Health Records Documentation PHC Remote Guideline

Target Audience	All Employees
Jurisdiction **Jurisdiction Exclusions**	Primary Health Care Remote CAHS; Primary Health Care Remote TEHS N/A
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Purpose

To provide Primary Health Care Remote staff with a guideline describing their responsibilities when utilising Electronic Health Records to document all relevant personal and health information of clients for each health encounter.

Guideline

1. General Information

The Electronic Health Record (EHR) is the primary health record of all Department of Health (DoH) remote Primary Health Care (PHC) clients. Authorised Users are required to utilise the EHR to document all relevant personal and health information of clients for each health encounter.

Health information should be documented by all health care providers, including visiting clinicians:

- during every consultation or immediately after the information and/or care has been provided
- when an event occurs to the client that could affect their condition
- where there is a change in the condition of the client
- where the information provided requires action by a health practitioner
- when it is necessary to inform and enable other health practitioners to care for and treat the client
- social situations that are relevant to care
- any treatment given, including changes in drug regimes or other treatments, and instructions provided about treatment or care
- dates and times of appointments including reminders given to clients, attendance / non attendance

Note: Clinicians are to obtain previous medical histories from other health facilities where appropriate to ensure a complete problem list is available via the EHR for the client.

The primary purpose of health records is to facilitate the quality and safety of client care. Clinical information recorded in the health record must therefore be systematic, accurate and relevant to ensure appropriate client care and allow for evaluating progress and health outcomes of clients.

Health records must also facilitate the continuity, integrity and accessibility of client health information and support quality review, financial reimbursement, education, research, public health and health planning functions.

Finally, health records act as a mechanism for professional accountability by providing a legal record of care. Health records may be required as documentary evidence in legal proceedings.

A consistent and systematic format for recording client information during a health care episode will assist health practitioners to meet these professional and legal requirements. Information in this guideline includes:

2. Procedure

2.1 Privacy and Confidentiality

All information in a client health record is confidential and must comply with the Information Act including the Information Privacy Principles defined in Schedule 2, the DoH Privacy Policy and with professional codes of conduct when recording client events. The NT Public Sector Code of Conduct reinforces the requirement that public sector staff adhere to the Information Act.

For further information see Privacy of Health Information Overview PHC Remote Guideline and Electronic Health Records Overview PHC Remote Guideline and Electronic Health Records User Access PHC Remote Guideline.

2.2 Client Health Record Identification

Client identification provides a positive method of linking a client to their health record, treatment and any other client related activity including filing of client clinical results. Accurate client identification is essential to ensuring information is recorded in the correct client health record.

The three key items of information used to identify a client and are used and recorded in the EHR are:

- **Name** (Family and given, and/or cultural or skin names)
- **Date of Birth**
- **Hospital Record Number** (HRN) **OR**
- **Address**, when actively verifying details with client or client representative. This may be recorded as community / outstation / homeland.

These are core identifiers and **must** be satisfied. An 'Alias' identified on the EHR may be used as an additional verifier.

PHC Remote CAHS staff also refer to the Patient Identification PHC Remote CAHS Information Sheet.

2.3 Recording Health Information

2.3.1 Accuracy and Objectivity

Documentation must be accurate and objective; that is, it must be a true account of what was stated, assessed, observed and undertaken. The health practitioner should record facts and actual events rather than impressions of the client.

Care and objectivity is important as clients have the right to seek access to their health records under the provisions of the Information Act. Any disparaging and unsubstantiated comments could become a matter reported to the Office of the Information Commissioner - NT or become the basis for litigation. See Privacy of Information Overview PHC Remote Guideline and Requests for Access to Health Information and Records PHC Remote Guideline.

2.3.2 Authenticity

All entries to health records are to be the individual health practitioner's accurate and complete statement of fact or clinical judgement.

Any information entered under a health practitioner's User Id and Password is legally attributable to that health practitioner. It is therefore imperative that health practitioners utilise their own login when recording entries on EHRs.

See 4.8 Recording Information received from non-Clinical Staff or other Third Party.

2.3.4 Timeliness

Entries regarding client care are to be made at the time of the event or as soon as possible after each event or consultation.

Clinical events will display chronologically in the client record. However, an access audit of the health record will accurately indicate the time and date that clinical information was actually entered. See 4.14 Documenting Health Care Retrospectively.

2.3.5 Intelligibility and Legibility

All information must be intelligible to other authorised users of the EHR. Comments in comments boxes or progress notes must be clear and unambiguous. Only abbreviations from the endorsed Abbreviations – Medical Terminology PHC Remote Information Sheet and Acronyms and Abbreviations List PHC Remote Information Sheet may be used.

