



RACGP

Quality health records in Australian primary healthcare

A guide





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While the text is directed to health professionals possessing appropriate qualifications and skills in ascertaining and discharging their professional (including legal) duties, it is not to be regarded as clinical advice and, in particular, is no substitute for a full examination and consideration of medical history in reaching a diagnosis and treatment based on accepted clinical practices.

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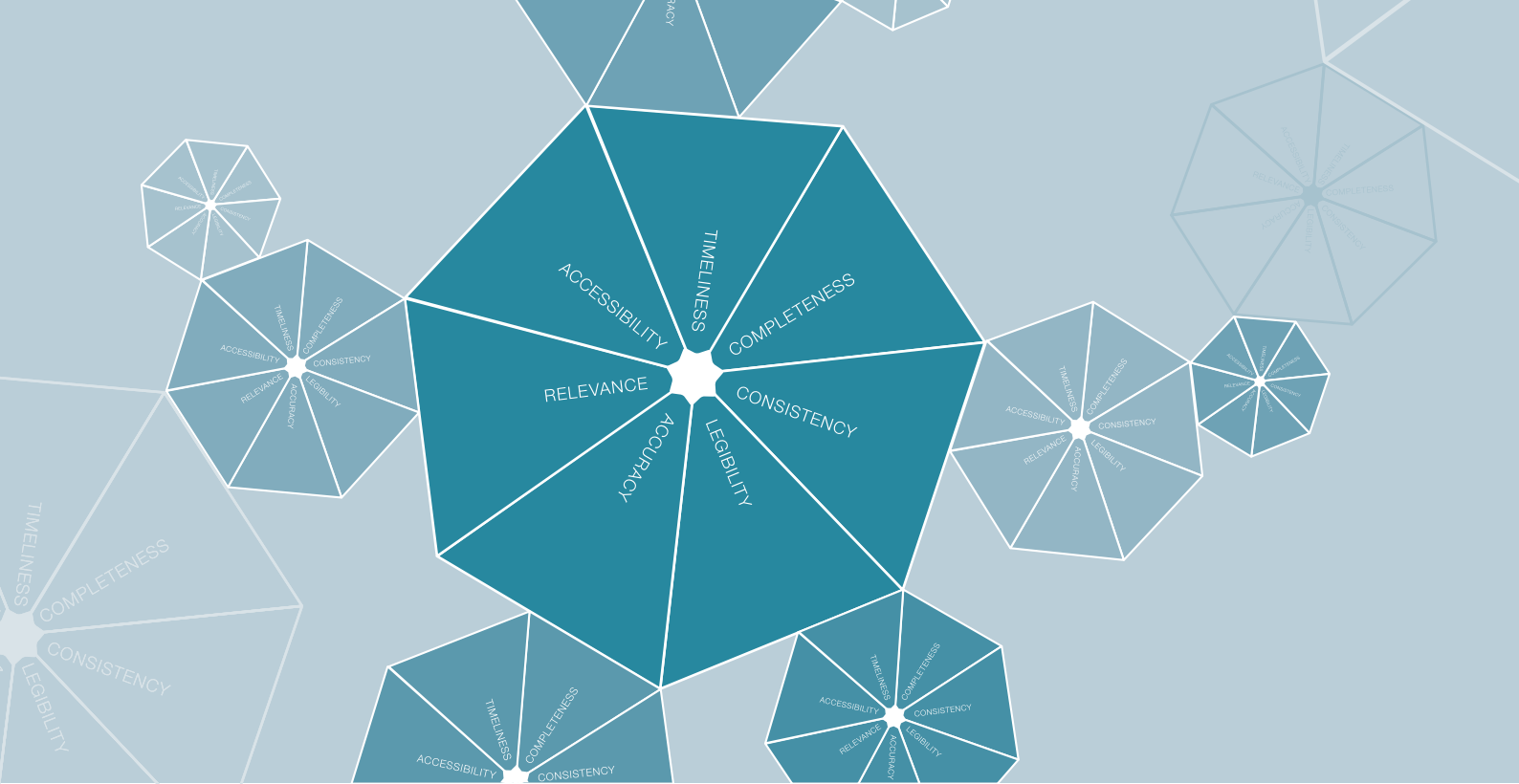
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The Royal Australian College of General Practitioners
100 Wellington Parade
East Melbourne VIC 3002 Australia

Tel +61 03 8699 0414
Fax +61 03 8699 0400
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RACGP

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Acknowledgements

Australians have a recognised right to receive safe and high-quality healthcare. Safe and high-quality healthcare depends on the sharing of health information from quality health records.

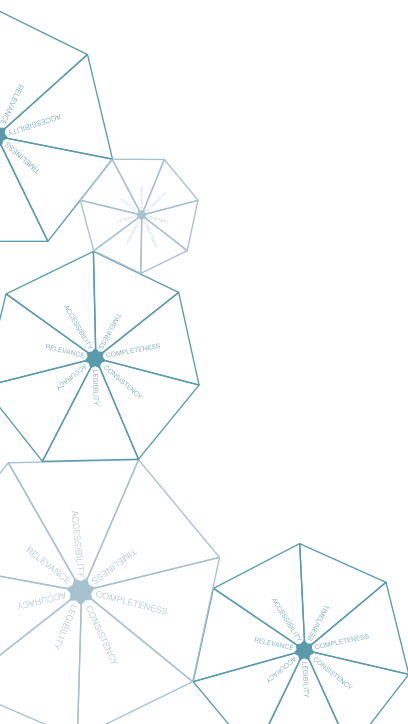
Until now, there has been no single document setting out common expectations on quality health records for the various regulated and self-regulated primary health disciplines in Australia. This has meant the sharing of quality information – within and between disciplines – has potentially been compromised, with a consequent impact on the continuity of healthcare.

With the intent of addressing this scenario, The Royal Australian College of General Practitioners (RACGP) convened an interprofessional Advisory Group to develop a guide on quality health records for application across the Australian primary healthcare sector.

Quality health records in Australian primary healthcare: A guide is based on work undertaken in the United Kingdom by the British Medical Association, the Royal College of General Practitioners and the Department of Health. The RACGP is grateful for the generous support that these organisations have demonstrated for our Australian project.

