Health Record Management Policy

1. Background

This purpose of this policy is to provide guidance on the governance, management, creation, content, filing, accessibility, storage, and disposal of health records within the WA Country Health Service (WACHS).

The health record has many functions including:

- facilitating and demonstrating the quality and safety of client care
- providing an effective communication tool between health care professionals
- documenting the course of a patient's illness, treatment, support and outcome
- enabling another health care professional to assume care of a patient
- allowing concurrent and retrospective evaluation of patient care
- providing a complete overview of the patient's medical history, past and present
- providing a means of documenting all care/support given to the patient during hospitalisation or within the community, which may be used as evidence in a court of law
- providing a basis for future planning of health resources
- providing clinical data and information for research, evaluation, education and statistical analysis
- providing information for financial and billing purposes.

Health information is valuable only if it is accurate, complete and available for use when needed.

2. Policy

The WA State Government owns all WACHS health records. Custodianship of the health records is with the individual service site or region. Health records within the WACHS are to be created for all new inpatients, outpatients, patients presenting to the Emergency Department (ED) as well as those seen in the community.

Health care records are inclusive of paper records and electronic records.

2.1 Patient Identification and Record Numbering

Every patient is to be registered once in the appropriate, approved patient administration system with a unique identification number allocated to be used for all health record documentation related to that patient. Preference is that this is the state-wide Unit Medical Record Number (UMRN) or that the identifier used is linked to this number.

The physical health record cover is to have the following information:

- Patient surname
- Patient given name(s)
- Medical Record Number (MRN) or UMRN
- Year sticker (retention)
- Appropriate stickers:
  - Drug / Medical Alert
  - Deceased
  - Barcode
  - Patient with Similar Name
- Statement regarding confidentiality of the health record
- Name of the health facility
- Volume number (where multiple volumes exist)
- Colour coding (for numerical filing systems only).

No other identifying information is to be placed on the cover of the health record.

2.2 Health Record Creation

A health record is to be created for all patients registered for a site where documentation is received or created.

- **Physical Hard Copy Record**
  Each patient has an individual file or volumes of files.
- **Electronic**
  Those sites that have an authorised scanned medical record or electronic health record management system.
- **Transient Files**
  If a patient is only attending the service for a one off emergency department or non-admitted visit rather than an individual file being created documents may be stored in a combined file usually in alphabetical order within the year of attendance.

2.3 Electronic Systems

With the utilisation of a number of clinical applications and systems there has been a shift in the creation and storage of health records and patient information. Traditionally, health records are paper-based format; however with certain endorsed clinical applications and systems this has seen a shift to electronic initiated and stored records.
Whilst systems serve to improve access to information and support clinical care, record management principles need to be adhered to. The below table articulates the printing requirements for electronically generated records within applications utilised in WACHS.

Application/System	Printing Requirements
Best Practice	Best Practice does not replace the paper record. Patient records produced in Best Practice are to be printed and filed in the relevant section of the paper-based health record.
BOSSnet	Nil – This is a digitised record with electronic form capability. This system is designed to replace the existing paper-based record and as such does not require printing for health record management purposes.
Community Health Information System (CHIS)	Nil – This is an electronic record. This system is designed to replace the existing paper-based record for Community Health services and as such does not require printing for health record management purposes.
Computerised Provider Order Entry (CPOE)	Nil – Ordering system. Any orders should be noted within the health record documentation.
EMDAT Dictation System	Any approved correspondence generated via EMDAT for release is to be filed in the Correspondence Divider of the health record.
Emergency Department Information System (EDIS)	The front page of the ED Notes Form (MR1) is to be printed from EDIS once the initial triage assessment is completed
Enterprise Bed Management (EBM)	Nil – Bed management tool. No printing for health record management purposes.
eReferrals	1. Accepted referral is to be printed at the first appointment for the patient, and filed with the relevant outpatient documentation a. BOSSnet sites do not require printing of eReferrals as these are available through the digital record 2. Nil requirements in printing cancelled or rejected referrals.
iSoft Clinical Manager (iCM)	Nil – Clinical viewing tool. No printing for health record management purposes. Staff may print Nurse Handover for local use but not required to be filed in the health record.
JourneyBoard	Nil – Clinical viewing tool. No printing for health record management purposes.
Notifications and Clinical Summaries (NaCS)	1. Completed inpatient discharge summary should be printed and filed in the relevant admission it pertains 2. Nil requirement for printing of excluded or ED summaries
Psychiatric Services Online Information System (PSOLIS)	PSOLIS recording occurs in both an inpatient and outpatient setting. All Great Southern Community Mental Health sites have integrated medical records with the health service. All PSOLIS activity is required to be printed and filed in the health record. This includes the following activities: 1. PSOLIS Referral 2. PSOLIS Activation and Deactivations 3. NOCC Measures - HoNOS is one of the NOCCs as is Kessler 10, LSP-16, SDQ PC1 and CGAS 4. Service Events (Multiple contact types: includes assessments, Contacts, Depot injection, family meetings) 5. Triage Events 6. Management Plans 7. Client Reviews 8. Outpatient Notes 9. Alerts