Handwritten comments on documents that need to be scanned and imported into the EHR must be legible and must be in black pen (for greater reproducibility). Ensure that carbon copies of the Trauma Form are legible. The quality of scanned documents must be checked to ensure that they are legible.

2.4 Standardised Format ISBAR / ISoBAR / SOAP

Health practitioners who have authorised access to PHC Remote EHRs are obliged to apply a standardised format when recording events in EHRs. Using a format provides a systematic approach for the health practitioner to solve a problem with the client and devise a plan that is agreeable to the client.

PHC Remote CAHS use ISBAR for both verbal handover and written documentation. PHC Remote TEHS use ISoBar for verbal handover and SOAP for written documentation. The ISBAR PHC Remote CAHS Information Sheet, ISoBAR PHC Remote TEHS Information Sheet and SOAP PHC Remote TEHS Information Sheet provide further information on these tools.

As far as possible information related to each component of the consultation should be entered as a Service Item (PCIS) / Clinical Item (EACS) to ensure the integrity of the EHR.

Progress notes are to be written to complement service items using ISBAR (CAHS) and SOAP (TEHS) formats depending on region.

2.5 Recording Alerts and Allergies

Clinicians must record issues that require particular attention or pose a threat to the client, staff or others including:

- clients with the same / similar names / identities must have an alert created on the client's health record to warn of the similarities and the potential confusion. Significant errors related to client health records should be thoroughly documented in the client's health record and reported through RiskMan
- allergies / sensitivities or adverse reactions, and any known consequences, including documentation of medicine allergies on the Medchart
- infection prevention and control risks
- behaviour issues that may pose a risk to themselves or others
- child protection / well-being matters
- clients with communications issues / needs, for example use of an interpreter required or hearing impaired using an Auslan interpreter
- vulnerable persons, eg antenatal, aged, frail, cardiac condition, renal disease, complex communication or behavioural issues
- other relevant alerts as identified

Clinicians must review the alert notification six monthly to ensure the alert is current. To prompt clinicians to review the Alert status, a review date should be entered in the client's EHR:

- PCIS an Alert review date is to be entered in the review date field. Also see PCIS Alerts for details on the process.
- EACS the review date is to be recorded as part of the Alert text, eg (insert Alert reason and "*please review <insert date>*".

2.6 Recording Telephone / Verbal Medicine Orders

See Prescriptions PHC Remote Guideline for detailed information on the procedure and documentation requirements.

All endorsed or authorised orders for medicines must be included on the electronic medication record utilised by the EHR.

When giving a telephone / verbal order wherever possible the Authorised Prescriber must access the client's EHR and the medicine order created immediately in the client's medication profile. This will assist the nurse / Aboriginal and Torres Strait Islander Health Practitioner (ATSIHP) to administer the medicine and record it appropriately. When the Authorised Prescriber is unable to access the client's EHR, the nurse / ATSIHP will use the phone order function in the EHR to record the medicine order. Reference is made to the telephone order in the progress notes.

2.7 Recording Telephone, Electronic and Video-Conference Consultations

ISBAR (CAHS) and SOAP (TEHS) formats apply equally to consultations /advice where telephone, electronic and video-conference facilities are utilised.

2.7.1 Telephone or Electronic Consultation with a Client

When clinical information is provided to a client / carer by telephone or electronically by e-mail, the consultation / advice and the identification of the caller must be documented in the client's health record.

2.7.2 Telephone or Electronic Consultation between Clinicians

Telephone calls or electronic communications related to client care, including calls from third parties, and any advice given, are to be documented as a Service Item (PCIS) / Clinical Item (EACS) in the client record as soon as possible after the call / communication.

2.7.3 Video-Conference Consultations

Client consent (which may be verbal) should be gained and recorded as part of a consultation conducted by video-conference. See Telehealth – Specialist Consultation.

2.8 Recording Information received from Non-Clinical Staff or other Third Party

If a staff member whose normal duties do not necessitate accessing health records has important health related information to convey, this must be recorded.

The information, should be put in writing and reported to a health practitioner with authorised access to health records. The information must then be recorded on the EHR by the health practitioner as follows:

- add a Progress Note indicating who the information was received from
- if appropriate, scan and import the signed and dated hard copy document into the appropriate client record
- name the document using the following format: **yymmdd_subject**, for example, **120403_child_neglect_reported**
- if using PCIS, send an Inbox Message to the health practitioner/s who need to be made aware of the contents of the scanned document
- if using EACS, send an e-mail to the health practitioner/s who need to be made aware of the contents of the scanned document

Note: written entries on forms must be compeleted in permanent ink that is readily reproducible. Black ball point pens meet this requirement.

