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1.0 ACKNOWLEDGEMENTS

In developing this practice brief, the Health Information Management of Australia (HIMAA) would like to acknowledge:

- The Medical Record Advisory Unit, Funding and Information Management, South Australian Department of Health, for use of the document: *South Australian Medical Record Documentation and Data Capture Standards, August 2000.*

2.0 INTENTION AND SCOPE

The intention of this practice brief is to describe the general aspects of an acceptable standard of documentation and information capture in the health environment. This brief can be utilised for quality assurance purposes, benchmarking, and to provide guidance in the design of health records, development of policies and procedures and good information management practices.

In general the content of this practice brief has been developed for paper based health records however many of the issues are relevant to the electronic environment and where applicable, this has been noted. Where a combination of an electronic and paper-based record exists for a patient, the information in both media should be cross-referenced so that the existence of each record and the record format is known. A standard approach should be adopted for cross referencing the existence of record formats for example, utilising a record tracking system, central registration system (such as the patient master index) or alert system.

The practice brief does not address the structure of the health record, nor does it attempt to address when a record should be created and what information besides clinical content should form part of the record. In addition issues regarding storage and dissemination of clinical information in the electronic environment are not addressed here. It is intended that these issues and other specialist documentation and information capture requirements be explored in future practice briefs.

This document has been prepared as a practice brief for information purposes and should not be interpreted as legal advice. It is not intended that the document over ride existing state or legislative requirements regarding the capture and recording of health information.

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1 For the purposes of this practice brief, the term patient has been used. However, as this brief is intended to be used widely throughout the healthcare industry, the terms patient, client and resident may also be used synonymously.

2 The patient master index (PMI) is a database register that uniquely identifies all patient’s who have received or are scheduled to receive a health service. The PMI contains patient identifying information and demographic details. For more information see the glossary of terms.
3.0 RECOMMENDED DOCUMENTATION POLICIES

In order to maintain an acceptable standard of documentation it is recommended that each health service undertake the following.

(a) Conduct an analysis of the relevant state / territory legal obligations and standards\textsuperscript{3} with regard to documentation and information capture requirements in health records.

(b) Based on this analysis, develop a documentation and information capture policy that addresses:

- The process for authenticating entries in the record
- The process for ensuring the reliability of the information in the record. In particular:
  - That the information is readable and can be understood
  - That the record is available at a given point in time
  - That the record is accessible in a format appropriate for the user
  - That changes to information in the record are appropriately managed
  - That user access to the record is managed
- Time frames for documentation
- The appropriate level of detail when documenting in the record
- The content of the is objective and reflects actual events

(c) Develop policies that address dual record systems including management of paper based, electronic and departmental records.

(d) Undertake regular reviews to ensure policies are met and to implement appropriate action where deficiencies are identified.

\textsuperscript{3} A range of quality and accreditation bodies have developed standards for the evaluation of health records, these include but are not limited to Australian Council on Health care Standards, Quality Improvement & Community Services Accreditation, Royal Australian College of General Practitioners.
4.0 GLOSSARY

The following is a list of terms, associated definitions and concepts used in this practice brief.

| Inpatient (admitted patient) | A patient who undergoes a health service’s admission process to receive treatment and / or care. This treatment and / or care is provided over a period of time and can occur in health service and / or in the person’s home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:

- The patient’s condition requires clinical management and / or facilities not available in their usual residential environment
- The patient requires observation in order to be assessed or diagnosed
- The patient requires at least daily assessment of their medication needs
- The patient requires procedure(s) that cannot be performed in a stand-alone facility, such as a doctor’s room without specialized support facilities and / or expertise available (eg. Cardiac catheterization)
- There is a legal requirement for admission (eg. Under child protection legislation)
- The patient is nine days old or less

There are two types of admitted patients, overnight stay patients and same-day patients.

A same day patient is one who is admitted and separated on the same date.

An overnight stay patient is a patient who, following a clinical decision, receives hospital treatment for a minimum of one night ie. who is admitted to and separated from the hospital on different dates.  

4 AIHW, National Health Data Dictionary, version 12
Metadata needs to accompany data, otherwise the data being captured or communicated cannot be understood. For example, the value 123 can be transmitted in a data file. However it is meaningless without additional information to explain the context of the value. Is it a street number, a clinical measurement, a test result or the number of services provided?

Metadata usually gives data a unique identity in a given context. Metadata is required to describe the context, content and structure of health information that makes up a health record. There is a range of metadata depending on the context in which the data is created.

For example, record keeping metadata includes:

- Registration and classification metadata – the metadata that gives a record its unique identity and classifies it in a classification scheme.
- Content, structure and context metadata – the metadata that gives a record content including title, abstract structure, type, format and context as well as identifying who created it, where, when and its relationship with other records.
- Recordkeeping process metadata – metadata that provides information or evidence about processes a record may have undergone such as viewing, transmitting, transferring custody, accessing, reviewing, sentencing, changing etc.

**NOTE:** *Australian Standard 5021:2005 The Language of Health Concept Representation* is a useful reference document.

Non-admitted patient

A patient who does not undergo a formal admission process. There are three categories of non-admitted patient:

- Emergency department patient (unplanned contact)
- Outpatient (planned contact)
- Other non-admitted patient (treated by health service employees off the hospital site – includes community / outreach services.

---

5 METeOR (meta data online registry) released by the Australian Institute of Health & Welfare in 2005 replaces the knowledge base as Australia's central repository for health, community services and housing assistance metadata and can be accessed from www.meteor.aihw.gov.au

6 AS ISO 15489 – Records Management 2002

7 South Australian State Records: *Recordkeeping Metadata* (Recordkeeping Advice 017), March 2004, version 1.0

8 AIHW, National Health Data Dictionary, version 12
### Patient Master Index (PMI)

An index or database register that uniquely identifies all patients who have received or are scheduled to receive a health service by the organisation (or health enterprise) which may consist of one or more health care sites. It is called an index because it serves as a guide to each patient’s health records by linking the patient’s name to the unit record number (unique identifier). The PMI is the key to locating a patient’s health information for continuing care purposes. The PMI contains patient identifying information and demographic details.

A patient must be registered on the PMI if they:

- Are admitted to the health service
- Attend a non-admitted service for example, an outpatient clinic or emergency department, or are provided a community based service
- Where the intention is that the patient will receive a service in the future\(^9\).

Once registered on the PMI the patient will be assigned a unit record number (unique identifier).

### Record

A record can be is defined as:

(a) written, graphic or pictorial matter; or a disk, tape, film; or

(b) other object that contains information or from which information may be reproduced (with or without the aid of another object or device).\(^{10}\)

In this practice brief the term record refers to the patient’s clinical, health or medical record and not just electronic storage of records. A health record comprises any health information generated as a result of clinical services being provided to a client at a health unit irrespective of media, for example either written or electronic.

X-rays, photographs, videos and electronic databases such as the Patient Master Index also constitute a record.

**NOTE:** There are other meanings of this term used in healthcare which are dependent on the context in which the record was created. In the health environment multiple records may exist for the patient in hardcopy or electronic format with many organisations and health clinicians contributing to the record.