Stork	1. Stork Summary to be printed as per NaCS Summary
Theatre Management System (TMS)	1. Intra-Operative Nursing Assessment to be printed (where completed) and filed as the Operation Record in the health record. 2. Operation Notes where completed should be printed and filed with the Operation Record in the health record.
webPAS	1. HC21 Private Patient Admission Form – to be printed where patient elects to be private for an admission and filed in the relevant admission 2. Admission Summary – to be printed at the discharge.
webPAS ED	1. The front page of the ED Notes Form (MR1) is to be printed from webPAS ED module once the initial triage assessment is completed 2. Clinical Notes directly entered into webPAS ED should be printed and filed with the relevant ED Notes (MR1)

Documents and clinically relevant information created in electronic systems not listed above should be printed and filed appropriately in the facility's paper-based record or scanned to an authorised medical record or electronic health record management system. For documents received in a paper-format the paper-based records management principles apply.

2.4 Components of the Health Record

The health record is a source-orientated document, meaning it is organised in sections according to services provided to the patient. All documents in the health record are to be contained within a folder or cover, and attached by a clip or other securing non-metal device.

Health records are to have dividers with identification tabs for each section within the record. These dividers are to be arranged in the following order:

- Alerts divider where required
- Demographic / attendance summary information
- ED / Outpatient Notes divider
- Additional dividers may be created for specific disciplines / programs
- Investigations divider
- Correspondence divider
- Legal divider
- Admission dividers (most recent on top)
- Additional dividers may be authorised for use via regional processes.

2.5 Collating and Filing of the Health Record

Health records are to be collated at the end of each attendance or on the patient's discharge from the health service, before being placed back into the filing system or are scanned. This is to ensure that the records and documentation are complete and easy to find.

The health record is to retain the original documentation except:

- where patients are transported and documentation relating to the transfer originals are sent with the patient (copies shall be made and retained in the health record)
- for outgoing correspondence (a copy is to be made and retained in the health record) or
- where there is a recognised patient hand held record.

The face of each form in the health record is to contain patient identification. This may be by using a patient identification label or handwritten name, date of birth and MRN/UMRN (in line with the WA Health Patient Identification Policy 2014).
No patient label is to be placed over the written name or existing label on a form.

All health record forms filed in the record must comply with the WACHS Health Record Form Management Policy and Health Record Form Design Guideline. Forms with no content (blank forms) are not required to be filed in the health record. Where a patient identification has been documented on the form with no content, this is to be shredded. Only forms with documentation should be filed in the health record. Prescription forms should be filed within the relevant event paperwork, after the MR forms (at the back).