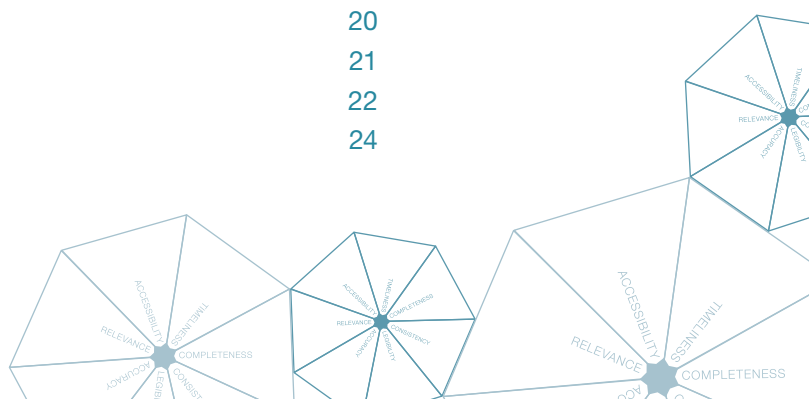
The RACGP would particularly like to thank members of the interprofessional RACGP Advisory Group on Quality Health Records in Australian Primary Healthcare and the numerous stakeholders who provided feedback that enabled the Guide to be refined through successive drafts.

This project has been funded under the *Personally Controlled Electronic Health Record Program* and is supported by the Australian Government Department of Health and Ageing.



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Preamble

The future is here

A complete medical record is essential to reliable continuity of medical care. A complete, highly structured, problem-oriented medical record will be invaluable to any physician and is essential to the busy one.¹

These arguments, put by Weed back in 1968, are even more pertinent in the information age of the 21st century, where health professionals need to deal scientifically with unique combinations of multiple interacting problems in a rapidly changing environment, and where patients have the right and the desire to access their own health information via a national e-health record system.

Quality health records are inarguably a cornerstone of safe, quality healthcare in the 21st century.

Background

The Australian primary healthcare sector comprises health professionals with primary contact status – doctors, nurses and allied health professionals. The majority of these health professionals are regulated by national boards working in partnership with the Australian Health Practitioner Regulation Agency. The primary healthcare sector also includes health professionals who are self-regulated.

Within the primary healthcare sector, health professionals share patient health information in order to achieve safe and effective continuity of care and optimal health outcomes for the Australian community. Increasingly, health records in the Australian primary healthcare sector are in electronic format and there is a move towards a national e-health record system. This contemporary environment has reinforced the importance of high-quality health records containing health information fit for sharing with colleagues and fit for sharing with patients as partners in healthcare.

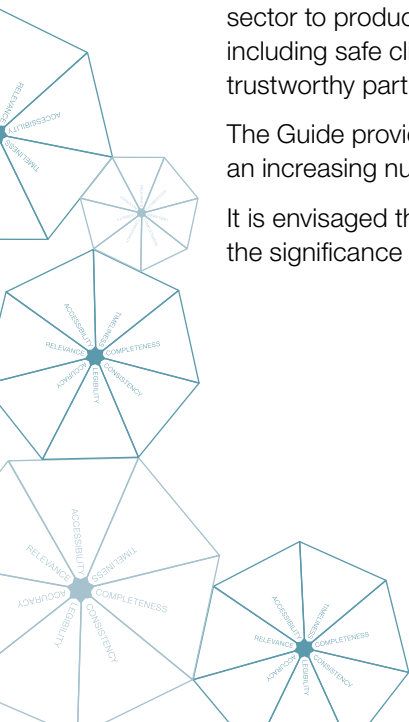
In this context, The Royal Australian College of General Practitioners (RACGP) initiated the development of *Quality health records in Australian primary healthcare: A guide* (the Guide) in consultation with colleagues across the Australian primary healthcare sector to establish core expectations on quality health records.

Purpose of the Guide

The Guide is designed to assist health professionals working in the Australian primary healthcare sector to produce, manage and use high-quality health records that are fit for a range of purposes including safe clinical decision making, good communication with other health professionals, trustworthy partnerships with patients and effective continuity of patient care.

The Guide provides a community reference on the essential attributes of quality health records, as an increasing number of Australians register to participate in a national e-health record system.

It is envisaged the Guide will support the education of health professionals and the community on the significance and the attributes of quality health records.



Why quality health records matter

The Guide is built on the concept that quality health records are fundamentally important because:

- Australians have a recognised right to receive safe and high-quality care²
- primary healthcare increasingly involves multidisciplinary teams that need to share health information
- health information fit for supporting safe and high-quality healthcare depends on quality health records
- Australians have a right to access their own health records³ and be partners in their own healthcare
- quality health records provide sound evidence of healthcare for medicolegal purposes.

Format of the Guide

The Guide is based on relevant themes from the scientific literature and, in particular, on the good practice guidelines⁴ jointly developed by the Department of Health, Royal College of General Practitioners and the British Medical Association for general practitioners in the United Kingdom (the UK guidelines).

The UK guidelines describe six key areas that have an important collective impact on the quality of health records. These six key areas have been adapted for the Australian environment as follows:

1. Information quality and primary healthcare
2. Essential attributes of quality health records
3. Capturing information in the consultation
4. Capturing information from other sources
5. System-specific issues
6. Information sharing and a national e-health record system.

The Guide describes a set of core principles for each of these six key areas and includes tips for compliance and clinical examples to illustrate the application of particular principles in day-to-day clinical practice within the Australian primary healthcare sector. The tips and examples are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

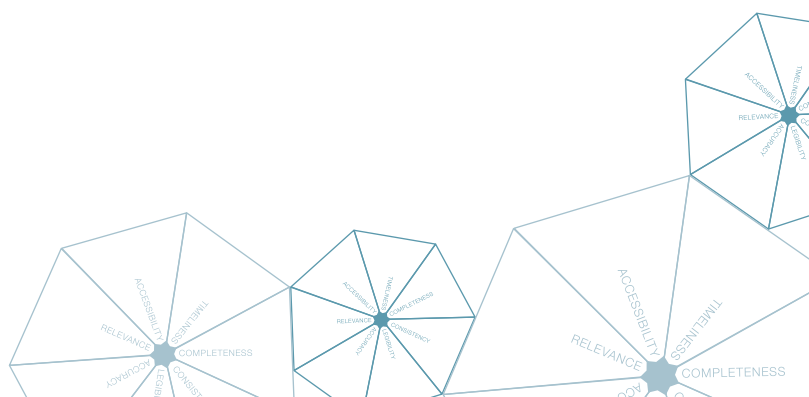
Scope of the Guide

The Guide is intended to be a user-friendly source of information on quality health records. The Guide is not designed to impose new professional obligations over and above recognised best practice.

