SA Health

Policy

Health Record Management

Version 2.1

Approval date: 21 March 2024

PDS Reference No: D0447

Government of South Australia

SA Health

1. Name of Policy

Health Record Management

2. Policy statement

This policy outlines the mandatory access, management and integrity requirements for health records, in accordance with the expectations of consumers and legislative requirements.

3. Applicability

This policy applies to all employees and contracted staff (including contractors, students, volunteers, consultants, employment agency staff and providers of outsourced services) with authority to access, create, modify, facilitate or handle a health record within the Department for Health and Wellbeing (DHW), Local Health Networks (LHNs) including state-wide services aligned with those Networks and SA Ambulance Service (SAAS).

Unless specified, this policy applies equally to new and existing health records regardless of format - electronic, hybrid or paper based.

Non-health/medical records are out of scope for this policy, refer to the Corporate Records Management Policy.

4. Policy principles

SA Health's approach to health record management is underpinned by the following principles:

- We will ensure complete and accurate health records are made, managed and preserved for as long as they are required for business and legislative accountability.
- We will ensure recordkeeping responsibilities are assigned to and implemented by appropriately trained and skilled staff.
- We will ensure security provisions are implemented to maintain health record integrity and authenticity.
- We will ensure physical, electronic and hybrid health records are managed to enable reliable and timely retrieval of records.
- We will ensure health records are clear, objective and thorough and created as close as possible to, the time of the encounter.
- We will ensure health records are only disposed of in accordance with the retention and disposal schedules under the State Records of South Australia.
- We will adhere to clinical and legal responsibilities by maintaining accurate and secure health information to support decision making.

5. Policy requirements

- Health facilities and business units must create local procedures to implement this policy.

Legal Responsibilities

- Staff must comply with privacy requirements regarding the usage, disclosure, storage and security of a health record as outlined in the Privacy Policy.
- Staff must ensure access to, and recording of all information (electronically and/or on paper), complies with the Protective Security Policy and the Information Security Policy.

Creation and Management of Health Business Systems

- The creation and review of business and record systems must be assessed and designed in accordance with the State Records Managing Digital Records in Systems Standard and Minimum Recordkeeping Metadata Requirements Standard.
- The Managing Digital Records in Systems Standard must be followed for electronic records to ensure the minimum requirements for managing, adopting and assessing records in digital business systems are met.
- Business and record systems must be assessed and comply with the State Records Managing Digital Records in Systems Standard and Minimum Recordkeeping Metadata Requirements Standard.

Creation and Receipt of Health Records

- A health record must be created and registered in accordance with the SA Medical Records Documentation and Data Capture Standards and Sunrise EMR Business Rules.
    - The creation of records is the responsibility of authorised staff as delegated within local procedures.

Access to Health Records

- Authorised staff must ensure creation of health records is in accordance with local procedure, the Office of Commissioner for Public Sector Employment (OCPSE) Code of Ethics and Privacy Policy.
- Access to a health records and use of linked clinical systems, including My Health Record, must be limited to SA Health staff with lawful authority, to ensure the proper management, usage, storage and disclosure of such consumer information.
- Access to linked clinical systems must only be for the provision of care to consumers.

Management of Health Records

- A health record must be created, formatted, utilised and stored as prescribed in the SA Medical Record Documentation and Data Capture Standards and the SA Client Identification Data Standards .
- LHNs and SAAS must maintain an adequate health record for each patient and ensure health record entries are only made by those authorised to do so.
- All staff must be appropriately trained and understand their responsibilities in relation to health records.
- All staff must ensure that the documentation recorded in a health record is respectful and thorough, does not contain demeaning or derogatory remarks, is legible, and recorded in a timely manner.
- All clinical staff must ensure clinical documentation is captured and recorded as outlined by their professional body and meets the clinical practice standards, medico-legal and statutory requirements.
- Staff working with a health record must ensure the health records are maintained in safe, secure and confidential environments. Any requirement to transport the records offsite must be approved by the medical records manager locally.
- Records must be registered and maintained within approved recordkeeping systems.
- The health records management systems and practices must be regularly monitored, audited and evaluated for accountability, compliance and opportunities for continuous improvement.

Amendments or Corrections to Health Records

- Clinical or administrative staff must only amend/correct a health record, where necessary, in accordance with the SA Medical Record Documentation and Data Capture Standards.
- If a consumer applies to have their own health record amended under section 30 of the *Freedom of Information Act 1991*, action must be taken in accordance with the Freedom of Information Policy.
- Official records must not be removed, deleted or destroyed from the record when amending or correcting a health record. All versions of amendments, corrections or updates must be retained, accessible and legible.

Disposal of Health Records (Transfer and/or Destruction)

- Health units must develop and implement a disposal plan which details disposal decisions and actions for the health records.
- Health records must only be disposed of in accordance with the retention and disposal schedules approved by State Records of South Australia.
- Endorsement for transfer or destruction of a health record must be obtained from the LHNs Chief Executive Officer or authorised delegate. Active disposal freezes must be complied with.
- Records must be disposed of in a planned and authorised way and in compliance with State Records requirements, including: Transfer of Official Records Standard, Appraisal Standard, Disposal Standard, General Disposal Schedule No 28 – Clinical and Clinical-Related Records of Public Health Units in South Australia and any relevant Disposal Schedules implementing disposal freezes.