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\(^9\) Medical Record Advisory Unit, Funding and Information Management, South Australian Department of Health: *Client Registration Best Practice Principles Brochure*, 2003

\(^{10}\) State Records Act 1997, South Australia
**Unit health record**

The unit health record (often called the unit record) is an entity within the health service (or health enterprise), that contains information about the patient which may be in paper format or a combination of paper and electronic format. Where dual formats or multiple records exist, the information in both media should be cross-referenced so that the existence of each format is known. For the purpose of the practice brief, the unit record is also referred to as ‘medical record’ and ‘health record’.

**Unit record number**

A unique identification number assigned to a patient to identify and link their health information over the continuum of care. The unit record number is assigned once the patient is registered on a central database such as the patient master index. The unit record is used to link various types of information and records for the patient.

- Each patient should be assigned only one unique unit record number within the health enterprise.
- A unit record number must not be reallocated to another patient even if the original patient dies or does not attend the health service again.\(^\text{11}\)

**NOTE:** AS 5017-2006 *Health Care Client Identification* is a useful resource document.

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\(^{11}\) Medical Record Advisory Unit, Funding and Information Management, South Australian Department of Health: *Client Registration Best Practice Principles Brochure*, 2003
5.0 HEALTH RECORD INTEGRITY

To develop an acceptable standard of documentation and information capture the integrity of the health record needs to be established.

Record integrity is dependent on a number of aspects:

a. Entries in the record are **authenticated** to identify who wrote what when and in the electronic environment who viewed what, when.

b. The **reliability** of the information contained within the record can be assured for example, the information has not been tampered with or altered and is readily available. In addition the information needs to be organised in a consistent manner that assists retrieval and is **accessible** in accordance with retention requirements.

c. The information is recorded in a **timely** manner.

d. The **content** of the record is of appropriate detail to meet record keeping requirements, for example, the information is unambiguous and clinically relevant.

e. The information documented in the record is **objective** and reflects actual events.

5.1 AUTHENTICITY

Entries in the health record should only be made by people authorised to do so by the health service.

Clinicians providing care to the patient and related treatment advice must document the care provided and verify that care (and advice) has been given by authenticating the entry. An authenticated entry is one which has been legibly written, signed by the author and includes the author’s designation, date and time the entry was made.

Any entries in the health record by clinical students should be authenticated by the student and countersigned by a fully qualified clinician.

**NOTE:** A means to manage the process of countersigning is required in the electronic environment.
<table>
<thead>
<tr>
<th><strong>TABLE 1: Authentication of paper-based records</strong></th>
</tr>
</thead>
</table>
| **T1.1**  
**Free text fields**  
e.g. progress notes  
Following each entry made in a free text field, the clinician should record:  
- The date of the entry. The date should be written in dd/mm/yyyy  
- Time of the entry. The date should be written in 24 hour clock.  
- Signature  
- Surname and initials printed  
- Designation e.g. medical officer, nurse, physiotherapist (a stamp is acceptable) (see 6.2 & 6.3)  
In the **electronic environment**, a free text field should not be editable after the entry is saved. If the entry is editable, a suitable system should be in place to track changes made by the editor, including the date and time. In free text fields an electronic signature or equivalent is required which is electronically date and time stamped and which clearly identifies the author. The signature should:  
- Not be able to be tampered with  
- Be viewable electronically  
- Be able to be printed where a paper copy of the record is required. |
| **T1.2**  
**Structured fields**  
e.g. Medication charts  
Clinical pathways  
Following the entry the clinician should document:  
- Date and time of entry  
- Signature and/or  
- Identifiable initials  
In the **electronic environment**, an electronic signature or equivalent is required which is electronically date and time stamped and which clearly identifies the author (as per T1.1). |
| **T1.3**  
**Test Results**  
- The medical practitioner should authenticate that the results have been viewed by signing and dating the result.  
- If the reports are presented **electronically**, or by some other method, there is a requirement for representation of clinician review and authentication (see also T7.1). |
5.2 RELIABILITY

The nature of business captured in the health record is proportional to the need for the information to be reliable. For example, health records need to be reliable as they are utilised as a communication tool between clinicians in managing a patient’s health care. If the record is not reliable the patient’s care may be adversely affected.

The reliability of the record is dependent on the record being complete and current; being able to demonstrate that the record has not been tampered with; the record is available when required; and that the information within the record is organised in a consistent manner that aids retrieval.

5.2.1 Legibility of Entries

The reliability of the health record depends in part on the legibility of entries. If the information cannot be read it may affect continuity of patient care and have legal and risk management implications, for example administration of the wrong medication. Due to these implications, it is recommended that only black pen is used to document in the record as it is easier to read, photocopy and scan information for electronic purposes.

Where possible original copies of documents / reports should be retained and filed in the record.

Use of abbreviations and symbols are discouraged due to the potential for misinterpretation.

Where abbreviations and symbols are used, this should occur where:

- A list of the abbreviations and symbols and their meanings are available for future reference

- There is only one meaning per abbreviation / symbol in the context of the speciality in which it is used. It is important to recognise that abbreviations and symbols evolve and not all come from the medical environment for example, the ability to text message and email has resulted in a unique terminology that utilises a range of abbreviations and symbols.

- The list has been approved by the health service record committee (or equivalent).

The Australian Dictionary of Clinical Abbreviations, Acronyms and Symbols is a useful tool describing the various abbreviations and symbols used in the health environment. The booklet is available for purchase from the HIMAA website www.himaa.org.au

Use of abbreviations in discharge summaries, correspondence and reports provided to outside parties and consent forms should be discouraged, as they can be misinterpreted.
Use of a standard clinical terminology such as SNOMED CT within the electronic environment will enable systems to provide a full description of terms, abbreviations and symbols which will help to overcome issues of misinterpretation.

5.2.2 Availability of the Record

An appropriate information management system is required to ensure the patient’s record and health information is uniquely identified, so that it can be managed across the continuum of care. In the health environment this is best achieved by registering the patient on the Patient Master Index\(^\text{12}\) and allocating a unit record number. The unit record number is used to identify and link the patient’s health information (which may consist of multiple records) over time.

The original health record must be maintained by the health service unless approval has been obtained from the appropriate authority to dispose of the record, for example, in accordance with a relevant disposal schedule. In circumstances where the original health record needs to be removed from the health service, for instance due to a legal request following receipt of a subpoena, Coroner’s request or presentation by a police officer with a warrant authorising production of the record; a copy of the health record should be made prior to providing the original to the third party. A suitable tracking system should be established to track the location of both the original record and the copy.

Consideration is required on how patient information in electronic format will be made available to a third party, for example will it be printable or presented electronically and include a record of the authentication process. Consideration is also required as to whether information should be maintained by the receiver (information system). It may be necessary to identify what information was available at a given point in time to support decision making including the date and time the information was received and when it was available for access.

Patient information should not be provided to a third party in a format that is unusable by that party. Further clarification may need to be sought from the requestor when information is stored in dual systems (paper and electronic); however, it should be generally considered that a health record provided in a format that is not usable by the requestor should be regarded as unreliable and not in accordance with law. Each health service will need to identify their own state’s evidential requirements for submission of records in a court of law.

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\(^{12}\) The patient master index (PMI) is a database register that uniquely identifies all patients who have received or are scheduled to receive a health service. The PMI contains patient identifying information and demographic details. For more information see the glossary of terms.
5.2.3 Accessibility of the Record

Information within the record should be organised in a consistent and logical manner to aid retrieval. Australian Standard AS 2828 outlines suggested record formats. The record also needs to be retained in accordance with relevant retention requirements (see appendix 1).

