean ‘abnormal’ results. For example, a normal mammogram in a woman with a breast lump, or a normal electrocardiogram in a patient with chest pain, does not preclude the need for further consultation, investigation and management. ‘Clinically significant’ is a judgment made by the practitioner that something is clinically important for that particular patient in the context of that patient’s healthcare. The judgment may be that an abnormal result is clinically important and requires further action. On the other hand, the result may be normal, but may still require further action.

The practice needs to have in place some process or system for following up – even if it is as basic as a simple diary entry or logbook containing ‘worrying’ or ‘high risk’ cases – so that where there is a concern about the significance of the test or result a reminder occurs. Generally, practitioners do not necessarily need to supervise such a system directly, but it needs to operate consistently where it is needed.

The practice needs to be able to identify unexpected significant results when they are received, particularly if the significance of such results was not raised in the consultation. In these circumstances practices need to alert the patient, who may not anticipate or understand the significance of the result.

Problems in follow up can be avoided or minimised through interventions at earlier points in patient care. The relationship between doctor and patient is a special one, based on trust and communication. While the patient is the ultimate decision maker, it is important for the patient to be well informed in order to make such decisions. Decisions need to be based on information that the PRACTITIONER has a duty to provide. The PRACTITIONER needs to convey the information to the patient in a way that helps the patient to understand it. A patient who makes a decision based on insufficient information is not making an informed decision. Once properly informed, however, there can be legally effective informed consent, and there can also be legally effective informed refusal.

One component of a records management system is the procedure for tracking files.

A tracking system, whether automated or manual, should be able to give you information on where a document or file is at any time.

All health records must be stored in a discrete and secure location and only be accessed by health professionals directly involved/ responsible for the care of the patient/ consumer and as consistent with the Health Privacy Principles.

Records must be stored in such a way that they are accessible and safeguarded against environmental damage. A typical paper document may be stored in a filing cabinet in an office. However, some organisations employ file rooms with specialized environmental controls including temperature and humidity. Vital records may need to be stored in a disaster-resistant safe or vault to protect against fire, flood, earthquakes and conflict. In extreme cases, the item may require both disaster-proofing and public access.

- **Primary Storage:** Refers to records that are held in the primary medical record collection contained within the compactus filing system.
- **Secondary Storage:** Refers to records that are held in a facility which are awaiting archiving or a destruction date, in accordance with the Disposal Schedule for Patient Records.
- **Tertiary Storage:** Refers to records that are held offsite in a remote location. E.g. aircraft hanger.

Modern record keeping technologies have transferred much of that information to electronic storage. In addition to on-site storage of records, many organizations operate their own or contract with commercial records centers.

Electronic information in health care includes databases, electronic health records and transferring health information by electronic means, including email communication and CD Rom/DVD’s. All health care practitioners should develop policies and procedures that meet standard client record guidelines.

Electronic records must also address confidentiality, privacy, consent, security, identification, and storage and retention procedures. You may keep records electronically, but only if capable of being printed on paper.

There are two types of electronic records broadly defined as **Electronic Medical Records (EMR) or Electronic Client Records (ECR)** and **Electronic Health Records (EHR)** that multiple health care professionals may be involved with.

Different States in Australia have different requirements regarding the retention of medical records.

The Commonwealth Privacy Act and National Privacy Principles do not stipulate a specific timeframe in which medical records can be destroyed. The guidelines suggest that legal requirements of individual States must be followed regarding retention of health information by health service providers.
Victoria and ACT

The Health Privacy Principles of the Health Records Act 2001 (Victoria) and the Health Records (Privacy and Access) Act 1997 (ACT) provide a similar timeframe as set out for NSW.

Destruction of records should be done securely and confidentially. The legislation in Victoria and the ACT requires that such schedules are kept. The process needs to be well-documented, starting with a records retention schedule and policies and procedures that have been approved at the highest level. A schedule which includes the patient’s name, date of birth and date of destruction should be maintained of records that have been destroyed including certification that they have been destroyed.

Regulation 7 of the Medical Practice Regulation 2003 (NSW) provides that:

• For adults - The record must be kept for at least 7 years from the date the patient was last provided with medical services or treatment
• For children (less than 18 years old) - The record must be kept until the patient attains or has attained the age of 25 years.

Normal administrative practice

The destruction of some public records is permitted without authorisation under normal administrative practice.