The Guide is applicable to all health professionals operating in the Australian primary healthcare sector whether as solo practitioners, members of single-discipline practice teams, members of multidisciplinary practice teams or members of larger organisations.

The Guide covers electronic health record systems, paper-based health record systems and hybrid health record systems (a combination of paper and electronic systems).

The Guide is general in nature and should be interpreted in the context of particular circumstances and particular risks (e.g. the imperative for quality that comes with the sharing of health information to sustain good continuity of care and the additional risks associated with hybrid health record systems⁵).



The Guide should be applied in the context of existing legislation, charters, codes of conduct, professional standards, clinical guidelines or policies and position statements relevant to particular disciplines and organisations within the Australian primary healthcare sector. For example, the Guide should be applied in the context of:

- the Australian Charter of Healthcare Rights⁶
- the Australian Safety and Quality Framework for Healthcare⁷
- privacy legislation
- legislation that regulates the health disciplines overseen by national boards working in partnership with the Australian Health Practitioner Regulation Agency
- legislation governing a national e-health record system.

Out of scope

The Guide does not cover separate issues such as prescriptive data requirements,^a mandatory reporting, clinical handover, technical infrastructure, technical systems, audit systems, privacy and confidentiality, retention of health records, desirable advances in electronic health record systems or changing from paper-based to electronic health record systems.

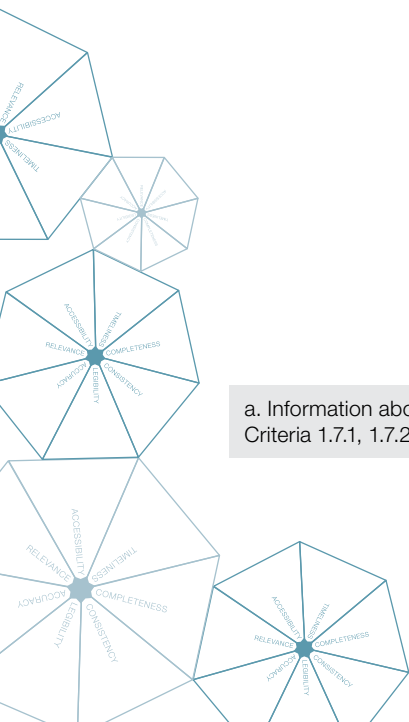
Sharing health information

Although issues of privacy and confidentiality lie outside the immediate scope of this Guide, they are nevertheless fundamental to the proper sharing of health information with other health professionals, patients and specified third parties, and to what health professionals need to consider before passing health information on to others.

In all instances where the Guide refers to the ‘sharing’ of health information, this is intended to cover:

- the appropriate use and disclosure of information by a health professional including circumstances where use or disclosure is required or authorised by law (e.g. where a health professional may need to use or disclose information to lessen or prevent serious threats to life, health or safety)
- a patient’s consent – whether express or implied – to the collection, use and disclosure of health information
- a patient’s right to access their own health information including circumstances where denying access is required or authorised by or under law (e.g. where access to the information would pose a serious threat to the life or health of any individual).

a. Information about the core content of health records, health summaries and consultation notes may be found in Criteria 1.7.1, 1.7.2 and 1.7.3 of the RACGP *Standards for general practices* (4th edition)



Terminology

The terminology used in the Guide is designed to enhance the clarity of the text.

Designated team member: This means a nominated member of the team charged with a particular role and related responsibilities where this role may constitute all or part of the person's work within the team and where the role may be shared with colleagues (e.g. nominated administrative staff responsible for managing health information from other sources). For a solo practitioner, the term 'designated team member' means that health professional.

Health information: This is generally used to mean information or an opinion, including information collected by a healthcare provider during a consultation, in relation to the health, illness or disability of an individual.

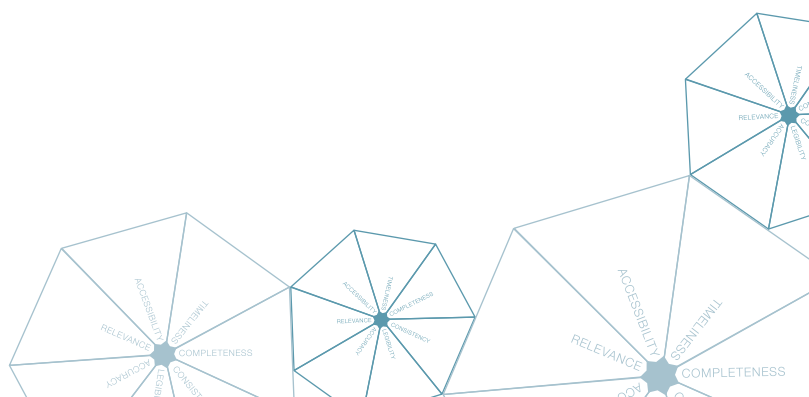
Health professionals commonly see the terms 'health data' and 'health information' as interchangeable although strictly speaking data are considered as raw facts (generally stored as characters, words, symbols, measurements or statistics) that require processing before they become information and knowledge.⁸ To enhance the clarity of the Guide, the term 'health information' is generally used to cover health information and health data.

Health professional: This is used to mean any clinician working in the Australian primary healthcare sector, whether as a solo practitioner, a member of a single-discipline practice team or a member of a multidisciplinary practice team.

Primary healthcare practices and organisations: In Australia, primary healthcare is largely delivered via office-based private practices and state-funded and managed community health organisations. While the Guide applies equally to such practices and organisations, to simplify the text, the term 'practice' is used to mean either a practice or a community health organisation.

Implementation and review

The Guide becomes available for use from July 2013 and will be reviewed by the RACGP from time to time in consultation with other key stakeholders.