2.9 Recording Refusal to Attend Recall / Refusal to Accept Medical Advice

See the Client Recall Systems PHC Remote Guideline which provides detailed information on the procedure and documentation requirements for when a client refuses to attend recall.

PHC staff have an obligation to ensure the client understands the importance and consequences of planned health care events, particularly for high priority recalls and in the event the client refuses medical advice / treatment. To promote understanding and attendance for planned recall, the following strategies may be employed:

- use of interpreter services for people speaking English as a second language
- the Medical Practitioner could speak with the client in person or by phone
- involve family members in the discussion and decision making (with the client's permission)

2.9.1 Refusal to Accept Medical Advice

In some instances the client may refuse to accept medical advice even after reasonable steps have been taken to inform them of the potential consequences and the recommended management. In this instance the Refusal to Accept Medical Advice PHC Remote Form (also available via the EHR) must be completed and signed by the client. The signed form must be scanned into the client's EHR as described in Electronic Health Records Overview PHC Remote Guideline.

2.10 Recording Client Clinical Incidents

All clinical incidents must be documented in the client's health record (as required by the Clinical Incident Management NT Health Policy). Staff must document in the health care record:

- RiskMan incident number
- Clinically relevant information about the incident

- Interactions related to open disclosure processes (see the Open Disclosure NT Health Guideline).

Note: Complaints are not recorded in the client health record.

2.11 Health Record Documentation by Students

After students have completed their consultation and documentation, the delegated supervisor must provide additional notes and endorse the student's entry as part of the same consultation. See Medical Students PHC Remote Guideline for further information.

2.12 Provider-to-Provider Client Information via the Electronic Health Record

2.12.1 Primary Care Information System - Inboxes

The PCIS Inbox Message system is an electronic communication tool (for provider-to-provider messages) that is exclusively for communicating specific client and health related information. Inbox Messages form a part of the client's legal health record and must only contain information related to the specific client.

Clinical staff must monitor relevant Inboxes for information regarding client follow-up from messages received and action / forward these as required.

The PHCM, Medical Practitioner or delegated officer must check personal and Work Unit Inboxes at least daily and assign the messages to the appropriate client/s using a minimum of three identifiers. Refer to URG Inbox Messaging for instructions on assigning messages.

Medical Practitioners, to effectively manage pathology results, must check their Inbox for electronic pathology results each working day. See URG Inbox - Witnessing e-Results.

2.12.2 East Arnhem Communicare System – Intray

EACS has a single Intray to receive pathology results, radiology reports, discharge notifications and summaries and other documents sent via SEMS collectively for the East Arnhem North remote health centres utilising Communicare. Staff must monitor the Intray at least daily and action information as appropriate. When clinical staff action documents in the Intray, the system automatically transfers the information to the clients EHR.

Where information cannot be sent via the Inbox / Intray, for example provider-to-provider messages / information, this may be sent via hard copy or e-mail provided the information is for the primary purpose of providing health. The e-mail must be printed and scanned into the client's EHR, naming the document as follows: **yymmdd_subject** for example: **"181030_e-mail_re_OPD_Appt**"

For details re scanning requirements, see Electronic Health Records Overview PHC Remote Guideline.

2.13 Correction to Documentation

Incorrect entries in EHRs can be corrected using the process described Making Corrections to an EHR Medical Record (PCIS / EACS).

2.13.1 Electronic Health Records

For medico-legal reasons, Users do not have the security access to allow the reopening and changing of consultations after they have ended the consultation. Requesting data correction includes PCIS Users notification via PCIS Inbox Messages and EACS Users notification via e-mail:

- the person requesting correction of data sends a message to the PHCM / Clinical Supervisor
- the PHCM / Clinical Supervisor verifies that the consultation is to be reopened and forwards to the Health Applications Support (HAS) Service Centre for actioning of the request.

See Electronic Health Records Overview PHC Remote Guideline for contact details.

2.13.2 Hard Copy Records

Corrections to hard copies of client related documents, including the PCIS Consultation Form (Hard Copy) / EACS Outage Consultation Form (Hard Copy) must be made as follows:

- draw a single line through the incorrect entry, so that the error is clearly visible after it has been ruled out. Correction fluid must not be used.
- write an explanatory note such as 'wrong record', 'incorrect information' or 'error' after the incorrect entry
- insert the date and time of the new entry, as well as the signature, surname, initials and designation of the person making the correction.

Note: written entries on forms must be completed in permanent ink that is readily reproducible. Black ball point pens meet this requirement. See Australian Standards Online Premium - Standard 2828 - Paper-based Health Care Records.