Access to the patient's health record needs to be managed to ensure unauthorised access does not occur. This will necessitate the development of business rules regarding access and security. For example:

- Defining who can access the record including the role of the person who accessed the record at the time. For example, a doctor accessing the record of a patient they are currently treating versus a doctor accessing a record of a patient they are not currently treating.
- Under what circumstances the record may be accessed. In general the record should only be accessed on a 'need to know basis' for immediate treatment of the patient. Business rules are required regarding the access on a day-to-day basis and other requests for example, research requests.
- The level of access available, for example the whole record versus components of the record and specifically which parts of the record.
- The date and time the record was accessed.
- Authority and process for providing and removing access.
- Implementing processes for managing access and security, for example locking the Medical Record Department, employee security tags for entry into the department, and security passwords in the electronic environment.

In the electronic environment transaction logs for the individual record can be utilised to identify record keeping processes as well as access and alterations to a record. It is useful to develop an automated process that alerts abnormal access patterns or access by exception, where access is defined as inappropriate / unauthorised so that corrective action can be taken.

Transaction logs form part of the metadata of the electronic record and should be used to identify who has accessed a record and when this occurred. The retention of transaction logs should be in accordance with the retention requirements of the health record\(^\text{13}\). Consideration also needs to be given to patients who may want to know who has accessed their record and the requirement to review the transactions.

5.2.4 Correction of Information and Version Control

Clinical information must not be deleted from the health record. If it is determined that the information is inaccurate, incomplete, misleading or out of date then the health service should take reasonable steps to correct this information. This includes adding

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\(^\text{13}\) There are two approaches for the storage of recordkeeping metadata (a) embedding the metadata within the particular record (b) maintaining metadata in a separate ‘repository’ or database and linking it to the appropriate record.
an amendment to the information if the correction is refused or opinion differs, and recording the name of the person who made the correction and the date it was made.

In general where information is incorrect, for example information is written in the wrong patient’s record, the following method should be used to correct the information:

- Draw a single line through the incorrect information (do not delete the information using liquid paper or by removing the page)
- Write an explanatory note such as ‘wrong record’ or ‘error’
- Record the correct information
- Authenticate the entry by inserting the date and time of the correction, the signature, designation, surname and initials of the person making the correction.

Where records are subject to change and alterations, a standard process is required to manage changes to the record. Where information is updated from time to time, it is important that the historical information is not deleted and can be accessed at a later date if required. However, from a risk management perspective the information viewed by clinicians should reflect the current health status of the patient.

**NOTE:** In the electronic environment a process to distinguish ‘interim’ versus ‘final’ versions of information such as a discharge summary is required. It would be useful to stipulate a time period that information may be in the interim format, so as to ensure a final version is made available as soon as possible.

In the electronic environment it is necessary to consider how the original unaltered version of the record and edits will be maintained, and how someone accessing the record will know that it has been edited. The health service should have procedures in place to identify and manage incidents where records have been altered or updated without approval and / or outside the official process.

### 5.2.5 Requests for Change in Accordance with Freedom of Information Legislation

Amendments to the record should be made in accordance with relevant state legislation, for example a request for correction under the provisions of the state’s Freedom of Information Act.

Where information is amended, it is important that the revised information is added as a notation and the original information is not deleted and can be accessed at a later date if need be. It is recommended that the existence of the annotation be included on the alert system (see T9.1) and a summary of the amendments filed in the correspondence section of the record. Where the application to amend the information is refused, the original request should be filed in the correspondence section of the record.

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5.3 TIMELINESS OF DOCUMENTATION / INFORMATION CAPTURE

When documenting in the record the timing and the order of events are critical.

Documentation should be in chronological order as events occur. If an entry is not in sequential order this should be indicated.

The date and time the event occurred should also be documented in addition to the date and time the entry was made, particularly if there is a significant time lapse between the event occurring and documenting the information in the record. It is acceptable to write short notes at the time the event occurred and for a more comprehensive account to be entered as soon as reasonably possible after the event but within 12 hours of the event occurring. Where a more extensive account is written at a later date, the entry should be marked as a ‘retrospective entry’ to reflect the time lapse.

Intervention in patient care or observations should not be documented ahead of time.

5.4 APPROPRIATE CONTENT OF DOCUMENTATION / INFORMATION

The creation of the health record requires a health service to define what information is to be included in the record. This is dependent upon a number of factors as outlined below.

5.4.1 Continuity of patient care

The health record is a method of clinical communication and care planning amongst clinicians. It is important that clinicians have a complete picture of the patient’s health status that is relevant to the current episode of care on which to base decisions regarding the appropriate course of management and treatment.

5.4.2 Legal requirements

The health record provides protection of the legal interests of the patient, clinicians and the health service.

Each health service should identify their own state’s legal requirements for creation and maintenance of records, as well as evidential requirements for submission of records in a court of law. In the electronic environment the metadata requirements will also need to be captured as part of the record, for example transaction logs and electronic signatures.

Appendix 1 provides a list of Commonwealth and State legislation, and the relevant sections of the Act, that pertains to the management of records.
5.4.3 Accountability purposes

Health services are accountable for the services provided; without a health record there is no evidence of the services occurring. The health service should regularly review and evaluate the health record to ascertain that the clinical information is sufficient for the purposes of providing and evaluating patient care; and for medico-legal purposes. Appropriate action should be taken to rectify any systematic deficiencies that are identified\(^{15}\).

5.4.4 Research, education and evaluation of care

The record forms a basis for evaluating the adequacy and appropriateness of the care provided and provision of clinical data for research and education.

5.5 ACCURATE AND OBJECTIVE INFORMATION

In the electronic environment, the ability to record information in a standard and accurate format is critical to the process of exchanging health information. A standard clinical terminology such as SNOMED CT\(^{16}\) adopted by NEHTA\(^{17}\) can provide clinical data with both consistent meaning and context. A standard clinical terminology will enable entry, storage and communication of clinical information in ways that allow it to be safely and consistently reused, retrieved and processed by different software applications.

In general, documentation (recording of information) should be objective and a true account of what was assessed, observed and undertaken.

When documenting in the record actual events should be recorded rather than subjective (emotional) statements about the patient. It is recommended that documentation is recorded in the ‘passive’ form and not in the ‘first person’, for example ‘The patient was transferred from the bed to the wheelchair’ and not ‘I transferred the patient from the bed to the wheelchair’.

All communications between the health care team should be documented along with the outcome of any decisions such as agreement or disagreement with the action taken.

\(^{15}\) A range of quality and accreditation bodies have developed standards for the evaluation of health records, these include but are not limited to Australian Council on Health care Standards, Quality Improvement & Community Services Accreditation, Royal Australian College of General Practitioners.

\(^{16}\) SNOMED CT - the Systemised Nomenclature of Medicine, Clinical Terms is a clinical terminology describing concepts, synonyms and relationships. Its purpose is to assist in the care of the patient by providing a language that is human readable and computer processable. SNOMED CT is endorsed by the Australian Ministers Advisory Council as the preferred clinical reference terminology for Australia.