Summary of principles for quality health records

Section 1: Information quality and primary healthcare

1.1 Information for multiple purposes

Health professionals should appreciate the range of primary and secondary purposes for which health records are used and quality health information is required.

1.2 Main purpose of health records

Health professionals should remember the main purpose of health records is to support safe and high-quality healthcare for individual patients and practice populations.

1.3 Expect to share

Health professionals should expect to share health information with colleagues and with patients to facilitate safe and effective healthcare.

1.4 Governance

There should be a designated person within each practice team who is responsible for championing quality health records, including quality improvement initiatives, education and training.

Section 2: Essential attributes of quality health records

2.1 Achieving the quality attributes

Health professionals should ensure the information they record in health records is complete, consistent, legible, accurate, relevant, accessible and timely.

2.2 Quality improvement

Health professionals should review their health records and record-keeping practices regularly in the areas of completeness, consistency, legibility, accuracy, relevance, accessibility and timeliness to identify areas for quality improvement.

Section 3: Capturing information in the consultation

3.1 Recording consultations

Every consultation should be recorded in the correct health record and the treating health professional should be identified.

3.2 Recording problems

The presenting problem(s), possible differential diagnoses and recommended management plan should be recorded in the correct health record.



3.3 Standardised terminology and recognised coding systems

When recording health information, health professionals should endeavour to use standardised terminology, nationally recognised coding systems and structured data entry to complement free text narrative.

3.4 Respectful language

Health professionals should use respectful and unambiguous language when recording health information using free text narrative.

Section 4: Capturing information from other sources

4.1 Incorporating information from other sources

Practices should have a documented system for receiving, reviewing and incorporating health information from other sources into the correct health records, and this system should support patient confidentiality, safe clinical handover and effective continuity of care.

4.2 Roles and responsibilities

Practices should have designated team members with defined roles and responsibilities for managing health information from other sources.

Section 5: System-specific issues

5.1 Policies and procedures

Practices should establish, implement and review documented policies and procedures to optimise the operation of their health record systems.

5.2 Managing risk

Practices should establish, implement and review documented policies and procedures for managing risk in their health record systems.

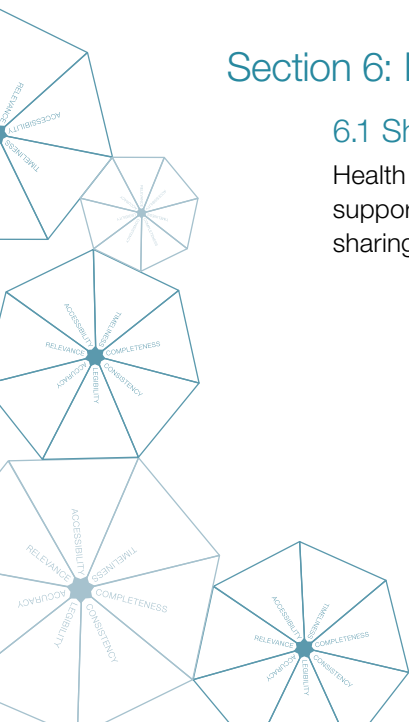
5.3 Education and training

Practices should provide appropriate education and training for clinical and administrative staff on the importance of quality health records, the essential attributes of quality health records and the successful operation of health record systems.

Section 6: Information sharing and a national e-health record system

6.1 Shared professional obligation

Health professionals have an obligation to capture and record information in ways that support accurate patient identification and that produce quality health information fit for sharing with colleagues and patients.

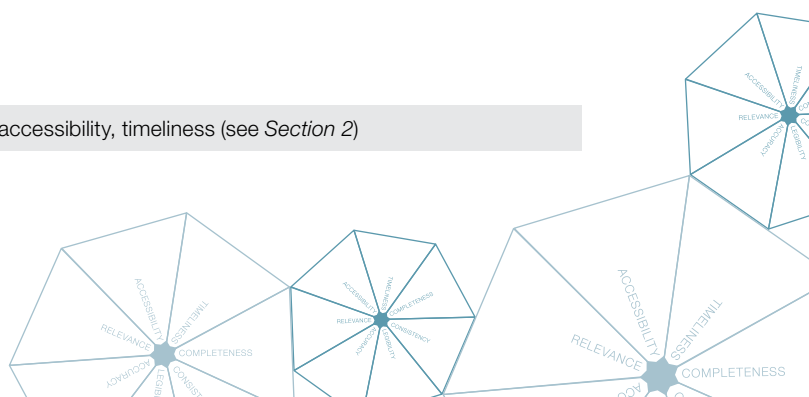


Sample compliance checklist for quality health records

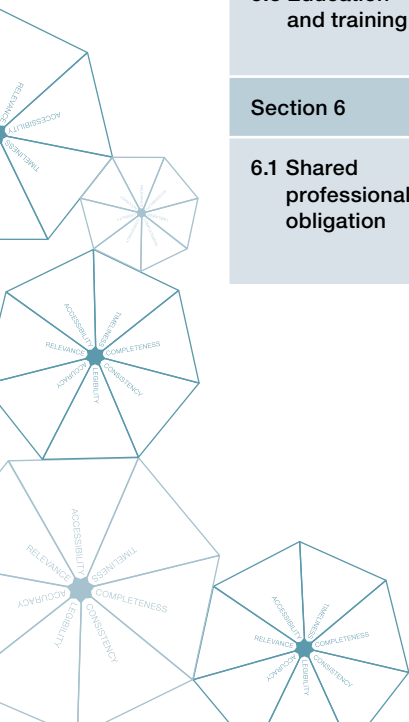
This sample compliance checklist provides examples of simple ways a practice could regularly assess the quality of its health records against the expectations outlined in this Guide. It is assumed practices will customise the checklist to suit their own circumstances using the tips for compliance listed under each section to generate their own ideas.