2.14 Documenting Health Care Retrospectively

2.14.1 Recording Care provided when the EHR was not Available

Documentation requirements apply equally in situations where direct care is provided outside the health centre or when there is a temporary EHR outage. Information must be recorded legibly in black pen on forms such as the PCIS Consultation Form (Hard Copy) / EACS Outage Consultation Form (Hard Copy) or the Trauma Form whenever direct client care is provided outside the health centre or during EHR outages.

Where applicable the person who conducted the original consultation must enter clinical data into the EHR retrospectively as a backdated Visit Consultation (PCIS). Users of EACS must backdate clinical items when they are entered. Clinical data must be entered as soon as possible after the event. Hard copy records, appropriately named, signed and dated must be scanned and imported into the individual clients health record.

For technical details on the Scanning and Importing process see Basic Steps (PCIS - *scroll down to Scanning and Importing table)* / EACS and for details such as naming conventions and privacy issues see Electronic Health Records Overview PHC Remote Guideline.

Emergencies or on-call consultations are to be documented during the event or as soon as practicable after the event. Telephone calls received by on-call staff who determine whether the client does or does not warrant care after-hours must be documented at the earliest opportunity following the telephone call.

See the PCIS URG Consultation Form (Hard Copy) for details on how to record a retrospective incident. EACS information is available in EACS Outage Consultation Form-Information Sheet and EACS Scanning and Importing.

2.14.2 Recording Historical Information

To ensure that records are complete, it is sometimes necessary to enter historical data in a backdated PCIS Non-Visit Consultation or in the EACS *No Client Contact* (*select this option from the Mode & Place check box)*. Examples of this type of data are information from newborn discharge summaries and historical immunisation records (see PCIS - Immunisations, pg 4).

2.15 Training and Resources

All health care personnel who document or manage PHC remote health records are required to undergo EHR training to suit their role and responsibilities. Specific training is also made available for the introduction of any significant upgrade rsulting in changes to documentation. A range of resources which support the training provided to all EHR Users. It is strongly recommended that PHCMs set aside time for staff to attend training sessions and ensure staff are aware of EHR resources.

See Electronic Health Records Overview PHC Remote Guideline for further information.

2.15 Audit of Health Records

Health records will be audited for compliance with this guideline. Clinical audits of documentation in health care records should involve a team-based approach with the clinical team consisting of medical practitioners, nurses, midwives, ATSIHP, allied health practitioners such as pharmacists, nutritionists and other health care personnel, as appropriate.

Health care record audit results should be:

- provided to relevant PHC Remote Managers for follow-up
- referred to PHC Management and relevant committees to facilitate quality improvement.

2.16 Archiving and Disposal of Historical Hard Copy Client Health Records

No further information must be added to the historical hard copy client health records.

These historical hard copy health records in health centres have been, or are in the process of, being archived and transferred to Secondary Storage facilities in Darwin and Alice Springs. The historical health records are held in these facilities awaiting archiving or a destruction date, in accordance with the Disposal Schedule Patient Records DS2002/1 – November 2002 - Disposal Schedule for Patient Records of NT Public Hospitals and Community Health Services No.2002/1

However, as per instructions from the DoH Chief Executive Officer, all record destruction has been deferred until further notice. There is currently no schedule in place. See Retention and Disposal intranet site.

Compliance

Adverse events will be recorded in the client's notes, and Riskman, for example recording client information in the wrong client health record	Relevant Manager **PHC CAHS:** Clinical Nurse Manager, Quality ana Safety PHC CAHS **PHC TEHS:** Safety and Quality Manager, PHC TEHS
Health care personnel utilising PHC Remote client health records will undertake appropriate training and utilise resources	Relevant Manager/s
Authorised health record audit reports will be reviewed and issues followed up as identified	Relevant Manager/s

Document Quality Assurance

	Method	Responsibility
Implementation	Document will be accessible via the Policy Guidelines Centre and Remote Health Atlas	Health Policy Guidelines Program
Review	Document is to be reviewed within three years, or as changes in practice occur	Atlas Development Officer, Primary Health Care CAHS
Evaluation	Evaluation will be ongoing and informal, based on feedback.	Atlas Development Officer, Primary Health Care CAHS

Key Associated Documents

Forms	PCIS Consultation Form (Hard Copy) EACS Outage Consultation Form (Hard Copy) Benzathine Penicillin G Injection for Rheumatic Fever - Consent Form (Child) (intranet) Refusal to Accept Medical Advice Form

