SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Hybrid Health Care Record Procedure
TYPE OF DOCUMENT	Procedure
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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
AUTHOR	SESLHD Health Records and Medicolegal Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Co-Chairs, SESLHD Health Records and Medicolegal Committee
FUNCTIONAL GROUP(S)	Records Management – Health
KEY TERMS	eMR, Health care record, medical record, clinical record, electronic medical record, paper medical record, electronic information
SUMMARY	This document outlines processes about the storage of electronic and paper based information in the health care record.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

1. PROCEDURE STATEMENT

This document has been developed to support the ongoing integration of electronic and paper based health care records. Clinical information systems that generate electronic health records include the core system Cerner electronic Medical Record (eMR), ARIA, MOSAIQ, ERIC, Palliative Care Information System and Titanium; and other diagnostic and specialised clinical information systems. It provides staff with a framework for identifying and retrieving both paper based and electronic health records to ensure effective and timely access to accurate and complete health information. This procedure applies to all heath care settings and sites within South Eastern Sydney Local Health District (SESLHD).

2. BACKGROUND

Traditionally, clinicians within SESLHD documented health information on paper that was stored within a physical central health record. SESLHD continues to develop and implement clinical information systems to support patient care. Increasingly, there are clinical services where clinical documentation is either produced and/or stored electronically. Consequently, SESLHD has a hybrid health record and requires a procedure to define and manage the changing state of the hybrid health care record.

DEFINITIONS

- **Electronic health record –** Electronic health record applications/systems such as Cerner eMR, eMaternity, eRIC, MOSAIQ, ARIA, or any other similar clinical information system.

- **Health record** – A documented account, whether in hard copy or electronic form, of a patient's health, illness and treatment during each visit or stay a health service (note: holds the same meaning as "Health care record", "Medical record", "Clinical record", "Clinical notes", "Patient record", "patient notes", "patient file", and so on

- **Hybrid health care record** -documentation of an individual's health information that is stored in multiple formats, both electronic and paper-based and in multiple physical locations and/or clinical information systems.

- **Transitional health record** - a health record with both computer readable and fully computable components. This type of health record is often representative of a system in transition from digitized format to a fully electronic health record.

- "**Source of Truth**" - in the event that a section of clinical documentation is available in both electronic and paper-based format. Refer to Appendix A - Components of the Hybrid Health Care Record.

3. RESPONSIBILITIES

3.1. Medical, Nursing, Allied Health and other clinical staff will:

- Adhere to all procedures relating to Hybrid Health Care Records listed below.
- Be aware of the accepted Source of Truth for the sections of the record for which they are responsible.

3.2. Health Record / Clinical Information Staff / Managers will:

- Adhere to all procedures relating to Hybrid Health Care Records listed below.
- Audit compliance of Hybrid Record management principles on a regular basis.

3.3. Ward Clerks and Administrative Staff will:

- Adhere to all procedures relating to Hybrid Health Care Records listed below.

3.4. Medical Administration / Clinical Practice Improvement staff will:

- Adhere to all Procedures relating to Hybrid Health Care Records listed below.
- Audit compliance of Hybrid Record management principles on a regular basis.

4. PROCEDURE

4.1. Defining the Source of Truth

- The table in Appendix A defines the Source of Truth in the event that clinical documentation is available in both electronic and paper-based formats.
- When patient information is solely available in electronic format, the Source of Truth is to be interpreted from the electronic health record and clinical information system which holds that information.
- When patient information is solely available in paper format, the Source of Truth is to be interpreted from the paper records alone.
- When hard copy information has been digitized (scanned), the Source of Truth is to be interpreted from the scanned image.
- When identical information is available in paper and electronic format (e.g. Operation Report) and there is an inconsistency between the sources of information, the Source of Truth is to be defined as per the table in Appendix A.
- In the event an electronic Source of Truth document is printed and a hand written clinical notation is added to this document, both the electronic document and the hand written notation must be integrated as the Source of Truth.

4.2. Communication of the Source of Truth

- A reference to any existing electronic information must be flagged on the cover of a patient's paper based health care record in line with Australian Standard – Paper based Health Records 2828.1 A reference to electronic information allows relevant staff to identify that there is more than one (1) source of information and the Source of Truth for specific information may vary.