Principle	Sample compliance check	Status
Section 1	Information quality and primary healthcare	
1.1 Information for multiple purposes	Education session on the primary and secondary purposes of health records	
1.2 Main purpose of health records	Education session on the importance of quality health records for safe and effective healthcare	
1.3 Expect to share	Education session on the proper sharing of health information with other health professionals, patients and specified third parties, and what health professionals need to consider before passing health information on to others	
1.4 Governance	Designated quality health record champion and responsibility for quality health records in the position descriptions of relevant team members	
Section 2	Essential attributes of quality health records	
2.1 Achieving the quality attributes	Random audit of health records (using CCLARAT ^b parameters) and quality improvement plans for health professionals who are not keeping quality health records	
2.2 Quality Improvement	Reminders to help health professionals improve the quality of their health records	

b. Completeness, clarity, legibility, accuracy, relevance, accessibility, timeliness (see Section 2)



Principle	Sample compliance check	Status
Section 3	Capturing information in the consultation	
3.1 Recording consultations	Health professionals have dedicated time to produce and maintain quality health records	
3.2 Recording problems	Contemporaneous recordings of consultations that at least include the presenting problem, possible diagnosis and management plan	
3.3 Standardised terminology and recognised coding systems	Standardised terminology and nationally recognised coding system that encompasses the full spectrum of diagnoses, clinical situations and observations	
3.4 Respectful language	Education session on the optimal use of standardised terminology, a nationally recognised coding system, accepted acronyms and respectful language	
Section 4	Capturing information from other sources	
4.1 Incorporating information from other sources	Random audit of the system for follow-up of tests and results and quality improvement plans to address near misses and mistakes	
4.2 Roles and responsibilities	Position descriptions of team members who manage health information from other sources clearly define their roles and responsibilities	
Section 5	System-specific issues	
5.1 Policies and procedures	Policies and procedures that address strengths and weaknesses to optimise the operation of the health record system	
5.2 Managing risk	Policies and procedures for managing risks in the health record system	
5.3 Education and training	Initial and ongoing training sessions for clinical and administrative staff to make the most of the health record system	
Section 6	Information sharing and a national e-health record system	
6.1 Shared professional obligation	Routine cross-checking of patient identity and correct health record before information is shared Staged plan for participating in a national e-health record system	



Section 1: Information quality and primary healthcare

Australians have a recognised right to receive safe and high-quality healthcare. Safe and high-quality healthcare depends on the sharing of health information from quality health records.

Explanatory notes

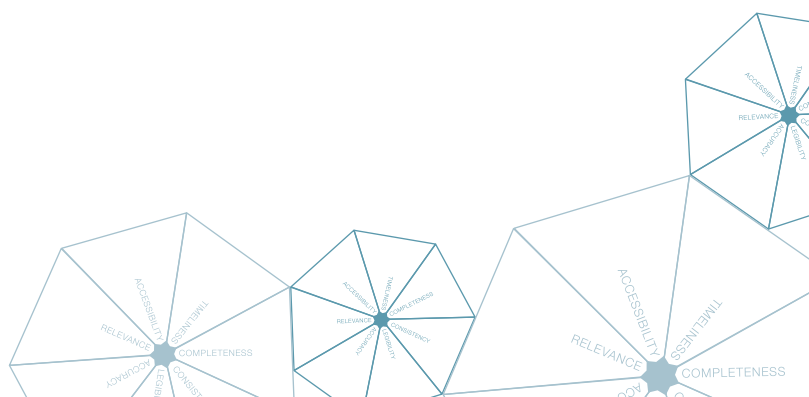
The Australian primary healthcare sector is a multidisciplinary environment. Quality health records facilitate the safe and reliable sharing of health information within and between health disciplines in the primary healthcare sector to achieve safe and effective patient care.

Health professionals are judged by the quality of their communication because good communication – based on good health records – drives continuity of care. In the context of contemporary healthcare, the sharing of health information with colleagues – an essential element of continuity of care – makes the quality of the health information highly visible.

Furthermore, quality health records enable patients to access health information that is meaningful, reliable and respectful and become active partners in their own healthcare.

Health records serve multiple primary and secondary purposes including but not limited to:

- a record of consultations provided by a range of health professionals to facilitate safe and effective healthcare for individual patients and practice populations
- a communication tool for health professionals
- a source of information to be shared appropriately with other health professionals to facilitate safe and effective continuity of patient care
- a source of information to be shared with patients to facilitate a partnership in healthcare based on trust and respect
- a tool for education, training and professional development
- a source of health information for clinical audits and quality improvement initiatives
- a source of health information to support the planning, commissioning, coordination and governance of primary healthcare services
- a potential source of data for approved research
- evidence for medicolegal purposes.



Principles

1.1 Information for multiple purposes

Health professionals should appreciate the range of primary and secondary purposes for which health records are used and quality health information is required.

1.2 Main purpose of health records

Health professionals should remember the main purpose of health records is to support safe and high-quality healthcare for individual patients and practice populations.

1.3 Expect to share

Health professionals should expect to share health information with colleagues and with patients to facilitate safe and effective healthcare.

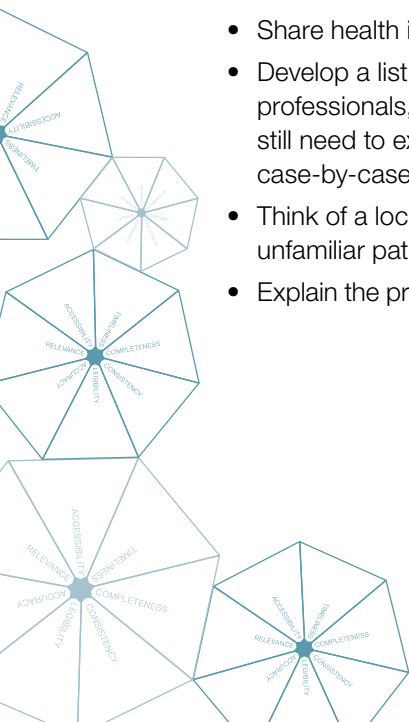
1.4 Governance

There should be a designated person within each practice team who is responsible for championing quality health records, including quality improvement initiatives, education and training.