Each section within the health record is to have filing undertaken as per the Australian Standard 2828:

a. Alert Divider (where required)

- This section documentation is for any alerts or advance health directive filed in Medical Record (MR) Number order.
- Where multiple forms of the same number are present, file in reverse chronological order.
- Alert forms/correspondence without MR numbers are to be filed at the back of the alert divider in reverse chronological order.

b. Emergency Department (ED) / Outpatient Notes

- This section documentation for each attendance is to be collated and then filed in reverse chronological order with the most recent information on top.
- This section can be split into ED (MR1) and Outpatient (MR5) attendances however this is at the discretion of the specific region.
- Subsequent dividers may be used to split specialties including Mental Health, Aged Care Assessment Team (ACAT), Allied Health, Home and Community Care (HACC), Hospice etc. The order of filing under these can be determined at a regional level.
- Sexual Assault Resource Centre (SARC) records shall be stored in the health record within a sealed yellow envelop behind the Emergency Department (MR1) for the presentation.

c. Investigations

- This section is to have documents filed in reverse chronological order.
- This section includes all pathology, x-ray, electrocardiogram, photographs not linked to inpatient procedures and other investigation reports.
- Where paper results are smaller than A4 size, a backing or mounting sheet is to be used. In the case of photographs or images on compact disks (CDs), envelopes may be used.
- Backing sheets are to be filed in numerical order with the investigations attached in reverse chronological order.
- Grouping similar types of reports together is optional depending on regional process (e.g. filing pathology results together).

d. Correspondence

- This section is to have documents filed in reverse chronological order.
- Where correspondence is smaller than A4 size, a backing sheet is to be used.
- This section is to include all incoming and outgoing correspondence

e. Legal

- This section is to have documents filed in reverse chronological order.
- This section is to include power of guardianship, power of attorney, and other legal information that is relevant to the patient's treatment.
- This section is not to have Freedom of Information or other patient information requests, legal correspondence relating to medical negligence matters, coronial enquiries or patient complaints. This is to be maintained in separate legal files.

f. Admission

- Each admission is to have a separate divider and admission dividers are to be in reverse chronological order.
- This section is to have forms filed in MR Number order.
- Where multiple forms of the same number are present, file in chronological order.
- Forms without MR numbers are to be filed at the back of the admission.
- Patient election forms and the Inpatient Summary (HA22) are to be filed at the front of the admission.

g. Photographs, Thermal Paper and Multimedia Records

As per the WACHS Clinical Image Photography and Videography Policy, clinical images taken of WACHS patients constitute a part of the patient's health record. Regardless of how or where they are captured, clinical images must be managed in the same way as other patient health information stored within the paper-based and/or electronic format, in accordance with the requirements of the *State Records Act 2000 (WA), Health Services Act 2016, Freedom of Information Act 1992* and all relevant legislation and policy.

All clinical images captured for clinical care purposes, regardless of format or output, must include minimum identifying patient details including **surname, first name, unit medical record number (UMRN)** and **date of birth.** Staff should be mindful that where minimum identification details are not recorded on a clinical image, physical characteristics captured within the image itself (e.g. unique tattoos or birthmarks) may still inadvertently identify the patient.

All clinical images constitute a part of the patient's health record and must be filed accordingly within the local facility health record (hardcopy) or stored, where appropriate, in the WACHS Medical Image Manager (MIM) database (electronic), where available.

Clinical images output to hard-copy format and for filing within the patient's health record, must be attached to a photography backing sheet and appropriately labelled with minimum identification details for filing within the Investigation section of the patient's health record. Video output to CD or DVD must be placed in a multimedia envelope, labelled with minimum identification details and filed in the investigation section of the patient's health record.

Any record produced on thermal paper (i.e. Echocardiogram, photographs, bladder scan results etc.) is required to be reproduced on non-thermal paper to ensure the preservation of the ink. Ink printed on thermal paper degrades over time and as such, ever effort must be made to preserve the record. As such, where reports and/or records are printed on thermal paper, staff are required to take a replication (photocopy) of the record and file this with the original in the patient's health record, to preserve the integrity of the record. Where the record is less than A4 size, the appropriate backing sheet should be used for filing.

2.6 Volumising Health Records

Health records that are difficult to handle due to size and weight need to be volumised, to ensure ease of use and to maintain a good condition. A record is to be no more than 35mm in thickness.

Where records extend beyond the maximum thickness, the volumising process below is to be undertaken:

1. Make up a new health record cover with all patient details ensuring all medical and patient alerts are brought across to the new record.
2. Identify the volume number on the file.
   Also document this on the original record or first volume.
   - Commencement and ending dates may also be documented.
3. Ensure the legal and alert dividers and all related documentation is brought to the new volume if in use.