Examples:

• Working papers; being notes and calculations used solely to assist in the preparation of other records such as corresponded, reports and statistical tabulations
• Drafts not intended for retention as part of record the content of which has been reproduced and incorporated into the record system
• Extra copies of documents and published material preserved solely for reference

Crimes (Documentation Destruction) Act 2006

• It is an offence for individuals or organisations to destroy documents that know are reasonably likely to be required for a future legal proceeding with the intention of keeping the documents out of evidence
• In Victoria, from 1 September 2006 it is an offence to destroy a document (including medical records) with the intention of preventing the document from being used in legal proceedings.

Disposal of records does not always mean destruction. It can also include transfer to a historical archive, museum, or private individual. Records should never simply be discarded as refuse. Most organizations use processes including pulverization, paper shredding or incineration.
Commerically available products can manage records through all processes active, inactive, archival, retention scheduling and disposal. Some also utilize RFID technology for the tracking of the physical file.

**Transferring patient records**

The confidentiality of patient information is essential to both patients and healthcare professionals.

The obligation to keep consumer information confidential is long standing and well understood by clinicians and consumers. The essence of the obligation is to protect health information from unauthorised use or disclosure by placing responsibility on the individual who holds the information to keep it confidential. Confidentially is enforced by both legislation and professional codes of conduct.

All external contracted service providers and partners in care provision are held to the same standard of accountability as hospitals. Patient and staff information shared or available to an external health care service or contracted service provider, should be protected to ensure that access and use of personal information is only as appropriate.

Information concerning the condition of the client should only be revealed to another person with the consent of the client or the client’s authorized representative (such as a solicitor). Determining who is an authorized representative may be difficult (e.g. the client is deceased, or the client is a minor whose parents are separated). A practitioner should seek legal advice for clarification in this situation.

Practitioners who are asked to prepare a report for a third parties (e.g. insurance companies, Workers’ Compensation Board) must take concise and accurate case notes. Clients should be informed of the purpose of any examination or treatment and the way it will be conducted. The client must be advised in advance that the prepared report will be disclosed to the third party requesting the report as well as to the client if so requested by the client.

Practitioners may refuse a request for access to information from a third party where:

- The information is protected by solicitor-client privilege;
- It is reasonable to expect that granting access would threaten the life or security of another individual;
- The information was collected in relation to a breach of an agreement or a contravention of federal or provincial laws; or
- The information was generated in relation to a formal dispute resolution process.

Practitioners may refuse a request for access to information from a third party when they have reasonable grounds to believe it would not be in the best interest of the client to make available that information, or where the information is protected by solicitor-client privilege.
When clients request that their health care practitioners (of any modality) transfer their records to another practitioner, the transfer should take place in a timely fashion. Practitioners may charge the client a reasonable fee to reflect the cost of the materials used, the time required to prepare the material and the direct cost of sending the material to the requesting practitioner.

Client health and safety should not be put at risk because of a delay in transferring client records. Inability to pay for the costs of copying should not prevent client access to records. Practitioners should be flexible in this regard.

In some circumstances, it will be better for the transferring practitioner to prepare a summary of the records rather than to provide a copy of the whole record. This needs to be acceptable to the receiving practitioner and the client. The original practitioner is still obligated to retain the original record, in its entirety, for the time period required by regulation.

(Adapted from Endeavour College of Natural Health | Guidelines for Client Record-Keeping)
SECTION 4– ELEMENT 4 MONITOR AND REVIEW OWN ROLE

Identifying opportunities for improvements to system and own work practices

The need to review and improve patient record systems is an ongoing process as each healthcare environment functions differently, often in significant ways. It is difficult to create a "one-size-fits-all" system, therefore as technology and systems evolve so do patient record systems.

An important consideration in the process of developing patient record systems is to plan for the long-term preservation and storage of records. These processes and methods need to ensure the future accessibility and compatibility of archived data with yet-to-be developed retrieval systems, and how to ensure the physical and virtual security of the archives.

Another important issue is the maintenance of patient privacy and security to void failures that can cause injury to the patient and violations to privacy therefore the best practices in software engineering and medical informatics must be deployed.

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

A needs analysis is useful for determining the requirements of a records system

- You need to collect all the relevant information to undertake the needs analysis
- When you have gathered all your information, you need to complete the vital step of analysing it and developing solutions
- Reporting includes a summary of your findings and your recommendations outlining each solution
- The more detailed your report and your solutions, the easier it will be to implement the changes
REFERENCES & RECOMMENDED READING

Standards for general practices (4th edition)

Endeavour College of Natural Health | Guidelines for Client Record-Keeping