Tips for compliance

These tips for compliance are designed to illustrate the application of the principles in day-to-day clinical practice. The tips are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- Make quality health records a key element of your risk reduction strategy.
- Designate a member of the team as the quality health record champion to lead by example, and allow this person dedicated time to fulfil this role.
- Include responsibility for quality health records in the position descriptions of all relevant team members to emphasise the collective commitment required.
- Educate team members on the importance of quality health records and how to produce and maintain them.
- Schedule staff meetings with quality health records as a key agenda item.
- Promote an expect-to-share mindset as a self-fulfilling driver of quality health records.
- Share health information that you would find helpful if you were the recipient of the information.
- Develop a list summarising what health information the practice generally shares with other health professionals, patients and third parties while making it clear that individual health professionals still need to exercise professional judgement on the proper sharing of health information on a case-by-case basis (see *Appendix A*).
- Think of a locum using your health records – could the locum use your records to manage unfamiliar patients safely, effectively and efficiently?
- Explain the primary and secondary purposes of health information to patients in your privacy policy.



Clinical examples

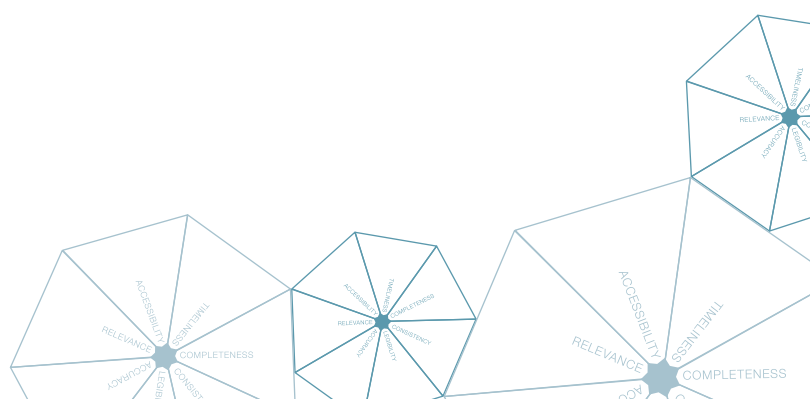
These clinical examples are designed to illustrate a typical day in a practice that keeps quality health records. The examples are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- A new health professional starts work and is readily able to continue the care of regular patients.
- A health professional sees a patient who has not attended the practice for a long time and is readily able to understand the patient's previous history and current medicines, and continue their care.
- A patient has presented at an emergency department, which makes an urgent request for a health summary. A health summary is quickly produced and sent to the department to complement personal communication with the patient's health professional.
- There are students doing a clinical placement. From the health records the students are able to understand where and why clinical guidelines were followed.
- A health professional receives a request for a report on a patient who has suffered a workplace injury. From the patient's health record, the health professional can readily produce a definitive report that supplants the need for further, time-consuming communication in the future.
- A claim of medical negligence is made against a health professional. The patient's health record constitutes good evidence of the clinical care provided to the patient to facilitate the management of the claim.
- A patient who is moving to another practice is able to share key health information with health professionals in the new practice, via their record in a national e-health record system.

Further information

Also check the General Resources section for further information.

- For further information on clinical risk management systems see RACGP *Standards for general practices* (4th edition) Criterion 3.1.2 (www.racgp.org.au/your-practice/standards/standards4thedition/safety,-quality-improvement-and-education/3-1/clinical-risk-management-systems).
- See the General Practice Data Governance Council (www.gpdgc.org.au/papers.html) for further information on the use, privacy, security and quality of general practice data for secondary purposes.



Section 2: Essential attributes of quality health records

Australians have a recognised right to receive safe and high-quality healthcare. Safe and high-quality healthcare depends on the sharing of health information from quality health records.

Explanatory notes

Safe and high-quality healthcare depends on access to quality health information at the time clinical decisions are being made.

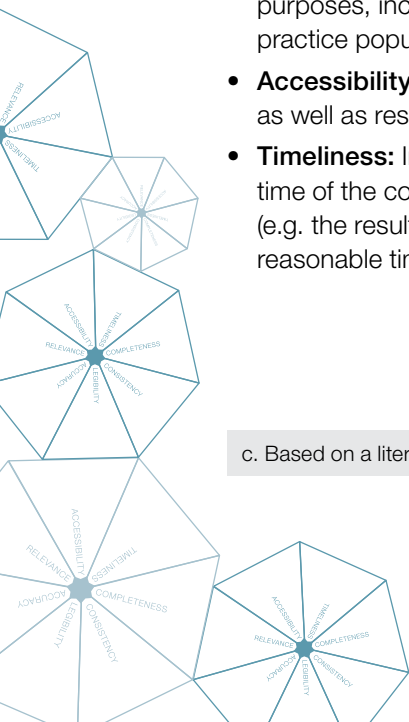
It has been suggested there are seven essential attributes of quality health records^c (CCLARAT):

1. **C**ompleteness
2. **C**onsistency
3. **L**egibility
4. **A**ccuracy
5. **R**elevance
6. **A**ccessibility
7. **T**imeliness.

For the purpose of this Guide, these seven essential attributes of quality health records are defined as follows.

- **Completeness:** Sufficient information collected in a consultation is then recorded in the health record, to reliably serve a range of purposes.
- **Consistency:** Standardised terminology and a recognised coding system are used to complement free text narrative.
- **Legibility:** Recorded health information is clear enough for others to read, where the recording system includes factors such as the identity of the person recording health information, handwriting, document scanning, the layout of forms and the selection of suitable typefaces.
- **Accuracy:** The record of a consultation in the patient health record correctly reflects the information captured in that consultation.
- **Relevance:** The information in health records is meaningful and sufficient for a range of purposes, including the provision of safe and effective healthcare for individual patients and practice populations.
- **Accessibility:** Health information is recorded and arranged in ways that make it readily retrievable as well as respectful, unambiguous and meaningful to others.
- **Timeliness:** Information captured in a consultation is recorded in the patient health record at the time of the consultation or as soon as practicable afterwards, and information from other sources (e.g. the results of a diagnostic procedure) is incorporated in the patient health record within a reasonable timeframe.

c. Based on a literature review undertaken by the RACGP in December 2012



Principles

2.1 Achieving the quality attributes

Health professionals should ensure the information they record in health records is complete, consistent, legible, accurate, relevant, accessible and timely.