When volumising a record, any and all information from a specific date is to be brought forward into the new record. This includes investigation reports, correspondence, ACAT and other health discipline records. Alerts and advance health directives are to be brought forward to the current volume.

2.7 Accessibility of Health Records

Health information must be available for use and disclosure when needed in compliance with the Policy Frameworks and the WACHS Authorisations Schedule. Health information is personal and sensitive in nature and patients have a right to expect that it will be treated in confidence by those who come in contact with it.

a. Access at the point of care

Clinical records must be available electronically or in hard copy at the point of care. WACHS sites and services must have procedures in place to enable and facilitate this access, including after hours.

b. Emergency access to records when a patient is unable to consent

In an emergency, if a patient is unable to consent to information use or disclosure, WACHS sites and services are able to request and provide access to clinical records to facilitate safe, appropriate, quality care.

c. Patient/consumer access to their health information

WACHS sites and services must ensure that patients and consumers are provided advice and have access to written/electronic material on how to access their health information including in accordance with Freedom of Information legislation and processes.

d. Sexual Assault Resource Centre (SARC) documentation

Is to remain sealed in a yellow envelop unless required by clinicians for subsequent medico-legal reporting.

2.8 Storage of Health Records

WACHS sites and services are to ensure the health record for a consumer / patient is in one central place, or be easily located or accessed when different parts of a health record are not stored together. There is to be a record of where all elements or components of the health record are at any given time.

Health records are to be situated in an appropriate environment to ensure ease of access, preservation and security of information.

a. Environmental Controls

To ensure preservation, health records are to be stored at a temperature of 23^{o}C (+/- 2^{o}) and 30-50% humidity. Storage areas are to be well lit and have sufficient space for storage and retrieval. The storage area is to be free of chemical contamination, dust, vermin and be protected from fire and flood.

b. Shelving

The preferred shelving for health record storage is open metallic shelving. Shelving comes in standard format of bays 900mm long, 420mm deep with shelves or guides situated at 300mm intervals. The highest shelf utilised is to be no higher than 2100mm.

Compactus shelving can be utilised, but is recommended for more low-usage areas due to manual handling Occupational Health and Safety issues in regards to moving the compactus.

c. Security

Secure areas are to be used to hold health records at all times. Health records require a dedicated room that has secured doors to limit access. Access to the health record storage rooms is to be such that only authorised staff are able to access. A register of keys/passes for these rooms is to be maintained to track who has access. No health records are to be stored in an open area such as a corridor.

d. Configuration of Storage Areas

Health record storage areas are to be organised according to the year of patient activity. The health records of most recent attendances are filed in primary storage. This location is to be convenient to admissions, ED and clinic areas. Health records are to be periodically culled or removed to an inactive storage area until the patient returns and the record is retrieved.

e. Terminal Digit Filing

Terminal digit filing is the preferred method to be used in all health record storage areas, except in very small facilities where alphabetical filing may be used. The UMRN/MRN is to be used as the basis for terminal digit filing.

2.9 Tracking of Health Records

Tracer cards, the Patient Administration System (PAS) or other databases are to be used to track the location of physical health records. For sites where a PAS or database are not utilised whenever a health record is removed from the primary storage area, a tracer card is to be filed in its place. The details to be recorded on a Tracer Card include:

- patient name
- date of movement (i.e. date the tracer card was created/updated)
- MRN
- destination/Location of record.

This is to ensure that health records can be found easily and quickly when required.

Where a specialised electronic tracking system (barcoding) is in place, tracer cards are not used as the physical record is tracked via the system.

If there are physical records held in multiple locations for a patient, these are to be noted in the PAS.

2.10 Transportation of Health Records

It is imperative that health record security be maintained at all times. There may be situations that arise which require health records to be transported within a health service and to external locations.

a. Internal Transportation of Records

All records leaving the primary storage area or circulating throughout a health service are to have the following in place:

- All patient identifying information hidden from view.
- An internal envelope or bag used to transport a single record.
- Multiple records are to have the top record turned face-in or have something covering the records.
- Authorised person is to take the records to their destination.

b. External Transportation of Records

Health records can only be removed from a health service grounds in accordance with specific regional procedures. Where authorised, records are:

- whenever possible, to be a certified copy of a health care record to be supplied to an external agency rather than the original record.
- to be placed in an approved transportation medium marked “Confidential” showing the appropriate address of the destination.

