**Canberra Health Services**

**Policy**

**Clinical Records Management**

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| Policy Statement |

Canberra Health Services (CHS) is required by law to keep full and accurate records of care provided and to ensure that clinical records are available to clinicians at the point of care.

All staff and clinicians are responsible for ensuring that comprehensive clinical records are maintained, and that personal health information and clinical records are protected against loss, misuse and unauthorised modification, access, disclosure or destruction.

Health Information Services (HIS) is responsible for managing and maintaining the centralised CHS clinical record, including storage, scanning and retrieval.

All clinical records of CHS are managed in compliance with:

* *Territory Records Act 2002* (Sections 17,17,19, 21)
* *Health Records (Privacy and Access) Act 1997*
* *Human Rights Act 2004*

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| Purpose |

The purpose of this policy is to establish the framework for the creation and management of CHS clinical records and personal health information.

Effective clinical record keeping practices are vital for CHS to support the delivery of high- quality patient care, operational efficiency, accountability, and transparency. They are also essential for demonstrating compliance with the National Safety and Quality Health Service (NSQHS) Standards.

The *Territory Records Act 2002* requires all ACT Government agencies to have a Records Management Program which supports a systematic approach to record keeping. The Territory Records Office (TRO) Standard for Records, Information and Data Management outlines seven principles of record management for ACT Government agencies: Strategy, Capability, Assess, Describe, Protect, Retain and Access.

In accordance with *Territory Records Act 2002* and the TRO Standard for Records, Information and Data Management, the CHS Records Management Program is comprised of the following documents:

* Records Management Program for Clinical Records;
* This Policy;
* The CHS Clinical Records Management Procedure;
* The Digitisation Plan for CHS Clinical Records; and
* The Records Disposal Schedule for CHS Clinical Records

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| Scope |

This policy applies to:

* Clinical records only – corporate records are out of scope;
* All clinical records and personal health information, in any format (hard copy or electronic), created and stored by any CHS facility; and
* All CHS staff and external agencies working on behalf of CHS, including, but not limited to, students, contractors and volunteers.

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| Principles of Record Management |

The TRO Standard for Records, Information and Data Management outlines seven principles of record management for ACT Government agencies. CHS complies with the principles of the TRO standard in the following ways:

**Principle 1: Strategy - Strategic Record Management and Governance**

HIS is responsible for the management, digitisation and storage of the centralised CHS clinical record, in accordance with the approved Records Management Program for Clinical Records.

The Clinical Records Management Program and Policy supports a centralised strategy for the management of clinical records. CHS is progressing towards a single, integrated clinical record, accessible on-line, by all relevant members of the treating team, under a single unique patient identifier. Currently this is achieved by:

1. Digitising paper clinical record forms into the scanned clinical record solution,  
   Clinical Patient Folder (CPF).
2. Allowing staff to enter clinical content directly into CPF via eForms.
3. Allowing staff to scan and email PDF documents to HIS for uploading into the CPF.
4. Importing electronic documents from specialty Clinical Information Systems (CIS) into the CPF.

The scheduled implementation of the Digital Health Record (DHR) in November 2022 will replace over 30 specialised systems and will be a major step towards achieving a fully centralised, single electronic clinical record. The DHR will interface with the CPF, providing the treating team with seamless access to the patient’s full CHS clinical record with scanned images dating back to 1994.

Where supplementary specialised CIS are in use these should interface with the centralised CHS clinical record system. The storage of clinical record documents in the Q drives of CHS staff or on personal drives is not permitted. If centralised storage or digitisation of some sections of the hard copy record is not feasible due to clinical or resourcing constraints, these records may be managed as decentralised hard copy records, under approval by the Chief Executive Officer (CEO), and their existence and location should be tracked accordingly in the Patient Administration System (ACTPAS).

**Principle 2: Capability – Assessment and Maturity Development**

HIS will be sufficiently resourced to sustain effective and efficient management of the centralised CHS clinical record. This includes financial, human and physical resources. Performance against record management and clinical coding Key Performance Indicators (KPIs) will be regularly monitored and reviewed as necessary to support improved performance and changing business requirements. Internal audits of record management activities including staff capability and skill levels will be routinely conducted.

**Principle 3: Assess - Capturing and Managing Full and Accurate Records**

A clinical record must be created and maintained for every patient accessing a CHS service. Clinical records created or generated at any CHS facility are Territory records and as such, are the property of the ACT Government. All CHS staff and contractors, including clinicians, are responsible for recording or documenting evidence of service delivery for every patient attendance/event in the clinical record. The CHS Clinical Records Management Procedure provides detailed guidance to staff on the creation and management of CHS records. HIS routinely monitors record creation and conducts audits on documentation and record content to support full and accurate records.

