SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Storage and retention of standardised testing protocols
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/686
DATE OF PUBLICATION	February 2021
RISK RATING	Low
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standard: Standard NS1
REVIEW DATE	February 2026
FORMER REFERENCE(S)	N/A
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
AUTHOR	SESLHD Health Records and Medico-Legal Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Co-Chairs, Health Records and Medico-Legal Committee
FUNCTIONAL GROUP(S)	Allied Health Records Management – Health
KEY TERMS	Release of Information, Medico-Legal, Privacy, Confidentiality, Requests for Information, Medical Records, Health Information, Documentation, Psychology, Speech Pathology
SUMMARY	Provide guidance for best practice when storing patient standardised testing protocols and materials separate from the central health record (paper/eMR).

Storage and retention of standardised testing protocols

SESLHDPR/686

1. POLICY STATEMENT

Provide guidance on storing patient standardised testing protocols separate from the central health record (paper/eMR).

2. DEFINITIONS

***Central Medical Record*:** the approved single health record for a site or facility that is managed directly by site HIMs/MRMs

Client/patient: any person to whom a health care provider owes a duty of care in respect of provision of health care services

Confidentiality*:* the restriction of access to information, and the control of the use and release of personal information, in order to protect patient privacy

Electronic Health Record: includes all electronic health record systems such as eMR Cerner, eMaternity, eRIC, MOSAIQ, ARIA or any other electronic medical record application/system.

Health Information:

(a) personal information that is information or an opinion about:

(i) the physical or mental health or a disability (at any time) of an individual, or

(ii) an individual's express wishes about the future provision of health services to him or her, or

(iii) a health service provided, or to be provided, to an individual, or

(b) other personal information collected to provide, or in providing, a health service, or

(c) other personal information about an individual collected in connection with the donation, or intended donation, of an individual's body parts, organs or body substances, or

(d) other personal information that is genetic information about an individual arising from a health service provided to the individual in a form that is or could be predictive of the health (at any time) of the individual or of any sibling, relative or descendant of the individual, or

(e) healthcare identifiers, but does not include health information, or a class of health information or health information contained in a class of documents, that is prescribed as exempt health information for the purposes of the HRIP Act generally or for the purposes of specified provisions of the HRIP Act

Health Record: a documented account, whether in hard copy or electronic form, of a client/patient's health, illness, and treatment during each visit or stay at a public health organisation

Note: holds the same meaning as “health care record”, “medical record”, “clinical record”, “clinical notes”, “patient record”, “patient notes”, “patient file”, etc.

HIM: Health Information Manager

HRIP Act (HRIPA): Health Records and Information Privacy Act 2002 (NSW)

Misuse of information: a staff member has knowingly and intentionally accessed, used and/ or disclosed information held by the health service for a purpose outside of, and unrelated to, their work duties. Such breaches of privacy may possibly constitute corrupt conduct.

MRM: Medical Record Manager

Satellite record: A record separate from the central medical record, paper or electronic that is temporarily or permanently stored with a specific clinician or within a specific department/unit and managed by that unit.
Note: holds same meaning as “sub-file”

Testing Protocol: Uniform, standardized resource/test administered to patients/clients by trained professionals which is often subject to copyright conditions

Testing Report: Report written by a trained professional post evaluation describing the result of the test protocol/s used administered to a patient/client.

3. RESPONSIBILITIES

3.1 All Employees will:

- Adhere to all aspects of this procedure
- Forward any requests for health information not for ongoing care purposes to the appropriate Health Information Unit for processing.

3.2 Health Information/Medical Record Managers will:

- Provide ongoing support for staff members with queries or issues.

3.3 Satellite record areas will:

- Promptly respond to any requests from the Health Information Unit for satellite record documentation.

4. PROCEDURE

4.1 Ownership, Responsibility and Accountability

All health records are the property of the LHD and do not belong to a specific department/service, healthcare provider, or the patient/client.

Responsibility and accountability for all satellite records is held by the individual department/service. The most senior clinician in each department/service will have overarching responsibility for ensuring the principles of this procedure are implemented and maintained.

4.2 Content of standardised testing protocol satellite record

The standardised testing protocol satellite record should only contain the stimulus, response forms/booklets, datasheets and clinical materials relevant to the interpretation of raw results.

All standardised testing protocol satellite records should include a disclaimer to the effect of:

> *This information is strictly confidential and should be interpreted only by a registered psychologist. It should not be released to the patient or any other persons unless disclosure is required by law or policy as it has the potential to cause harm through misuse and misinterpretation.*

The report that results from any standardised testing instrument, any other clinical notes, referral documents, correspondence, or documents provided by the patient or external health care facilities must be stored in the central health record or eMR.

4.3 Creation of paper or electronic standardised testing protocol satellite records

The creation of satellite records is widely discouraged however the LHD acknowledges that in unique circumstances, this may be appropriate. In this case, in order to uphold the integrity of the testing materials, minimise the risks associated with inappropriate interpretation and to meet the test manufacturer's legal requirements for use, the creation of a paper/electronic satellite record has been approved.

