MEDICAL RECORDS (C7.1A)

OVERVIEW

Our practice has a system to manage our patient health information. Our practice maintains a patient health record system that suits the needs of our practice, and the administration of this system is such that ensures each patient has a dedicated health record that is complete, maintained, and facilitates the provision of safe and high quality healthcare.

CONTENT OF MEDICAL RECORDS

Accurate medical records are an essential component of patient care. Their main purpose is to store clinical data for use by doctors in patient management and as a means of communication with other doctors and health care professionals.

The record should be such that a doctor other than the patient's usual doctor can confidently provide care to the patient.

The record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times and to ensure that this information is only available to authorised members of staff. See Privacy Policy for more information.

The record should not contain any prejudicial or irrelevant statements. See Equal Opportunity Policy for more information.

1. Each patient has an individual file, either on hard copy or electronic record or a combination of both which contains all the patient's clinical information, including
    - progress notes
    - health summary sheet (if a regular patient),
    - medication list
    - record of telephone calls of a clinical nature
    - documentation of referrals
    - response to referrals,
    - notation of home, after hours and hospital visits,
    - notation of preventative care,
    - screening for early detection
    - reports of pathology and X-ray results
2. Each doctor/patient encounter, should be documented at the time or as soon as possible after the consultation and include
    - the date of consultation
    - the reason for the consultation
    - the problem managed
    - the management plan, including the date of planned review; and
    - prescribed medications, including strength, directions for use and

- number of repeat scripts
- Complementary or over-the-counter medicines used by the patient (to minimise drug interactions)
- any preventative care undertaken
- documentation of any referral to other health care providers
- briefly note information given to the patient
- where appropriate documentation that implicit consent was given
- where appropriate documentation that explicit consent was given
- identification of who conducted the consultation

3. Records of patients who attend on a regular basis should contain a Health Summary, which includes
   - a pertinent social and family history
   - active problems
   - past problems
   - allergies and sensitivities active
   - medication, immunisation and management
   - risk factors
4. A patient who fails to attend (DNA) or who did not wait (DNW) the doctor that the patient was booked with has to denote the above in the Best Practice patient's notes.
5. Corrections in the electronic record should be recorded by referring to the date of the original entry and the associated amendment.
6. Important or significant telephone or electronic communication between practice and patient is recorded in the patient health records. All emails are archived and saved on the backup.
7. Where a child has parents with different addresses and Medicare numbers etc. (dual family), the clinical record and administrative record are contained under the primary carer's name. If the other carer attends the consultation with the child, the details on scripts, Medicare forms etc. are manually changed.

HEALTH SUMMARIES

A current up to date patient health summary assists in providing ongoing care, both within the practice and when referring to other health care providers.

Health summaries are developed progressively and need to be accessible during consultations for doctors, nurses and other health care providers who all contribute to keeping them up to date. Care is taken to enter data using accepted coding or drop down selections rather than free text to assist with practice audits and chronic disease registers or CQI activities that require identifying patients with risk factors or particular chronic diseases.

90% or more health records of patients who have attended our practice on a regular basis (3 or more times in the last two years), have their known allergies recorded in the health summary and

75% or more or more have a comprehensive health summary that has been updated to reflect recent important events.

It is recommended that GPs clarify a patient's current medicines list and known allergies at every patient contact and patients on multiple medicines should be provided with the most recent list of their medicines.

A Health Summary should contain documentation of:

- known drug allergies and sensitivities including any adverse medicines events
- accurate and current medicines list (include prescription, non prescription and complementary products if known)
- current health problems/ diagnoses
- relevant past health history including immunisations and positive family history of disease
- any health risk factors (eg smoking, nutrition, alcohol, and physical activity)
- relevant social history including cultural background

STORAGE AND ADMINISTRATION OF THE RECORDS SYSTEM

1. All accounts, medical records, other files containing patient information, prescription pads, letterhead and other official documents must be stored in areas inaccessible to the public.
2. Authorised staff must have ready access to the medical records.
3. Breach of patient confidentially is a serious offence and staff are advised that the following actions constitute a breach of confidentiality, which may result in disciplinary action being taken against the person responsible:
    - discussing patients' conditions with staff colleagues, unless necessary for patient care, family and friends
    - leaving patients' files where they may be viewed by non-staff.
    - discussing patient matters within hearing of others
4. Staff are to be particularly vigilant with telephone calls which may be overheard by other patients in the waiting room and files kept at the front desk for any reason. See also Privacy Policy.