**Principle 4: Describe – Control Records and Metadata Management**

All CHS patients should be registered in the Patient Administration System (ACTPAS or DHR). Patient registration generates the allocation of a unique numerical identifier for each patient which is used to reference all clinical records for that patient, across different systems and locations. All clinical systems should capture consistent structured metadata elements around patient identification and clinical record management according to appropriate data definitions. The collection and use of personal health information will be in strict accordance with legislation. See Principle 5 below for further information about appropriate access to patient records and clinical data. Staff should use approved forms endorsed by the Clinical Forms Review Panel to capture and record personal health information in CHS clinical records.

**Principle 5: Protect - Security**

The security of personal health information captured and used by CHS is the responsibility of all staff. CHS staff must ensure that clinical records are stored under adequate security to prevent loss, unforeseeable damage, unauthorised access or modification and inappropriate disclosure. This includes the physical security of hard copy clinical records and the security of electronic information through password and login protection. Refer to the Acceptable Use of ICT Resources Policy for additional information.

Clinical Records can only be removed from CHS premises with appropriate authority. CHS staff are granted access to clinical records and personal health information to deliver patient care and/or to perform a specific role. All access to electronic clinical information systems is tracked, logged and closely monitored.

CHS is required to maintain the confidentiality and privacy of patient information collected and managed by CHS and will conduct regular audits to ensure that access to health records is authorised, appropriate and meets legislative requirements. Any suspected breaches will be investigated and if proven, may be considered misconduct and may be subject to disciplinary action.

**Principle 6: Retain – Records Disposal Arrangements**

As Territory records and CHS clinical records must be retained and managed in accordance with legislative guidelines and approved Records Disposal Schedules. All active hard copy clinical records will be converted to digital storage, on discharge or as soon as practicable after the attendance/encounter, as per the CHS Digitisation Plan.

The digitisation of active Canberra Hospital inpatient clinical records commenced in 1994 and has been expanded over the years to cover all CHS services. Three months after scanning, when verification and quality assurance procedures have been completed, the paper version of the record is destroyed, in accordance with the Territory Records Office - Records Disposal Schedule for Source Records. The scanned version stored electronically within the CPF is recognised as the official CHS clinical record. The destruction of any other hard copy or inactive clinical records requires HIS and TRO approval prior to destruction, regardless of the age of the records.

**Principle 7: Access**

CHS clinical records must be retained as evidence of service delivery and be available in accordance with legislation to support open disclosure and transparency. The *Health Records (Privacy and Access) Act 1997*, gives patients the right to request access to their health record (fees apply). CHS patients can do this by completing a Record Access Request Form (available from HIS).

This legislation also limits the sharing of personal health information to members of the treating team, health service providers involved in the care of the patient (including the patient’s GP), the referring doctor and other authorised persons, including those needed to access the records for funding purposes or quality management/improvement.

All health professionals involved in patient care are responsible for obtaining access to relevant clinical systems as necessary for the provision of patient care. CHS must maintain clinical records and personal health information in such a way as to ensure that the records remain searchable, retrievable and accessible into the future for as long as necessary, in accordance with retention periods stipulated in the Records Disposal Schedule. This includes ensuring that record and information accessibility is protected and maintained through system upgrades and data migration strategies when technological advances are implemented.

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| Roles & Responsibilities |

**All CHS Staff**

All staff are responsible for adhering to this policy regarding the creation and management of clinical records and the appropriate collection and use of personal health information in relation to the work they perform on behalf of CHS.

This includes:

* Keeping and maintaining full and accurate clinical records;
* Ensuring that patient privacy and confidentiality are maintained at all times by observing relevant policies and adhering to the requirements of the *Public Sector Management Act 1994* and the *Health Records (Privacy and Access) Act 1997;*
* Only accessing clinical information systems and individual clinical records when necessary for performing the duties of their role;
* Ensuring that clinical records are managed securely and appropriately and are not destroyed without proper authorisation from HIS and/or the TRO; and
* Completing all necessary clinical system and privacy training.

Additional responsibilities also exist for certain categories of staff as outlined below.

### **Chief Executive Officer (CEO)**

The CEO is responsible for:

* authorising this policy;
* promoting compliance with this policy;
* supporting and fostering a culture of good recordkeeping in the organisation; and
* ensuring the Clinical Record Management Program is adequately resourced.

### **Chief Information Officer (CIO)**

The CIO is responsible for:

* ensuring that clinical systems capturing and storing personal health information are adequately maintained, supported, integrated and upgraded to ensure that information is managed securely and protected from loss due to system incompatibility.

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### **Health Information Services (HIS)**

HIS is responsible for managing the centralised CHS clinical record and implementing and monitoring clinical record keeping, legislative and best practice requirements across CHS.

This includes:

* the identification of clinical record management requirements;
* the provision of high-level advice around clinical record keeping issues to senior management;
* timely digitisation of all active clinical records to ensure that the records are available to the treating team for patient care;
* ensuring that effective record keeping strategies, policies, procedures, processes and records disposal schedules are developed, maintained, reviewed and communicated in compliance with legislative and best practice/standards; and
* ensuring that systems capturing and storing clinical records and personal health information are adequately maintained, managed and upgraded to ensure that record integrity is preserved and protected from loss due to system incompatibility.