4.3. Updates and Corrections

- Whenever possible, amendments to patient information must be completed in both the paper and electronic record management systems (if archived in both formats) for consistency of data between systems.

- Updates and corrections should be undertaken in the source electronic health record or clinical information system.

4.4. Printing

- Printing of information stored within electronic health records should be avoided whenever possible unless the information is required for ongoing patient care, medico-legal purposes or there is a strict requirement to file the particular information in the paper health care record.
- Any printout of an electronic Source of Truth document should be destroyed once the document is no longer required, unless there is a hand written clinical notation added to this document, then must be retained.
- Information directly entered into clinical information systems does not require a printed signed copy as the user and date/time is recorded automatically.
- Medical Record Request (MRR) is the Cerner eMR functionality that is utilised for printing from Cerner eMR. Report Request is utilised by services that are required to print for Release Of Information (ROI) purposes and requires access to a particular citrix server. Both forms of printing are restricted to authorised staff only.
- Publication – at times it is necessary for partial or complete "publishing" (i.e. printing) of the patient's health care record. By utilising the above functionality, all pages should include the SESLHD logo and patient identifiers within the page header and a confidentiality disclaimer as a standard footer.
- All pages printed will include a print date/time stamp and identifier for the staff member printing the document.
- The section order of printing should be based on the event set hierarchy.
- Similar principles apply to printing from other Electronic Health Records

4.5. Filing

- Where the Source of Truth is a paper document, it should be filed in the patient record as soon as possible after the presentation / visit or (if approved) scanned into the appropriate clinical information system
- If a paper version of a document exists and its Source of Truth is electronic, it should be destroyed and not filed, unless there is a hand written clinical notation added to this document.
- All paper-based information must be filed within the health care record of the patient. This will include electronic Source of Truth documents which have an additional hand written notation added to the printout. This is particularly relevant for forms with signatures or written consent as these are the primary document/the "Source of Truth".
- Detailed guidance in relation to loose leaf filing is contained in the table below:

CATEGORY OF LOOSE SHEETS	INCLUDES, BUT IS NOT LIMITED TO:	RETENTION
Internal diagnostic and investigative reports	○ SEALS reports ○ Medical Imaging reports ○ EEG ○ Urology	Retain only if: ○ Not accessible electronically in an electronic Health record ***and/or***

	○ Audiology ○ Cardiac reports ○ Ophthalmology ○ Orthoptics	○ Available electronically, but with handwritten notations ***Otherwise destroy*** (includes those with signatures only)
External diagnostic reports	○ External Medical Imaging reports ○ External pathology reports ○ External correspondence	Retain only if: ○ Pertains to a current / recent patient and have not been scanned into the eMR or a patient with an upcoming episode of care Destroy if: ○ No evidence of recent or planned attendance (after investigation) ***and/or*** ○ No facility MRN assigned
Fax confirmations / internal administrative paperwork	○ Fax confirmations ○ Paper-based requests for information	Retain if: ○ Request is more than 3 months after discharge of the patient ○ Request includes written patient consent Destroy if: ○ Printed / sent electronically from the eMR and audit trail is maintained ***or*** ○ Electronic register of the request and the information sent is maintained

5. DOCUMENTATION

Not required

6. AUDIT

As per:
NSW Health PD2012_069 Health Care Records – Documentation and Management
SESLHD Documentation in Health Care Record Procedure (SESLHDPR336)
District Audit Tool - Documentation in Health Care Records
Medical Administration / Clinical Practice Improvement Units and / or Health Information Managers will audit compliance of Hybrid Records Management on a regular basis with particular focus on documentation, amendments to hybrid record information and compliance in printing practices of electronic patient information.