\(^{17}\) NEHTA – the National E-Health Transition Authority Limited, is a not-for-profit company established by the Australian Commonwealth, State and Territory governments in 2005. It aims to develop better ways of electronically collecting and securely exchanging health information. More information can be obtained from www.nehta.gov.au/
### 6.0 DOCUMENTATION PRACTICE GUIDELINES

Tables 2 – 9 below provide guidance on the information content requirements of various forms of documentation.

**TABLE 2: Clinical Documentation – Medical Practitioner**

| T2.1 Patient history | A relevant medical history should be documented within 24 hours of admission and prior to any surgical procedure. Where the patient’s history is captured prior to this period, for example one month beforehand, the history should be reviewed to determine if the patient’s health status has changed.

Where possible a standard history format[^18] should be adopted.

In circumstances where the patient’s treating practitioner is also the patient’s General Practitioner, a relevant history should still be documented in the health record held at the health service. |
| T2.2 Physical examination | A physical examination of the patient should be performed and documented on admission or within 24 hours of admission, and prior to a surgical procedure. The entry is to include the date and time of the examination.

In general the degree of detail depends upon the age and sex of the patient, the patient’s symptoms, other physical findings and laboratory data.

Where the patient is examined some time prior to admission or surgery, another examination should be conducted to determine if the patient’s status has changed.

In circumstances where the patient’s treating practitioner is also the patient’s General Practitioner, a relevant physical examination should still be documented in the health record held at the health service. |
| T2.3 Documented diagnosis | A provisional diagnosis should be documented after completing the patient history and physical examination. The diagnosis may be amended following investigation.

It is acceptable to describe the diagnosis as a ‘query’, ‘probable’ or ‘suspected’ diagnosis if the patient is being treated for that condition and there is uncertainty regarding a definitive diagnosis at the time of writing. |

[^18]: A standard history may include but is not limited to: presenting complaint or illness, past medical history, family medical history, summary of presenting signs and symptoms, psychosocial history, allergic responses and drug reactions (if known), and immunisation status.
<table>
<thead>
<tr>
<th>T2.4 Planned treatment</th>
<th>Investigations and treatment planned by the medical practitioner are to be clearly documented in the progress notes and elsewhere in the record eg. Medication forms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2.5 Consultant / specialists review</td>
<td>Where a second opinion is sought from a specialist, the findings and recommendations for treatment should be documented in the progress notes or on a specific form, for example Specialist or Consultant Report and filed in the record as required.</td>
</tr>
<tr>
<td>T2.6 Drug Orders</td>
<td>All orders for drugs must be written, legible and authenticated by the medical practitioner responsible for the care of the patient in accordance with drug regulations of each state. A note indicating the patient’s sensitivity to any medication / drug must be included on the medication form and alert system (see T9.1).</td>
</tr>
<tr>
<td>T2.7 Consent requirements</td>
<td>Informed consent must be obtained in accordance with the relevant state / territory’s legislation. Sites are encouraged to develop their own practices to obtain consent, however the following can be used as a guideline. In general, a medical practitioner should explain the diagnosis or findings that warrant the procedure. The medical practitioner should explain to the patient (or patient’s representative) wherever practicable and reasonable: The nature, consequences and risks of the proposed medical treatment The likely consequences of not proceeding with the medical treatment; and Any alternative treatment or courses of action that might reasonably be considered in the circumstances of the particular case. To ensure that consent obtained from a patient is valid, it must: Be given voluntarily Be given with the knowledge of the material risks of the procedure Cover the procedure performed Cover the reason for the procedure Be given by a person legally and mentally competent to consent to medical treatment. Written consent ( a signed consent form) should be obtained for: Any surgical procedure Administration of an anaesthetic. Consent for the anaesthetic does not have to be obtained at the same time as consent to the primary...</td>
</tr>
</tbody>
</table>
procedure, this may undertaken as part of the pre-anaesthetic consultation (see T2.8)

- Procedures that may be regarded as sensitive (eg. breast, vaginal, genital or rectal examinations)
- Taking of photographs, video or audio recordings for inclusion in publications and educational material
- Blood transfusions

<table>
<thead>
<tr>
<th>T2.7 Consent requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent should always be obtained prior to administering pre-operative medication that is likely to impair cognitive powers.</td>
</tr>
<tr>
<td>A consent form for elective surgery should be completed at the time of consultation with the surgeon and prior to being placed on an elective surgery waiting list.</td>
</tr>
<tr>
<td>Consent must also be obtained for tissue(s) samples collected during a procedure. The patient must be advised of the intended use of these samples, including those intended for diagnostic and treatment purposes and / or ethically approved research, education and laboratory quality procedures.</td>
</tr>
<tr>
<td>The consent process may require the presence of another clinician as witness during the procedure. Where another clinician is present, this should be noted in the patient’s record.</td>
</tr>
<tr>
<td>Obtaining a patient’s signature on a consent form is not synonymous with obtaining consent. A consent form does not constitute consent but merely evidence that a procedure has been discussed between the medical practitioner and the patient. Wherever possible, discussions between the medical practitioner and the patient should also be documented in the patient’s (health) record, including the risks and consequences of proceeding with a procedure and specifically any concerns raised by the patient. Diagrams used to describe procedures should be included in the patient’s record. A notation should be made in the record if a patient is provided with material such as a drug information sheet or an educational video.</td>
</tr>
<tr>
<td>Should the patient seek to challenge the procedure or treatment they received or the adequacy of information provided to them about that procedure, evidence may be required to support the actions of the medical practitioner.</td>
</tr>
</tbody>
</table>

---

19 Note: This is a Victorian requirement for consent which is considered best practice.
Patients should be given the opportunity to sign a consent form in their own language if available. If a form is not available in a patient's own language, the form should be translated verbally by a professional registered interpreter (where possible), who should indicate on the consent form that such a verbal and literal translation has been given.

**NOTE:** Relevant standards and legislative requirements regarding consent should be sourced for each individual state / territory.

<table>
<thead>
<tr>
<th>T2.8 Anaesthesia Consultation</th>
<th>The Australian and New Zealand College of Anaesthetists have developed a range of guidelines for the administration of an anaesthetic available from <a href="http://www.anzca.edu.au/">www.anzca.edu.au</a>. These include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Pre-anaesthesia consultation (PS7)</td>
</tr>
<tr>
<td></td>
<td>• Anaesthesia record (PS6)</td>
</tr>
<tr>
<td></td>
<td>• Consent for anaesthesia &amp; sedation (PS26)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>T2.9 Operative Record</th>
<th>An operative record must be completed following surgery and filed in the health record. The operation record should include (as a minimum):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Date of the operation</td>
</tr>
<tr>
<td></td>
<td>• Pre-operative diagnosis</td>
</tr>
<tr>
<td></td>
<td>• Post-operative diagnosis</td>
</tr>
<tr>
<td></td>
<td>• Name of the surgical procedure performed</td>
</tr>
<tr>
<td></td>
<td>• Details of the procedure performed, including diagrams that are clear and self-explanatory</td>
</tr>
<tr>
<td></td>
<td>• Operative findings</td>
</tr>
<tr>
<td></td>
<td>• Record of tissue removed, altered or added eg. details of prostheses</td>
</tr>
<tr>
<td></td>
<td>• Record of pathology ordered</td>
</tr>
<tr>
<td></td>
<td>• Post-operative instructions</td>
</tr>
<tr>
<td></td>
<td>• Name of responsible consultant</td>
</tr>
<tr>
<td></td>
<td>• Name of surgeon</td>
</tr>
<tr>
<td></td>
<td>• Name of assistant surgeon</td>
</tr>
<tr>
<td></td>
<td>• Signature of surgeon who performed the operative procedure</td>
</tr>
</tbody>
</table>
| T2.10 Review of laboratory / imaging results | The responsibility for the follow-up of test results lies with the medical practitioner who ordered the tests. Appropriate protocols should be in place to ensure the results of all ordered tests are received and reviewed by the medical practitioner who ordered them.