### **Managers and Supervisors**

Managers are responsible for ensuring that all clinical records generated by their area in both paper or electronic form are captured, maintained and appropriately stored in accordance with this policy and the CHS Clinical Records Management Procedure.

Managers and supervisors are also responsible for ensuring that staff, consultants and/or contractors are made aware of their clinical record management obligations and the information resources and training available for privacy and record management.

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| Evaluation |

**Outcome**

* The management of CHS clinical records is compliant with relevant legislation and standards; and
* Clinical records are available to clinicians at the point of care to support high quality care.

**Measures**

* Annual clinical record documentation reviews are conducted to determine compliance with policy, documentation and record-keeping requirements; and
* Annual completion of TRO Records Management Maturity Assessments.

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| Related Policies, Procedures, Guidelines and Legislation |

## Policies and Procedures

* Clinical Record Management Procedure
* Acceptable Use of ICT Resources Policy

**Codes**

* ACT Government Code of Conduct
* ACT Government Code of Ethics

Standards

* Australian Standard (AS2828.1) Health records paper-based health records
* Australian Standard (AS2828.2) Health records digitized (scanned) health records
* Territory Records Office Standard for Records, Information and Data
* Australian Commission on Safety and Quality in Health Care (the Commission) National Safety and Quality Health Service (NSQHS) Standard 1 – Clinical Governance

Legislation

* *Coroners Act 1997*
* *Crimes Act 1900*
* *Electronic Transactions Act 2001*
* *Evidence Act 1971*
* *Financial Management Act 1996*
* *Freedom of Information (FOI) Act 1989*
* *Health Records (Privacy and Access) Act 1997*
* *Human Rights Act 2004*
* *Information Privacy Act 2014*
* *Mental Health Act 2015*
* *Ombudsman Act 1989*
* *Privacy Act* 1988 *(Commonwealth)*
* *Public Sector Management Act 1994*
* *Territory Records Act 2002*
* *Work Health and Safety Act 2011*
* *Working with Vulnerable People (Background Checking) Act 2011*

**Other**

* Australian Charter of Health Care Rights
* CHS Clinical Record Digitisation Plan
* CHS Records Disposal Schedule for Clinical Records
* Guide to Health Privacy (2019) https://www.oaic.gov.au/privacy/guidance-and-advice/guide-to-health-privacy

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| Definition of Terms (only use this section if needed, delete if not needed) |

**Clinical Record**

Also referred to as “Health Record”

**Health Record1**

Any record, or any part of a record:

1. held by a health service provider and containing personal information; or
2. containing personal health information.

**Health Service1**

1. any activity that is intended or claimed (expressly or by implication) by the person providing it, to assess, record, improve or maintain the physical, mental or emotional health of a consumer or to diagnose or treat an illness or disability of a consumer; or
2. a disability, palliative care or aged care service that involves the making or keeping of personal health information;
3. but does not include any service declared by regulation to be an exempt service.

**Health Service Provider1**

An entity that provides a health service.

**Patient**   
In this document the term ‘patient’ refers to patients, consumers and clients under the care of CHS.

**Point of Care2**

The time and location of an interaction between a patient and a clinician for the purpose of delivering care.

**Record1**

A record in documentary or electronic form that consists of or includes personal health information in relation to a consumer (other than research material that does not disclose the identity of the consumer), and includes:

1. a photograph or other pictorial or digital representation of any part of the consumer;
2. test results, medical imaging materials and reports, and clinical notes, relating to the consumer;
3. any part of a record; and
4. a copy of a record or any part of a record.

**Record keeping**

The making and maintaining of complete, accurate and reliable evidence of business transactions in the form of recorded information.

**Records Management**

The organisational function of managing records to meet operational business needs, accountability requirements and community expectations. “Records Management” covers but is not limited to the creation, keeping, protecting, preservation, storage and disposal of, and access to records of the agency.

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| References |

**1** *Health Records (Privacy and Access) Act 1997*

[*http://www.legislation.act.gov.au/a/1997-125/current/pdf/1997-125.pdf*](http://www.legislation.act.gov.au/a/1997-125/current/pdf/1997-125.pdf)

**2**Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards guide for hospitals. Sydney: ACSQHC; 2017

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| Search Terms |

Clinical record, CPF, digitisation, health record, medical record, patient record, records disposal, RDS, record management, scanned record, DHR

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*Policy Team ONLY to complete the following:*

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| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval* |
| *24 June 2022* | *Complete Review* | *Paul Ogden, CFO* | *CHS Policy Committee* |
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*This document supersedes the following:*

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| *Document Number* | *Document Name* |
| *CHHS18/084* | *Clinical Records Management Policy* |
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