Key Legislation, By-Laws, Standards, Delegations, Aligned & Supporting Documents	Authorised Clinical Protocols and Procedures Manuals PHC Remote Guideline Client Recall Systems PHC Remote Guideline Electronic Health Records Overview PHC Remote Guideline Electronic Health Records User Access PHC Remote Guideline Medical Students PHC Remote Guideline On-Call Expectations PHC Remote Guideline Patient Identification PHC Remote CAHS Information Sheet Prescriptions PHC Remote Guideline Privacy of Health Information Overview PHC Remote Guideline Requests for Access to Health Information and Records PHC Remote Guideline Telehealth – Specialist Consultation PHC Remote Guideline Information Sheets: Abbreviations – Medical Terminology PHC Remote Information Sheet Acronyms and Abbreviations List PHC Remote Information Sheet ISBAR PHC Remote CAHS Information Sheet ISoBAR PHC Remote TEHS Information Sheet SOAP PHC Remote TEHS Information Sheet PCIS Website URG Consultation Form (Hard Copy) URG Making Corrections to a PCIS Medical Record URG Inbox Messaging URG Inbox - Witnessing e-Results TIPS Inbox Messages TIPS Assessments Diary Recall Visit and Non-Visit Consultation Service Items Immunisations Medications – Quicklist (CARPA) EACS Website EACS Outage Consultation Form -Information Sheet EACS Scanning and Importing Reason For Encounter Telephone Call Clinical Item Tip DoH Privacy Policy Information Act Office of the Information Commissioner - NT Code of Conduct Records Management, see Retention and Disposal page; Patient Records DS2002/1 – November 2002 Clinical Record Documentation NT Hospitals Policy Clinical Incident Management NT Health Policy

	Open Disclosure NT Health Guideline Australian Medical Council and Medical Board of Australia Code of Conduct - Section 8.4 Code of Professional Conduct for Nurses in Australia Australian Standards Online Premium - Standard 2828 - Paper-based Health Care Records Remote Primary Health Care Manuals website
References	As above

Definitions

Preferred Term	Description
Authorised Prescriber	a medical officer, nurse practitioner or other health practitioner (eg Dentist, Optometrist) who is authorised to issue a prescription under the NT Medicines, Poisons and Therapeutic Goods Act, and issues the prescription in the course of practicing within their scope of practice.
Consultation	an interaction where a health practitioner works with the client, a partner, the family or relatives to solve the client's identified health needs and results in the health practitioner intervening by providing support, medication or treatment for the client's health need or a preventative purpose.
EACS	East Arnhem Communicare System. An electronic health record and version of Communicare specifically adapted for use in selected East Arnhem North health centres to record client personal and health information.
EACS Intray	a repository to receive and view investigation results and other documents sent via SEMS to EACS health centres. For details see 2.6.2 EACS Intray.
Electronic Health Record (EHR)	a systematic collection of electronic health information about individual clients. The EHR is the **primary** health record into which client personal and health information must be entered.
ISBAR (Identify, **S**ituation, **B**ackground, **A**ssessment and Agreed Plan, **R**ecommendation)	an acronym used to describe the standardised format of documentation and clinical handover required by health staff working in the PHC Remote CAHS health centres and is to be applied when recording events in the EHR. For details, see ISBAR PHC Remote CAHS Information Sheet and Section 2.5 of this document.
ISoBAR (Identify, **S**ituation, **O**bservation, **B**ackground, **A**gree a plan, **R**ead Back/Responsibility/Risks)	an acronym used to describe the standardised format of verbal clinical handover required by health staff working in the PHC Remote TEHS health centres and is to be applied when conducting a clinical handover either face to face or via telephone. For details, see ISoBAR PHC Remote TEHS Information Sheet and Section 2.5 of this document.
PCIS	Primary Care Information System. An electronic health record utilised in most NTG remote health centres for client personal and health information.

Preferred Term	Description
PCIS Inbox	a collection of sent and received messages belonging to an individual provider, work unit or client. PCIS Inboxes (Provider, Work Unit or Client) enable one provider to communicate with another about a client, eg discharge summary, pathology and radiology results, etc. For details see 2.6.1 PCIS – Inboxes.
Scheduled Substance Treatment Protocol (SSTP)	is a protocol for possessing, supplying or administering a scheduled substance as approved by the Chief Health Officer under Section 254 of the Act.
SOAP (**S**tory, **O**bservations, **A**ssessment, **P**lan)	acronym used to describe the standardised format to be applied when recording events in the EHR. For details, see SOAP PHC Remote TEHS Information Sheet and Section 2.5 of this document.

Evidence Table

Reference	Method	Evidence level (I-V)	Summary of recommendation from this reference
N/A	N/A	N/A	N/A