For legal purposes and good clinical practice, the medical practitioner who ordered the test must verify that the laboratory/imaging results have been reviewed by initialling and dating the result. An **electronic signature**, which is date and time stamped, and includes the identity and designation of the practitioner, should be in place to indicate that electronic reports have been viewed. Any action taken based on the result should be noted in the record. |
|---|---|
| T2.11 Progress Notes | Following admission and initial examination of the patient, the attending medical practitioner should complete admission documentation which summarises the general condition of the patient and the problem or symptom that is being treated.

Additional documentation should be made following review of the patient which should include:
- Therapeutic orders and diagnostic tests
- Findings
- Decisions made
- Plans for treatment
- Reasons for change in treatment regime
- Procedures undertaken
- Patient’s reaction
- Patient’s status at the time treatment was discontinued and plans for follow-up care. |
| T2.12 Minimum documentation (in progress notes) | The medical practitioner should also document in the progress notes each time they visit and review the patient. As a minimum this should be:
- Whenever there is a significant event or change in the patient’s condition
- Daily for acute patients i.e. at least every 24 hours
- Weekly for long stay patients. |
### T2.13 Discharge Information

A range of documentation should occur at discharge which includes:

- Making a note in the progress notes detailing the time and date of discharge, destination and into whose care the patient has been discharged.

- Completing a discharge summary for ongoing care purposes

- A summary outlining relevant information for clinical coding and financial purposes. **NOTE:** In some cases the discharge summary may be utilised by clinical coders to extract information for clinical coding purposes. However, it is recognised that the discharge summary is often inadequate for coding purposes and a separate summary that meets coding requirements may be required.

The **discharge summary**\(^{21}\) is a concise summary of the patient’s episode of care and is utilised to inform health care providers of the patient’s health status when they next utilise the health care system. For example when the patient:

- Visits their general practitioner

- Receives treatment at the health service

A copy of the discharge summary should preferably be given to the patient on discharge, with the original filed in the health record. However, if this is not possible a discharge summary should be completed ideally within 24 hours of discharge (but within a maximum of one week) and a copy forwarded to the patient’s general practitioner (where applicable).

In circumstances where the medical practitioner treating the patient at the health service is also the patient’s general practitioner, it is strongly recommended that a summary of the inpatient episode is documented in the progress notes of the health record.

In completing the Discharge Summary:

- It is the responsibility of the medical practitioner and consultant responsible for the patient to prepare a complete discharge summary within 24 hours of discharge.

- The medical practitioner is responsible for completing all outstanding discharge summaries prior to the completion of their employment with the health service. In the event that the responsible medical practitioner does not complete all outstanding discharge summaries, the responsibility should be delegated to the next most senior medical officer.

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\(^{21}\) It is recognised that additional information regarding events summaries has been developed by NEHTA and is available at [www.nehta.gov.au](http://www.nehta.gov.au). The context of describing the completion of discharge summaries in this brief relates primarily to the hardcopy record.
The discharge summary should include (as a minimum):

- Name of the patient, unit record number, ward and address where the patient may be contacted, this may be a home address or institution eg. Nursing home
- Admission and discharge dates
- Name of the medical practitioner responsible for the patient and name of the consultant (where relevant)
- Presenting complaint
- Relevant past medical history
- Examination findings and treatment history
- Principal diagnosis, if a definitive diagnosis cannot be made at the time of discharge, it is acceptable to describe the diagnosis as a ‘query’, ‘probable’ or ‘suspected diagnosis’ if the patient has been treated for that condition.
- Other primary conditions
- Complications
- Comorbidities / pre-existing conditions
- Details of investigations, operations and procedures performed during the admission
- Any adverse events
- Prognosis and patient’s status on discharge
- List of discharge medication
- Information provided to the patient and family
- Arrangements for follow-up care eg. Appointments and check-ups
- Person responsible for future review and treatment of the patient
- Name, signature and designation of the person completing the discharge summary
- Date and time of completion of the discharge summary

**NOTE:** In the electronic environment a process to distinguish ‘interim’ versus ‘final’ versions of the discharge summary is required. It would be useful to stipulate a time period that information may be in the interim format, so as to ensure a final version is made available as soon as possible.
# TABLE 3: Documentation in progress notes - General

<table>
<thead>
<tr>
<th>T3.1 Progress Notes</th>
<th>Progress notes include information related to the course of the patient’s illness, response to treatment, observation, plans for continued care, reasons for actions taken and the status of the patient at discharge. Progress notes should be written as events occur and in chronological order. Documentation should be continuous with no gaps ie. no empty spaces between rows. Where there is a need to start writing on the next row, draw a line through the blank space so that information cannot be added at a later date. Information should be of sufficient detail to describe significant changes in a patient’s condition, treatment provided and the patient’s response. That is, documentation should justify the patient’s admission, treatment and length of stay in the health service. Where changes in treatment have occurred, the reason for the change should be clearly documented. All communications should be recorded, stating what was discussed and the outcome (if there was agreement or disagreement). Progress notes should be integrated with all clinical staff utilising the same progress note. This is the best means to facilitate communication between the health care team. Documentation should occur in the progress notes when: • A significant event occurs. For example, the patient falls out of bed • A decision is made to alter the patient’s treatment • A test or investigation has been ordered • The patient’s condition has improved or deteriorated • A consultation has occurred. For example, the patient’s condition has been reviewed by the medical team • Observations of the patient’s condition have been taken and any associated changes in the care plan for the patient noted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>T3.2 Advice provided over the phone</td>
<td>Clinical advice provided over the phone should be recorded on a progress note and filed in the patient’s health record if they have one and where adequate identification details are provided. The details recorded should include: • Patient identifying information for example, name and date birth • Date and time of the telephone call</td>
</tr>
<tr>
<td>• Signs/symptoms/history described by the patient</td>
<td></td>
</tr>
<tr>
<td>• Clinical information provided</td>
<td></td>
</tr>
<tr>
<td>• Authentication by the clinician providing the advice</td>
<td></td>
</tr>
</tbody>
</table>