Each patient should have their own individual folder for testing protocols. The cover of each folder must identify the patient by name and MRN. Each document in the folder must identify the patient by name, sex, date of birth, and MRN.

Each testing protocol satellite record must be registered in Patient Document Tracking (PDT) within iPM. This ensures that information that should not be widely reviewed is secure balanced with the requirement that all health information is discoverable.

Furthermore, an entry must always be made in the central (main) progress notes of the patient to the effect that a consultation occurred, including the date, time and nature of the consultation.

A signed/verified copy of all interpretative reports must also be placed in the patient health record, either imported in to the electronic medical record or placed in the central medical record.

4.4 Registration and tracking of standardised testing protocol satellite records in iPM Patient Document Tracking

In accordance with NSW Health PD2012_069 *Health Care Records – Documentation and Management*, satellite records must be registered and locations managed within the central record tracking system to ensure the information is easily identifiable and accessible.

The record tracking system used in SESLHD is iPM Patient Document Tracking (PDT)

4.4.1 Searching for a satellite record
Search PDT to see if patient already has a registered testing protocol satellite record for the for department/service as per the *Patient Document Search QRG*

4.4.2 Creation of a new satellite record
To be used if patient does not have a testing protocol satellite record for department/service
Create a record as per the *Adding a Document Type or Volume QRG* ensuring correct entry of the following fields:
- Document type
- Storage location
- Storage service point
- Current location
- Current service point
- Comment

4.4.3 Creating a new record volume
To be used when current testing protocol volume is too large or offsite
Create a record volume as per the *Adding a Document Type or Volume QRG* ensuring correct entry of the following fields:
- Document type
- Storage location
- Storage service point
- Current location
- Current service point
- Comment

4.4.4 Moving a satellite record
To be used when a record is stored in another location (including offsite or destruction)
To move a satellite record volume follow the *Dispatching a Document Volume QRG*

4.4.5 Deleting a satellite record
Only to be used when volume created in error

Contact local Health Records Department for assistance.

4.5 Storage and security of standardised testing protocol satellite record (Paper and electronic)

All health information must be protected from unauthorised access, alteration, or loss through appropriate security measures.

Under no circumstances are records, paper or electronic, to be removed from the facility by staff.

4.5.1 Paper satellite records
Access to where the records are stored must be controlled and adhere to standards set out by the State Records Act.
Compliance must be in line with SESLHDPR/218 *Records Management – Storage and Protection* with the associated audit conducted yearly.

4.5.2 Electronic satellite records
Health information held in electronic form outside of an eMR must be stored on a secure SESLHD network drive with access restricted. Information held electronically must be accessible to more than one person within the organisation and be able to be produced on paper.

Paper records may be relocated to authorised offsite storage for archiving where required.

4.6 Release of health information stored in satellite records

Release of all health information within NSW Health must be in accordance with:

- The Health Records and Information Privacy Act 2002
- NSW Health Privacy Manual for Health Information (2015)

Staff within the department/service may release information to other appropriately credentialed health professionals for ongoing care purposes only. All other requests for health information, including from patients, must be processed by the appropriate Health Information Unit.

Satellite records must be made available to Health Information Unit staff for release when required. If a patient/client or their authorised representative has requested their health record, appropriateness regarding the method for release of standardised testing protocols should be discussed with the relevant clinician or department/service.

Note: The patient has a legal right to access, or authorise access to, their own personal health information, if there are concerns about interpretation, integrity of test materials, or harm to the patient/others, the method/timing of release may be changed – for example, review with a clinician and explanation of scoring methods.

4.7 Retention and disposal of standardised testing protocol satellite record

All health records, paper or electronic, must be retained in line with the General Disposal Authority (GDA) 17. Satellite records must be retained for the same period of time as the central medical record (paper or electronic).

Any disposal of records that have exceeded their minimum retention period must be done so with reference to SESLHDPR/220 *Records Management – Destruction Of* as well as review/guidance from the appropriate Health Information Unit/Manager and authorisation from the appropriate Executive Unit.

5. DOCUMENTATION

- SESLHD iPM Quick Reference Guides

6. AUDIT

Audit to be conducted by department once a year to ensure appropriate processes are being followed. Results to be reported to the appropriate Health Information Unit.

7. REFERENCES

- Health Records and Information Privacy Act 2002 (NSW)
- State Records Act 1998 (NSW)
- NSW State Records General Disposal Authority (GDA) 17 (2019)
- NSW Health Privacy Manual for Health Information (2015)
- NSW Health Policy Directive - PD2012_069 Health Care Records – Documentation and Management (2012)
- SESLHD Procedure – SESLHDPR/220 Records Management – Destruction Of
- SESLHD Procedure – SESLHDPR/218 Records Management – Storage and Protection

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
30/07/2020	0	Margaret Suda, A/Manager, Health Records, Health Information Unit, Prince of Wales Hospital
9/09/2020	1	Draft review and approved SESLHD Health Records & Medico Legal Committee
November 2020	1.1	Draft for comment period, minor amendment to hyperlink only
November 2020	DRAFT	Processed by Executive Services and submitted to Clinical and Quality Council.
February 2021	1	Approved by Clinical and Quality Council. Published by Executive Services.