Health records sent off site are to be delivered by courier or authorised staff member.

Health records are **never** to be transported by a client or patient.

Health records are to be returned to the health service in a prompt manner. (Excludes records sent for off-site storage.)

A register is to be kept of all records that have left the health service grounds and is to be signed in and out by an authorised staff member.

Where an authorised government agency delegate such as police collect the original or copy of the record from site, a receipt is to be obtained (see Appendix 1).

Original health care records are never to be transported through the Australia Post system. Copies of records can be sent through Australia Post, but Registered Mail (for tracking) is to be used. Where an authorised staff member is not able to escort the record, the use of courier services is preferred.

2.11 Scanned Records

Those sites that have an authorised scanned medical record are to comply with the Australian Standard 2828.1 in terms of divider and filing of forms as outlined above.

2.12 Health Record Restoration

When paper records are damaged by insect, vermin, water or fire, there are dedicated restoration processes that can be undertaken. Regions are to have their own Disaster Management Plans with regard to health records. The State Records Office is the first port of call in the event of a disaster to provide expert advice. The following are possible ways of restoring information damaged by fire, flood or vermin.

a. Fire Damage
Where paper records are damaged by smoke, soot, use of extinguishers and flame there may only be a small amount of information left. When restoring fire-damaged paper, there is a need to determine what is recoverable. Photocopying documents where some information is still readable may be required. Each record is to be meticulously logged with patient name, MRN and box number when put into boxes or crates and moved to another location.

b. Water Damage
Health records are to be immediately removed from the wet environment to a clean, dry room where the temperature and humidity are as low as possible to prevent mould. Records are to be frozen until vacuum drying is possible. Wet and frozen records are to be stored in crates on wooden pallets to facilitate moving. Photographs are to be copied and not frozen as the image will disappear. Where there is minimal damage by flame and water, air-drying can be used to restore the paper.

c. Insect or Vermin Damage
Where physical damage has occurred to paper records or cleansing of health records is required, care is to be taken to preserve as much information as possible. Immediate appropriate fumigation is to be undertaken. Where records are damaged beyond further use, they are to be recorded within a register prior to destruction of remains. A record entry is to be made of the date and preservation undertaken and by whom.

2.13 Health Records Retention and Disposal

The disposal of health records is governed by the Information Management Policy Framework - Patient Information Retention and Disposal Schedule.

2.14 Health Records Management Training

All WACHS staff are required to undertake training in recordkeeping as part of their orientation and ongoing mandatory learning requirements. Additionally those staff employed within the health information service or access health records shall receive regionally relevant training pertinent to their site or service.

3. Definitions

Chronological order	Order of filing whereby the older document is filed on top and the most recent is filed at the back of the section. This should read like a book from the beginning to the end. For example, from admission date to discharge date.
Cull	Removal of health records from the current filing system (primary storage) to secondary storage or another long term storage site.

Health Record	A health record is the compilation of information for a patient's health history, past and present, organised in such a manner that critical information concerning a patient is immediately accessible.
MR number	Unique Medical Record form identifier used on paper forms. Used in conjunction with the form title to identify a form and provide an order of filing for staff. Used also as a quick index to locate a form in the health record.
MRN	Created through the HCARe Patient Administration System (PAS) and is a patient's identification number within that respective database. The Unit Medical Record Number (UMRN) is the patient's unique identification number used in The Open Patient Administration System (TOPAS) and WebPAS applications where it is known as Unit Record (U/R).
Offsite storage	Process whereby health records are kept in a dedicated and authorised repository location outside the health service. This includes but is not limited to companies such as ZircoDATA, Compu-Stor and local companies.
Patient Administration System (PAS)	Electronic systems to support patient, area management and reporting needs in the hospital. Used to record patient demographic and episode details for identification and data linkage. Current systems that exist are The Open Patient Administration System (TOPAS), WebPAS and HCARe Client Management System (CMS).
Primary storage	Area where the health records of current patients are stored. Records are generally those of patients who have attended the facility or had a service within the last three (3) to six (6) years. The timeframe is set by each site and relates to the amount of storage available.
Reverse chronological order	Order of filing whereby the most recent information is filed on top and the older documents by descending dates are filed beneath. For example, a service provided in April would sit on top a service provided in March of the same year.
Secondary storage	The location of non-active health records on site.
Terminal digit filing	Is the filing methodology in which the record number is broken into three sections utilising the last two digits to determine the shelf location the middle digits for the section and then the first digits for the file sequence.
Tracer card	A card that records information about a health record to track its location throughout a health service facility or external location.