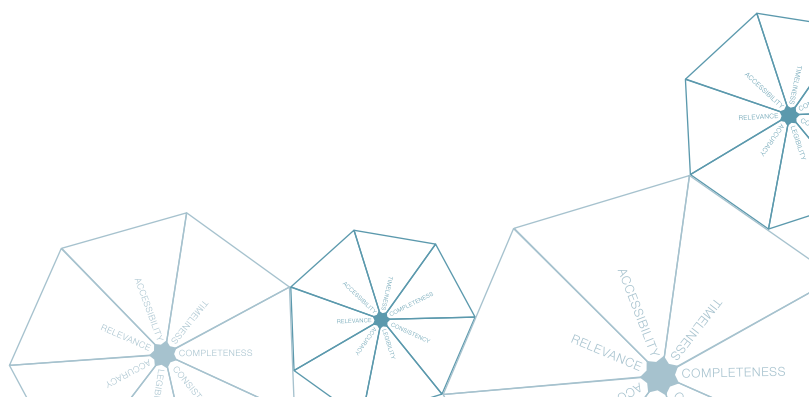
2.2 Quality improvement

Health professionals should review their health records and record-keeping practices regularly in the areas of completeness, consistency, legibility, accuracy, relevance, accessibility and timeliness to identify areas for quality improvement.

Tips for compliance

These tips for compliance are designed to illustrate the application of the principles in day-to-day clinical practice. The tips are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- Educate team members on the importance of quality health records and the essential attributes of quality health records.
- Do regular random audits of your health records (using CCLARAT as your review parameters) and formulate quality improvement plans for health professionals who are not keeping quality health records.
- Use an audit tool (e.g. a tool on your clinical information system or a commercially available tool) to evaluate and improve the quality of your health records.
- Role play a patient consultation scenario in a team meeting and get health professionals to record and then compare their consultation notes.
- Use reminders (e.g. reminders on screensavers) to help health professionals improve the quality of their health records.
- Keep quality improvement initiatives dynamic and manageable – focus on one or two areas for improvement at a time.
- Acknowledge or reward health professionals who keep outstanding health records.
- Implement a dedicated complaints process for health records to address problems raised by other health professionals or patients and educate team members on the importance of quality health records.



Clinical examples

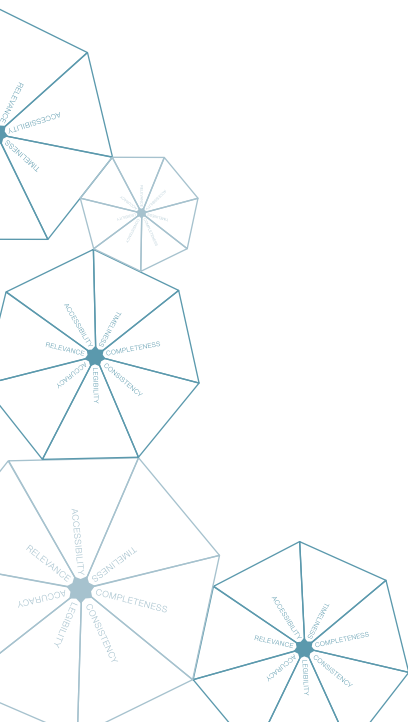
These clinical examples are designed to illustrate a typical day in a practice that keeps quality health records. The examples are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- A patient is unable to see their usual health professional and is given an appointment with another practitioner. The 'replacement' practitioner is able to use the patient's health record to continue the patient's care without wasting time trying to interpret the record, without repeating history taking/examinations/diagnostic investigations, and without damaging the patient's trust.
- As required, health professionals obtain patient feedback on shared health summaries they create and upload for a patient's record in a national e-health record system. The practice de-identifies this patient feedback and reviews it at staff meetings as a quality improvement activity.
- A health professional receives a request for a medicolegal report. From the patient's health record, the health professional can readily produce a definitive report that may supplant the need for further, time-consuming communication or a subpoena in the future.
- The practice passes a Medicare audit on the basis of its health records.

Further information

Also check the General Resources section for further information.

- For further information on managing complaints see RACGP *Standards for general practices* (4th edition) Criterion 2.1.2 Patient feedback (www.racgp.org.au/your-practice/standards/standards4thedition/rights-and-needs-of-patients/2-1/patient-feedback).



Section 3: Capturing information in the consultation

Australians have a recognised right to receive safe and high-quality healthcare. Safe and high-quality healthcare depends on the sharing of health information from quality health records.

Explanatory notes

A health record can only be as good as the information available and captured in a consultation, and then recorded in the patient's health record.

Clinical information is inherently variable, uncertain and inaccurate as a result of the use of language, the way clinicians reach diagnoses or select what to record and the variability of clinical terms used by different disciplines.⁹

This means the health professional has a professional obligation to capture and record health information in ways that:

- support accurate patient identification
- produce quality health information for future consultations
- produce quality health information for sharing with colleagues and patients
- produce quality health information suitable for a range of other purposes.^d

Electronic health record systems are designed to be human-readable and software-readable. Both these dimensions are important for recording and arranging information in ways that produce quality health information suitable for a range of purposes.

Principles

3.1 Recording consultations

Every consultation should be recorded in the correct health record and the treating health professional should be identified.

3.2 Recording problems

The presenting problem(s), possible differential diagnoses and recommended management plan should be recorded in the correct health record.

3.3 Standardised terminology and recognised coding systems

When recording health information, health professionals should endeavour to use standardised terminology, nationally recognised coding systems and structured data entry to complement free text narrative.

3.4 Respectful language

Health professionals should use respectful and unambiguous language when recording health information using free text narrative.