If the patient does not already have a record the progress note should be maintained in a central location filed by patient name. Alternatively the conversation could be recorded in a central register or message book.
### TABLE 4: Clinical Documentation - Nursing

| T4.1 Nursing Assessment | A registered nurse should assess the patient on arrival or within 24 hours of the patient’s admission. The assessment should be recorded in either the progress notes or a designated assessment form. The assessment should include:  
  - Time of admission  
  - Current medication (if relevant)  
  - Reason for admission and medical diagnosis  
  - Condition on arrival  
  - Allergies or reactions  
  - Whether the family are aware of the admission etc.  
  - Relevant risk assessments e.g. falls, dementia |
| T4.2 Care Plan | A care plan should be developed which is based on the patient’s assessment and condition. The care plan should incorporate multi-disciplinary management and be individualised where appropriate. |
| T4.3 Progress Notes | The progress notes and care plan provide an accurate, concise and complete record of the patient’s progress and response to care. Nursing staff should ensure that documentation occurs on:  
  - Admission and initial assessment of the patient to the ward and within 24 hours  
  - Inter-ward transfers – where applicable a brief summary of progress, location transferred to and name of responsible medical practitioner  
  - Pre-operative / procedure – date, time and type of procedure to be performed  
  - Post-operative / procedure – date, time patient returned from theatre, state of consciousness, pain status, baseline observations, assessment etc.  
  - Incidents – if incidents occur, for example the patient slips in the shower, record the date and time of occurrence and a brief summary of the incident in the record (the associated incident report should not be filed in the patient’s record)  
  - As events / interventions occur – eg. tests are performed, blood taken. |
- Observations – eg. BP, temp, pulse etc. which may be recorded on specific forms
- As a minimum of once per shift - the patient’s status is noted at least once per shift even if there is no change in the patient’s status

**T4.4 Drug Orders**

When administering drugs to a patient according to the medical practitioner’s instructions, the registered nurse should document the following on the medication form:

- The time and date the prescribed drug is administered and/or
- The date the prescribed drug is ceased

**NOTE:** Administration of drugs via the phone is subject to a different process which will vary from state to state.

**T4.5 Recovery Record**

A recovery record outlining pertinent information regarding the patient’s condition on arrival, during and transfer from the recovery room following surgery should be maintained.

**T4.6 Discharge Documentation**

Discharge planning should commence prior to or at the time of admission. A discharge plan should be documented in the progress notes outlining the clinical needs of the patient prior to discharge.

A note should also be made in the progress notes when the patient is discharged. This should include:

- Date and time of discharge
- Patients intended destination eg. Home
- Referral to other health services as required
- Discharge medication provided to the patient
- Any follow-up appointments

**T4.7 Transfer Documentation**

When an inter-ward transfer occurs, the following minimum information should be documented in the progress notes:

- A brief summary of the patient’s progress to date
- The ward the patient is being transferred to
- The name of the medical practitioner (consultant) notified of the transfer
### TABLE 5: Allied Health Documentation

| T5.1 General | Where possible, treatment provided by allied health clinicians should be recorded in the patient’s unit health record\(^{22}\). There may be circumstances where individual disciplines maintain departmental records separate to the unit health record. In this instance, a summary of the information should be included in the unit record from time-to-time to facilitate continuity of care. In addition, the departmental record and unit health record should be cross-referenced to indicate the presence of each. |
| T5.2 Initial Entry | The initial entry should indicate acknowledgment of referral, including who referred the patient, from where the patient was referred and treatment previously provided. |
| T5.3 Assessment | An initial assessment of the patient should be noted in the progress notes. |
| T5.4 Progress report | Regular assessment of the patient’s progress and interventions should be documented in the progress notes for continuity of care purposes. |
| T5.5 Discharge report | At the time of discharge or when ongoing treatment ceases\(^{23}\), a note should be made in the progress notes (or separate form) outlining the patient’s condition, recommendations for further management, equipment supplied and other arrangements made for the patient. |

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\(^{22}\) The unit health record is an entity within the health service (or health enterprise) that contains the patient’s health information.

\(^{23}\) It is recognised that additional information regarding events summaries has been developed by NEHTA and is available at [www.nehta.gov.au/](http://www.nehta.gov.au/).
### TABLE 6: Non-admitted Patient Documentation

| T6.1 General | All non-admitted patients who receive a service must be registered on the Patient Master Index\(^{24}\) and allocated a unit record number\(^{25}\). Non-admitted patient information should be documented in the unit health record. Where documentation in the unit health record is not possible a record management system must be in place to ensure that the patient’s health information is stored in a manner that facilitates prompt access and retrieval; and complies with access, security and retention requirements, for example the patient’s non-admitted information (forms and associated documentation) must be filed in a central location by unit record number. When a unit health record (physical hard copy) is created, all non-admitted information must be filed in the record.  

| T6.2 Outpatient & Outreach | As a minimum the following information should be documented:  
- Date and time of occurrence of the service  
- Relevant history of illness or injury  
- Relevant physical examination & assessment  
- Treatment / intervention provided  
- Diagnostic and therapeutic orders / plans  

| T6.3 Emergency Attendance | The following information should be documented as part of the emergency attendance:  
- Demographic details  
- Date, time and means of arrival  
- National triage score  
- Date and time first seen by the nurse  
- Date and the time seen by the clinician  
- Care given prior to arrival (a copy of the ambulance record may be included in the record)  
- History of the presenting illness, physical findings, vital signs  
- Diagnostic and therapeutic orders including the results  
- Clinical observations and treatment given  

\(^{24}\) An index or database register that uniquely identifies all patients who have received or are scheduled to receive a health service. For more information see the glossary of terms.  
\(^{25}\) A unique identification number assigned to a patient when they receive a health service, it is used to identify the patient and their associated health information over the continuum of care. For more information see the glossary of terms.
| • Patient’s state on discharge and any instructions given to the patient / family for follow-up care |
| • Date and time of discharge |

A summary outlining the care and treatment provided to the patient during the emergency service (where the patient does not become an inpatient) and management plans should be documented. The most common receiver of the event summary is the patient’s General Practitioner but could be other health care providers involved in treating the patient.
TABLE 7: Diagnostic Reports

| T7.1 General | Diagnostic reports are to be accessible to health care practitioners within 24 hours (of the laboratory completing the analysis) to facilitate treatment of the patient. To eliminate excessive reports, daily reports should be destroyed when cumulative reports are made available. Cumulative reports should be clearly marked as such. The reports are to be incorporated into the patient’s health record after the medical practitioner has signed and dated them.

The ordering of investigations and tests, as well as any subsequent abnormal results and action taken / recommended by the medical practitioner based on the result, should be documented in the progress notes of the patient’s health record. To ensure this occurs a process needs to be in place to ensure the results are reviewed in a timely manner and appropriate action taken.

Reports containing test results (whether written or in electronic format) should provide sufficient information to clearly specify:

- Identity of the patient (this may include the patient name, date of birth and sex as well as the unique identifier allocated by the health service, or other relevant information as requested by the diagnostic service provider)
- The result(s) of the test(s) being reported
- The type of specimen on which the testing was performed
- The date and time (if appropriate) of specimen collection
- The quantitative or qualitative result
- The units of measurement
- Age and gender related reference intervals if appropriate
- The identity of the laboratory or laboratory group which performed the test(s)
- The requestor and address(es) for delivery
- The identity of the laboratory or organization issuing the report; and
- The name of the person responsible for the issued report.26

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26 National Pathology Accreditation Advisory Council, Standards for Pathology Laboratories (standard 7)
NOTE: In the electronic environment the report of the diagnostic result forms part of the health record. If a dual system exists, a hard copy of the test result should be printed and filed in the paper based health record. The medical practitioner should authenticate the result by signing and dating it.

For the complete management of test results in the electronic environment (i.e. no hardcopy printed) appropriate record management requirements such as authentication and clinician review processes, version control and metadata requirements are required. For example, metadata needs to be made available:

- To identity the patient
- Indicate who ordered the test
- When it was ordered, date and time
- The laboratory that performed the diagnostic test,
- The date and time the results were released by the laboratory
- The date and time the results were received at the health service
- The medical practitioner who reviewed the results (including an appropriate signature)
- The date and time the results were reviewed.