7. REFERENCES

NSW Ministry of Health Policy Directive PD2012 069 - Health Care Records – Documentation and Management
SESLHDPR/336 - SESLHD Documentation in Health Care Record Procedure
District Audit Tool - Documentation in Health Care Records
SESLHD Single Document Capture in eMR: Scanning and Importing (SESLHDPR/513)
AS 2828.1-2012 Health records - Paper-based health records
AS 2828.2(Int)-2012 Health records - Digitized (scanned) health record system requirements
National Safety and Quality Health Service Standards

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
22/04/2009	0.1	Ivan Koprivic, UPI Systems Officer – SESIH (Endorsed by SESIH HIM Committee). Approved by Area Clinical Council 22/04/2009
01/05/2009	0.2	D. Martin – inclusion of definition – Source of Truth
04/09/2012	1.0	D. Martin on behalf of the SESLHD Health Information Managers
26/03/2013	1.1	SESLHD Health Records and Medico-Legal Working Group
04/09/2013	1.1	Re-formatted by District Policy Officer.
11/5/16	2.0	SESLHD Health Records and Medicolegal Working Group
June 2016	2.1	Updates endorsed by Executive Sponsor
September 2020	3	Executive Sponsor updated from Chair, SESLHD Health Records Steering Committee to Director Clinical Governance and Medical Services. Risk review date amended to be in line with a Low Risk rating
May 2021	4	Major Review Commenced. SESLHD Health Records and Medicolegal Committee – review and endorsement with revision to sponsor, national standards and appendix
June 2021	4	Draft for comment period.
July 2021	4	Final version approved by Executive Sponsor. To be tabled at Clinical and Quality Council for approval.
August 2021	4	Approved at August Clinical and Quality Council.

APPENDIX A

SECTION OF HEALTH CARE RECORD	INCLUSIONS (not limited to)	SOURCE OF TRUTH (FORMAT)	
		PAPER	ELECTRONIC
Front Sheets	Front Sheet (Printed from iPM PAS)	✓	
	Client Registration Form	✓	
	Request for Care Type Change	✓	
Discharge Forms	Discharge Referral/Summary		eMR
	Medical/Attendance Certificate	✓	eMR
	Transfer Forms, Discharge Checklists etc.	✓	
	Death related discharge forms	✓	
Consent/Legal Forms	All forms requiring a physical signature	✓	
Advance Care Documents	Directives, Plans, discussions and other ACD documentation		eMR
Mental Health Forms	Tribunal, Consent and other legal	✓	
	Progress notes, mental health assessments and care plans		eMR
Pre-Admission	RFA documents and pre-admission checklists and questionnaires	✓	
Emergency Admission	ED clinical documentation		eMR
	External documentation including referrals, ambulance report, diagnostics	✓	
ICU (Intensive Care Unit)	Progress notes Medications Observations		ERIC
Progress Notes	Progress notes		eMR
	Drawing sheet	✓	
Nursing Assessment and Care Plans	Management plans, assessment charts	✓	
	Clinical pathways	✓	
	Labels / alerts		eMR
	SNAP Data forms	✓	
	Risk tools ie. ADRA, VTE Assessment, PACE/SEPSIS, OMS, Pressure area, IDC (some differences between sites in terms of implementation)		eMR
Allied Health	Labels and progress notes		eMR
Requests/Referrals	SEALS, Medical imaging		eMR
	Community Nursing Referral	✓	
Cardiac Forms	Chest Pain Pathway	✓	

Operation Notes	Operation/procedure reports, clinical procedure checklists 1 & 2		eMR
	Anaesthetics, pre & post checklists, count and tracking sheets	✓	
Diagnostic Results	Machine print outs ECGS and other diagnostics available in eMR	✓	eMR
	Mounting sheet	✓	
Observation Charts	Standard observation charts, neurovascular observation charts, bowel charts		eMR
	Other observation charts	✓	
Fluid Balance Charts	Fluid balance summaries and charts	✓	
Medications	Regular and paediatric medication charts	✓ Community and Outpatients	eMR / eMEDS
	Insulin, analgesia, blood product charts	✓	
Maternity	Assessments Progress Notes		eMaternity
Cancer Services	Assessments Outpatient letters Referrals Treatment Medications External diagnostics		MOSAIQ/ARIA
Dental Services	Treatments Progress notes		Titanium
External Correspondence	Referrals Letters Results Subpoenas Chapter 16A	✓	