Patient Health Records Management Policy

A patient health record is a comprehensive document containing sensitive health information compiled by a health professional over the time they are treating a person. Its primary purpose is to:

- Correctly identify a person
- Record symptoms and signs
- Support diagnosis
- Justify management decisions.

The practice also routinely records the person the patient wishes to be contacted in an emergency.

The practice uses at least three approved identifiers for each patient encounter or activity such as making appointments, writing prescriptions, writing referrals to other providers, giving results or entering results or correspondence into records.

All practice staff are trained to check for approved patient identifiers as a matter of course.

Approved patient identifiers are those items of information accepted for use in patient identification and include:

- patient name (family and given names)
- date of birth
- gender (as identified by the patient themselves)
- address
- patient record number where it exists.
- Individual Healthcare Identifier.

Note: A Medicare number is not an approved identifier.

Our practice is working toward recording the cultural backgrounds of our patients in our active patient health records.

Format of Health Records

To enhance continuity of care, each patient must have their own individual file (as opposed to a family file). This record must contain:

- All clinical information relating to the patient
- Contact and demographic information including the patient's full name, date of birth, gender and contact details
- Self-identified cultural background (e.g., Aboriginal and Torres Strait Islander)
- The preferred contact in an emergency.
- Next of Kin

Complete Health at Crossways uses an electronic file system.

Content of Health Records

Our practice ensures that at least 75% of active health records contain a health summary including:

- Adverse medicines events
- Current medicines list
- Current health problems
- Past health history
- Risk factors (height, weight & blood pressure at defined intervals)
- Immunisations
- Relevant family history
- Relevant social history.

Our practice also ensures that:

- 90% of active health records contain a record of allergies in the health summary
- Significant face-to-face, telephone or electronic communication is recorded in the patient record
- Health records are updated to show recent important events including immunisations, births and family history changes

'Active health records' are considered to be records of a patient who has attended our practice three or more times in the past two years.

Consultation Notes

Our practice also documents consultations including those outside normal opening hours, home or other visits and clinically significant telephone or electronic consultations.

Consultation must include the following:

- Date of consultation
- Reason for consultation
- Relevant clinical findings
- Diagnosis
- Recommended management plan and where appropriate expected process of review
- Prescribed medicine (including medicine name, strength, directions for use/dose frequency, number of repeats, and date medicine started/ceased/changed)
- Any relevant preventive care undertaken
- Documentation of referral to other health care providers or health service
- Any special advice or other instructions
- Identification of who conducted the consultation, e.g., by initial in the notes, or audit trail in electronic record
- Evidence that problems raised in previous consultations are followed up.

Patient health records must show evidence that problems raised in previous consultations are followed up.

Complete Health at Crossways is working toward recording preventive care status (e.g., currency of immunisation, smoking, nutrition, alcohol, physical activity, blood pressure, height and weight [body mass index]) as part of the patient's health record.

To ensure that quality consultations continue in the event of computer failure, our practice prints templates from the clinical software program and store in a central location. These can then be used as part of the consultation with hand written notes scanned with a notation in consultation notes indicating the location of hand written notes. Alternatively, hand written

notes can be entered into the clinical software when the computers come online. This forms part of the practice **Disaster recovery plan**.

Cultural Backgrounds

Our practice ensures that we record the Aboriginal, Torres Strait Islander, or any other relevant cultural background of our patients in the health record to ensure the highest quality of ongoing and continuing care. These help to specialise our deliverance of care, including lifestyle risk factors, specific consultations, or just a general background for the patient's specific demographics.

Health Records legislation

State	Legislation
Victoria	Health Records Act
NSW	Health Records and Information Privacy Act 2002
ACT	Health Records (Privacy and Access) Act 1997