Retrieval

- All health records, including those stored in business systems, digital repositories, or the cloud, must be stored in a manner to allow for adequate searching and retrieval.

Audits

- Health units must undertake regular audits of health record management practices to ensure compliance with legislation, standards and policy requirements.
- All health units must participate in audits, including: SA Health Record Audits, SA Health Risk Management, Internal Audit Services and State appointed external audits (such as State Records of South Australia), at any time, and in accordance with approved audit plans.
- Staff must comply with the Risk Management, Integrated Compliance and Internal Audit Policy.

Breaches

- All incidents and/or breaches must be reported to management via the process set out in the Clinical Incident Management Policy and Privacy Policy.
- Where a breach of legislation or common law is suspected, the matter must be referred to Governance Advisory Services, DHW.
- Data breaches of records linked to the My Health Record system must be reported to the Office of the Australian Information Commissioner (Cwth).

6. Mandatory related documents

- Acceptable Use Policy Summary
- *Australian Health Practitioner Regulation Agency (AHPRA) - Good Medical Practice: A Code of Conduct for Doctors in Australia*
- Clinical Incident Management Policy
- Coronial Process and the Coroners Act 2003 Policy
- Corporate Records Management Policy
- Freedom of Information Policy
- *Freedom of Information Act 1991*
- *Health Care Act 2008*
- *Information Security Policy*
- Privacy Policy
- Protective Security Policy

7. Supporting information

- AS ISO 15489 Australian Records Management Standard
- Office of the Commissioner for Public Sector Employment - Code of Ethics
- Premier and Cabinet - PC012 Information Privacy Principles (IPPS) Instructions
- SA Medical Records Documentation and Data Capture Standards
- South Australian Client Identification Data Standards
- State Records of SA - Appraisal Standard
- State Records of SA - Information Management Strategy
- State Records of SA - Managing Digital Records in Systems Standard
- State Records of SA - Minimum Recordkeeping Metadata Requirements Standard
- State Records of SA - Transfer of Official Records Standard

8. Definitions

- **Clinician**: means a health care provider trained as a health professional. Includes registered and non-registered practitioners, and teams of health professionals who spend most of their time providing direct clinical care. The term ‘clinician’ refers to the treating medical or surgical clinician, anaesthetists and other consulting health professionals, midwives, and nurses.

  For the purpose of this policy, the definition from the Australian Commission on Safety and Quality Health Care, and the Australian Institute of Health and Welfare has been utilised.
- **Consumer:** means a person who has used, or may potentially use, health services, and includes family and carers. In mental health, a consumer refers to the user or potential user of health services and does not include their family, carer or other support persons. Consumers are also identified as patient, client, participants, service user, resident or guest.
- **Disciplinary action:** means punitive measures taken in relation to proven matters of misconduct; a public sector agency may reprimand or suspend an employee without remuneration on the grounds of misconduct. Disciplinary action may also take the form of a reduction of remuneration, a change in the employee’s duties to a different place, or termination of the employee’s employment.

- **Disposal**: means the authorised transfer or destruction of records/information, in accordance with relevant State Records SA legislation, Standards and disposal schedules.
- **Electronic record**: means information/records which have been created in a digital format within a system/database information and information/records which have been created in a physical paper-based format and then transferred in digital format within a system/database.
- **Health facility**: means any location where healthcare is provided. This definition includes hospitals, clinics, outpatient care and specialised care.
- **Health record:** means the composition of all information collected about a consumer during interactions with the health system (also known as the medical record). The health record encompasses information which is not just collected by, or for the use of, the health professions, but is used for further applications such as research and ethics, public health, and as part of the discovery process in a medico-legal context. A health record applies to both paper-based records, electronic recording systems and a hybrid of both.
- **Health unit**: means any location where clinical documentation is created or captured. This differs from the definition of a **Health Facility** in that healthcare may not necessarily be provided at a health unit. This definition includes sites such as virtual care centres.
- **Management of records and documents:** means access, creation, capture, use, storage, disclosure, sharing, archiving, amending, deleting, and destroying.
- **Official record**: means a record made or received by an agency in the conduct of its business. An official record can be written, graphic or pictorial matter; or a disk, tape, film or other object that contains information or from which information may be reproduced (with or without the aid of another object or device).
- **Statewide services:** means Statewide Clinical Support Services, Prison Health, SA Dental Service, BreastScreen SA and any other state-wide services that fall under the governance of the Local Health Networks.

9. Compliance

This policy is binding on those to whom it applies or relates. Implementation at a local level may be subject to audit/assessment. The Domain Custodian must work towards the establishment of systems which demonstrate compliance with this policy, in accordance with the requirements of the Risk Management, Integrated Compliance and Internal Audit Policy.

Any instance of non-compliance with this policy must be reported to the Domain Custodian for the Information Management Policy Domain and the Domain Custodian for the Risk, Compliance and Audit Policy Domain.

10. Document ownership

Policy owner: Domain Custodian for the Information Management Policy Domain

Title: Health Record Management Policy

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11. Document history

Version	Date approved	Approved by	Amendment notes
1.0	20/06/2017	Deputy Chief Executive, Finance and Corporate Services	New policy
2.0	19/04/2023	Chief Digital Health Officer	Updated to align with the new Policy Framework template and requirements.
2.1	21/03/2024	Chief Digital Health Officer	Minor review

12. Appendices

Nil