In addition, the test result and metadata must remain accessible for the retention period of the health record in order to meet freedom of information requests, legal, risk management and evidential requirements.

Electronic transmission of test results and / or reports must be provided in a secure and confidential manner. Prior to providing access to patient results, the laboratory must verify the fidelity of the results in the transmission process27.

Urgent test results may be communicated by telephone or similar procedure to a responsible medical practitioner or other authorised person, with due care to prevent mistakes. The result must be documented in the progress notes of the patient’s health record. A telephone or verbal report should always be followed by an authorised written or electronic report.

<table>
<thead>
<tr>
<th>T7.2 Medical imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>A report of the findings of the medical image and implications for the patient should be documented by the radiologist. The report should be made available to the medical practitioner who ordered the x-ray (usually the practitioner responsible for the patient’s care) and filed within the</td>
</tr>
</tbody>
</table>

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27 National Pathology Accreditation Advisory Council, Standards for Pathology Laboratories (Standard 7)
patient’s health record within 24 hours of receipt.

In circumstances where the x-ray is taken by the medical practitioner (or other qualified person) and not viewed by a radiologist, the medical practitioner should document the findings on x-ray in the patient’s health record for example, ‘x-ray of femur indicated no abnormalities detected’.

<table>
<thead>
<tr>
<th>T7.3 ECG Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECG reports should be generated by the cardiologist and filed in the patient’s health record within 24 hours of receipt. The ECG tracing should be filed in the health record, by attachment to an A4 backing sheet or inserted into an envelope, which is filed in the record.</td>
</tr>
<tr>
<td>If this is not possible due to space issues, the ECG tracings are to be stored securely and a reference made in the health record of the existence of the tracings.</td>
</tr>
<tr>
<td><strong>NOTE:</strong> Some types of paper used in ECG tracings may fade over time and appropriate measures for retention are required for example, utilizing paper that does not fade or photocopying the ECG tracings.</td>
</tr>
</tbody>
</table>
### TABLE 8: Correspondence

| T8.1 General | Correspondence relating to patient care should be maintained in a separate section of the patient’s health record, known as the correspondence section. 
This should include:  
- Correspondence received by the health service, for example referral letters, requests for information  
- Correspondence produced by the health service, for example transfer and referral letters  
Correspondence less that A4 in size should be attached to an A4 size correspondence form. A suitable adhesive such as permanent glue should be used to attach the correspondence. If hard copy correspondence is converted to electronic format business rules are required to manage the conversion process, for example:  
- Capture of the associated metadata  
- A means of authenticating that the electronic version is a true and accurate representation of the original hard-copy  
Business rules are also required to manage the use of emails when exchanging information about the clinical condition of the patient, for example:  
- Clearly defined circumstances when email can and cannot be used  
- Who can send emails and to whom they may be sent  
- Security requirements for the use of email such as encryption  
- When and how the email is to be incorporated in the patient’s health record (whether electronic record or paper)  
- How metadata associated with the email is captured and stored |
### TABLE 9: Other Information Requirements

| T9.1 Alert / adverse reaction | A process to manage adverse reactions and alert information needs to be incorporated into the record. This process will differ in the paper versus electronic format. NEHTA\(^28\) has developed a range of specifications for alert and adverse reactions. However, regardless of record format, business rules regarding the management of the alert system need to be considered, for example:

- What alert / adverse reaction information will be included
- Who can enter or remove information pertaining to the alert / adverse reaction
- Authentication by the person entering the information, that is who recorded the alert / adverse reaction and the date and time
- When the alert / reaction occurred and the severity (where relevant)
- Who reported the alert / adverse reaction eg. patient, carer, administrative purposes
- Length of time the alert is valid, including a review date
- If the alert is removed, authentication by the person who removed the alert

In the electronic environment, the means for viewing and printing any alert information needs to be considered.

In the paper environment, information regarding an alert / reaction should be documented on an alert form which is filed in the front of the medical record. A sticker or stamp is then placed on the front cover of the record to indicate the presence of the alert form. The actual nature of the alert should not be recorded on the front cover of the record.

The following type of information may noted on the alert / adverse reaction form:

- Drug reaction / allergies (an alert sticker should also be placed on the patients medication form see T2.6). The agent that caused the reaction and any signs and symptoms the patient experienced
- Any other sensitivities or reactions
- Serious systemic and infectious diseases

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- Bleeding disorders
- Biohazard information / sticker
- Presence of anticipatory directions and / or medical power of attorney
- Determinations under the Guardianship and Administration Act
- Annotation to information under the FOI Act
- Suicide risk
- Drug trial information
- Presence of departmental or enterprise records including patient handheld records
- Patient with a similar name
- Other legislative requirements applicable to the patient eg. child protection related issues

<table>
<thead>
<tr>
<th>T9.2 Patient identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each form in the health record must contain the patient’s identification. Patient identification requirements for medical record forms are outlined in Australian Standard AS2828. Minimum patient identification should include:</td>
</tr>
<tr>
<td>- Patient name (given name and family name)</td>
</tr>
<tr>
<td>- Unit record number</td>
</tr>
<tr>
<td>- Sex</td>
</tr>
<tr>
<td>- Date of birth</td>
</tr>
<tr>
<td><strong>NOTE</strong>: An appropriate means of addressing patient identification in the electronic environment is required particularly if the electronic record is made available in hardcopy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>T9.3 Departmental Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where ever possible a unit health record(^{29}) should be maintained for the patient. Separate records should not be created where the unit health record is sufficient for keeping and maintaining information relating to services in a specific department. Basic identifying information such as contact details, next of kin, primary diagnosis and medication information may be kept within a department without being considered a departmental record which is separate to the unit health record.</td>
</tr>
<tr>
<td>Where departmental records are created, the following general principles are applicable:</td>
</tr>
</tbody>
</table>

\(^{29}\) The unit health record is an entity within the hospital (or health enterprise) that contains all health information about the patient. For more information see the glossary of terms.
• The patient’s unit health record should reflect the fact that a departmental record exists, for example by use of the alert system or tracking system.

• Departments wishing to maintain a departmental record should ensure adequate record management practices are in place. These include appropriate storage and access requirements are adhered to, legislative retention / disposal periods are met and the record is secure.

• To facilitate continuity of care, a summary of the information contained in the departmental record should be made from time to time and filed in the unit health record.

If the patient has a personal health record such as a ‘Pregnancy hand-held record’ this should be noted in the alert system of the unit health record. It is recommended that the original hand-held record is to remain with the patient during the course of care. When the care is completed the record is to be photocopied with the original filed in the unit health record and a copy offered to the patient.
APPENDIX 1 – Legal Obligations

The following is a list of Commonwealth and State legislation and the relevant sections of the Acts that pertain to the management of records and information.