Unit medical record number (UMRN)	Unique number used for identifying each patient that is retained from first attendance to after death.
Volumising	Health records of frequent attending patients can become so thick that additional folders are needed to house one, complete health record.

4. Roles and Responsibilities

Health Information Manager
The Health Information Manager (HIM) is responsible for the systems management of health records within the region. The HIM is responsible for monitoring compliance and undertaking procedure development with regard to health record management in the region. They are also the point of contact for significant issues and concerns in relation to health records.

Operations and Site Managers
Operations and Site Managers are responsible for implementing and ensuring compliance with systems and processes established by the Health Information Manager for health records management. Operations and site managers are accountable for health records management for their respective hospitals / sites.

All Staff
All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to work.

5. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Evaluation

Monitoring of compliance with this document is to be carried out by the regional Health Information Manager or delegate, at least annually using the following means and methods:

- Audit Tools as specified in the WACHS Health Record Auditing Procedure
- Regional reviews – incorporating adhoc and opportunistic feedback
- Surveys to evaluate health record management in WACHS
- Monitoring and reporting on Freedom of Information (FOI) applications.

Evaluation and audit findings, and FOI reports will be reported to the Regional Executive and to the WACHS Executive via the WACHS Information Governance Committee.

7. Standards

National Safety and Quality Health Service Standards (Second edition 2017) – Action 1.16 – 1.18

Health records must systematically and clearly document the clinical elements of the National Safety and Quality Health Service Standards.

EQuIPNational Standards – Standard 14: Information Management - 14.1.1 and 14.4.1

8. Legislation

Freedom of Information Act 1992 and Regulations
State Records Act 2000 and Regulations
Occupational Safety and Health Act 1984 and Regulations 1996

9. References

Australian Standard 2828.1 (2012) – Paper based health records
Australian Standard 2828.2 (2012) – Interim Digitised (scanned) health record system requirements
International Standard 15489-1 and 15489-2 on Records Management
New South Wales State Records Guidelines

10. Related Policy Documents

WACHS Documentation Clinical Practice Standard
WACHS Residential Aged Care Health Record Procedure
WACHS Health Record Form Management Policy
WACHS Health Record Form Design Guideline
WACHS Health Record Auditing Procedure
WACHS Clinical Image Photography and Videography Policy

11. Related WA Health System Policies

MP 001/16 Data Stewardship and Custodianship Policy
MP 0015/16 Information Use and Disclosure Policy
MP 0067/17 Information Security Policy
OD 0559/14 Information Storage and Disposal Policy
OD 00486/14 Patient Identification Policy 2014
MP 0010/16 Patient Confidentially Policy
MP 0002/16 Patient Information Retention and Disposal Schedule

12. WA Health Policy Framework

Information and Communications Technology Policy Framework
Information Management Policy Framework
Legal Policy Framework

This document can be made available in alternative formats on request for a person with a disability

Contact:	Program Manager Health Information Management (K.Ivey)		
Directorate:	WACHS Business Services	**TRIM Record #**	ED-CO-16-45079
Version:	2.00	**Date Published:**	27 February 2019

Appendix 1

Release of Health Records

Health records relating to:

Mr / Miss / Ms / Mrs: _____
(Patient's Name)

Were received by: _____
(Court Officer / Police Officer)

On: _____
(Date)

For: _____
(Requesting Authority)

Clerk of the Court / Police Officer: _____
(Please print name)

Signature: _____

Authorised Hospital Staff Member: _____
(Health Information Manager / Nurse Manager)

Signature: _____