<table>
<thead>
<tr>
<th>COMMONWEALTH LEGISLATION AND BODIES</th>
<th>Privacy Act 1988 (Commonwealth)</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.privacy.gov.au/">www.privacy.gov.au/</a></td>
<td>Privacy Act 1988 (Cth) incorporates the amendments made to it by the Privacy Amendment (Private Sector) Act 2000 (Cth).</td>
</tr>
</tbody>
</table>

Additional information regarding recordkeeping can be accessed from the following websites:
www.naa.gov.au

<table>
<thead>
<tr>
<th>COMMONWEALTH LEGISLATION AND BODIES</th>
<th>Electronic Transactions Act 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Validity of electronic transactions</td>
<td></td>
</tr>
<tr>
<td>9 Signatures</td>
<td></td>
</tr>
<tr>
<td>10 Production of document</td>
<td></td>
</tr>
<tr>
<td>11 Retention of information and documents</td>
<td></td>
</tr>
<tr>
<td>13 Time and place of dispatch and receipt of electronic communications</td>
<td></td>
</tr>
<tr>
<td>14 Attribution of electronic communications</td>
<td></td>
</tr>
</tbody>
</table>

Freedom of Information Act 1982

The Commonwealth FOI Act is aimed at extending ‘as far as possible, the Australian community’s right of access to information in the possession of the Commonwealth’. The Commonwealth Attorney-General’s Department is the agency with overall responsibility for the legislation with implementation by each government agency. The Act applies to the documents held by the majority of Commonwealth agencies. Australian State and Territories have also enacted their own FOI legislation that applies both to state and local government agencies.

<table>
<thead>
<tr>
<th>AUSTRALIAN STANDARDS</th>
<th>AS 2828—1999, Paper-based health care records</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AS 5017-2006 - Health Care Client Identification</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STATE LEGAL OBLIGATIONS</th>
<th>RELEVANT ACTS PER STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>ACT Health Records (Privacy and Access) Act 1997</td>
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New South Wales | Electronic Transactions Act 2000 No 8 |
These acts can be accessed from the website
www.legislation.nsw.gov.au
Additional information regarding record keeping practices can be found on the State Records website

<table>
<thead>
<tr>
<th>No.</th>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>7</td>
<td>Validity of electronic transactions</td>
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<td>Signatures</td>
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<td>Attribution of electronic communications</td>
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<td><strong>Evidence Act 1995 No 25</strong></td>
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<tr>
<td>48</td>
<td>Proof of contents of documents</td>
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<tr>
<td>51</td>
<td>Original document rule abolished</td>
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<td>Division 1 Request to produce documents or call witnesses</td>
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<td><strong>Freedom of Information Act 1989 No 5</strong></td>
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<td>Right of access to agencies’ documents</td>
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<td>25</td>
<td>Refusal of access</td>
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<td>31</td>
<td>Documents affection personal affairs</td>
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<td>32</td>
<td>Documents affection business affairs</td>
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<td>39</td>
<td>Right to apply for amendment of agencies’ records</td>
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<td><strong>State Records Act 1998 No 17</strong></td>
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<td>12</td>
<td>Records management obligations</td>
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<td>Part 6 Public access to State records after 30 years</td>
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<tr>
<th>Northern Territory</th>
<th><strong>Information Act 2003</strong></th>
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<tbody>
<tr>
<td><a href="http://www.nt.gov.au/dcm/legislation">www.nt.gov.au/dcm/legislation</a></td>
<td>The Act applies to public sector organisations and provides for the responsible collection and handling of personal information, public access to and correction of personal information, and records and archives management in the public sector.</td>
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<td><a href="http://www.nt.gov.au/dcis/nta/">www.nt.gov.au/dcis/nta/</a></td>
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<tr>
<th>Queensland</th>
<th><strong>Health Services Act 1991</strong></th>
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<tr>
<td>These acts can be accessed from Queensland Office of parliamentary counsel at</td>
<td>62A Confidentiality</td>
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<tr>
<td><a href="http://www.health.qld.gov.au/legislation/default.asp">www.health.qld.gov.au/legislation/default.asp</a></td>
<td>62D Disclosure to person who has sufficient interest in health or welfare of person</td>
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<td>62F Disclosure of confidential information in the public interest</td>
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<td>21 Right of access</td>
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<td>South Australia</td>
<td>Evidence Act 1929</td>
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<td>These acts can be accessed from the website:</td>
<td>45A Admission of business records in evidence</td>
</tr>
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<td><a href="http://www.legislation.sa.gov.au/index.aspx">www.legislation.sa.gov.au/index.aspx</a></td>
<td>23 Copies so transmitted to be as valid and effectual as originals</td>
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<td>Additional information regarding record keeping practices can be found on the State Records website</td>
<td>Part 6 – Computer evidence</td>
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<td><a href="http://www.archives.sa.gov.au">www.archives.sa.gov.au</a></td>
<td>59A Interpretation</td>
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<td>59B Admissibility of computer output</td>
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<td>Freedom of Information Act 1991</td>
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<td>30 Right to apply for amendment of agencies’ records</td>
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<td>31 Applications for amendment of agencies’ records</td>
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<td>35 Refusal to amend records</td>
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<td>37 Notations to be added to records</td>
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<td>State Records Act 1997</td>
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<td>13 Maintenance of official records</td>
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<td>14 Standards relating to record management practices</td>
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<td>15 Surveys of official records and record management</td>
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<td>16 Inadequate record management practices to be reported</td>
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<td></td>
<td>17 Damaging, etc., of official records</td>
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<td>23 Disposal of official records by agency</td>
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<tr>
<th>Tasmania</th>
<th>Freedom of Information Act 1991</th>
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<tr>
<td><a href="http://www.thelaw.tas.gov.au/">www.thelaw.tas.gov.au/</a></td>
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<td>37 Notations to be added to records</td>
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<td>Website</td>
<td>Text</td>
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38 Form of request for amendment of information  
44 If request refused  
45 Notice to be added to the information |
| | Evidence Act 2001  
48 Proof of contents of document  
146 Evidence produced by processes, machines and other devices |
| | Archives Act 1983  
10 Preservation of State Records  
20 Disposal, destruction of State Records  
21 Alterations  
Personal Information Protection Act 2004  
16 Personal information protection principles |
| Victoria  
Part 5 – Access to Health Information  
Freedom of Information Act 1982  
Public Records Act 1973 |
| Western Australia  
Part 3 Record Keeping Plan for Government Organisations  
Freedom of Information Act 1992  
Part 3-Amendment of personal information  
Division 1-Applications for amendment  
45 Right to apply for information to be amended  
48 Agency may amend information  
50 Request for notation or attachment disputing accuracy of information  
51 Other users of information to be advised of requested amendment  
52 Agency may give reasons for not amending information  
FOI Regulations 1993 |
APPENDIX 2 – List of Stakeholders Consulted

The practice brief was distributed to the following organisations for comment.

- Australian Association of Social Workers
- Australian Society of Anaesthetists Ltd
- Australian Society of Orthopaedic Surgeons
- Australian Nursing Federation
- Australian Physiotherapy Association
- Australian Association of Occupational Therapists
- Curtin University, School of Health Information Management
- Dietitians Association of Australia
- La Trobe University, School of Health Information Management
- Medical Indemnity Protection Society
- Royal Australian and New Zealand College of Psychiatrists
- Royal Australian College of General Practitioners
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal Australasian College of Physicians
- Royal Australian College of Surgeons
- Rural Doctors Association of Australia
- The Australian Psychological Society
- The University of Sydney, School of Health Information Management
- Queensland University of Technology, School of Health Information Management

The brief was also distributed to the HIMAA State Branches for comment by HIMAA members.