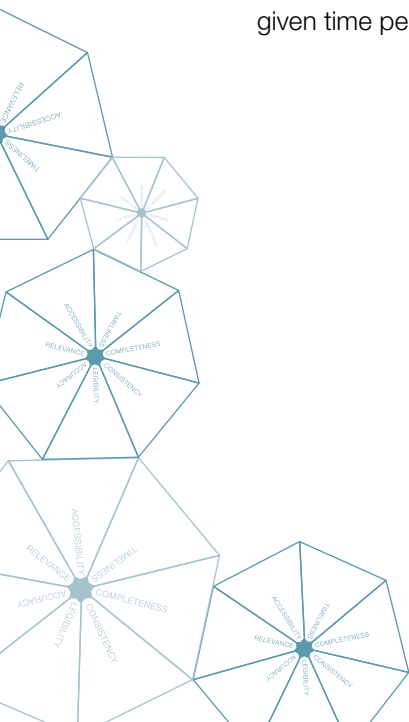
d. See explanatory notes in *Section 1*



Tips for compliance

These tips for compliance are designed to illustrate the application of the principles in day-to-day clinical practice. The tips are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- Check the patient's contact details are up to date.
- Check the patient's name from the health record before calling the patient.
- Whether a consultation is in-person, by telephone, by email or via videoconference, make sure you ask (not prompt) the patient to confirm their identity and match this with the correct health record before commencing the consultation.
- Endeavour to make contemporaneous recordings of consultations and at a minimum record the presenting problem, possible diagnosis and management plan (encompassing the patient's priorities and desired outcomes) so current health information is always readily available (e.g. for referrals or urgent clinical handovers such as an emergency hospital admission or a suicide risk).
- Use an electronic clinical information system that includes a standardised terminology set linked to a nationally recognised automated coding system (e.g. SNOMED CT-AU) that adequately encompasses the full spectrum of diagnoses, clinical situations and observations usually managed by your practice, to support consistency in the recording of diagnoses, procedures and observations.
- In a multidisciplinary practice, organise a meeting of the different disciplines to agree on standardised terminology and acceptable acronyms and abbreviations.
- Educate team members on the importance of quality health records, your standardised terminology set and recognised coding system, and respectful language.
- Avoid idiosyncratic acronyms, abbreviations and jargon.
- Maintain an accessible list of recognised acronyms and abbreviations that are generally understood by the health disciplines in your practice in the context of a patient's case, and that are generally understood in the broader health community.
- Use standard clinical tools to capture and record consistent health information from particular patient populations (e.g. a set of template questions for baby checks linked to automated fields in the health record).
- Provide brief gaps throughout daily appointment schedules as dedicated time for health professionals to make timely consultation notes and thereby manage the risk of notes being recorded in the wrong health record later on, especially if multiple records are left open at any given time pending completion of these notes.



Clinical examples

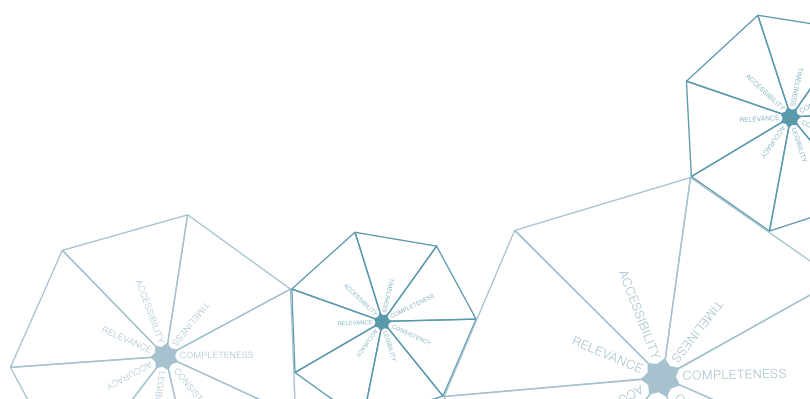
These clinical examples are designed to illustrate a typical day in a practice that keeps quality health records. The examples are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- The practice can quickly and accurately identify patients with a specified clinical diagnosis without undertaking a laborious review of all health records because it uses a standardised terminology set linked to a nationally recognised coding system within its clinical information system.
- A health professional can readily identify an important clinical milestone (e.g. the date of a patient's last seizure for a driving licence assessment) because the practice uses standardised terminology and a nationally recognised coding system to record health information.
- The practice can take full advantage of Medicare incentives because it uses a standardised coding system that readily identifies particular patient populations (e.g. patients with diabetes or asthma).
- A patient requests access to health information recorded in their health record over the past 6 months. The practice can safely provide a copy of this information – as required by privacy legislation – because the record contains respectful language and the health information is recorded and arranged in ways that make it understandable to the patient as a partner in healthcare.

Further information

Also check the General Resources section for further information.

- See www.safetyandquality.gov.au/wp-content/uploads/2012/01/32060v2.pdf for Australian Commission on Safety and Quality in Health Care Recommendations for terminology, abbreviations and symbols used in the prescribing and administration of medicines.
- Australian Primary Care Collaboratives at www.apcc.org.au have demonstrated the benefits of standardised terminology and nationally recognised coding systems in improving the safety and quality of healthcare for particular patient populations and the benefits of adopting tested change management strategies for implementing new approaches to clinical care.
- For further information on consultation notes see RACGP *Standards for general practices* (4th edition) Criterion 1.7.3 (www.racgp.org.au/your-practice/standards/standards4thedition/practice-services/1-7/consultation-notes).
- For further information on patient identification see RACGP *Standards for general practices* (4th edition) Criterion 3.1.4 (www.racgp.org.au/your-practice/standards/standards4thedition/safety,-quality-improvement-and-education/3-1/patient-identification).
- Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT-AU) provides core general terminology for electronic health records – adapted for the Australian setting – which can be used to represent clinically relevant information consistently, reliably and comprehensively when implemented in software applications. For further information see NEHTA (www.nehta.gov.au/our-work/clinical-terminology/snomed-clinical-terms).



Section 4: Capturing information from other sources

Australians have a recognised right to receive safe and high-quality healthcare. Safe and high-quality healthcare depends on the sharing of health information from quality health records.

Explanatory notes

Practices and organisations in the primary healthcare sector receive large volumes of health information from different sources in different formats. This information has to be reviewed and incorporated into the correct health records so it can be used to support safe clinical handover and effective continuity of patient care.

Principles

4.1 Incorporating information from other sources

Practices should have a documented system for receiving, reviewing and incorporating health information from other sources into the correct health records, and this system should support patient confidentiality, safe clinical handover and effective continuity of care.

4.2 Roles and responsibilities

Practices should have designated team members with defined roles and responsibilities for managing health information from other sources.

Tips for compliance

These tips for compliance are designed to illustrate the application of the principles in day-to-day clinical practice. The tips are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- Review the position descriptions of team members who manage health information from other sources to ensure their roles and responsibilities are clearly defined.
- Train and support team members responsible for managing health information from other sources.
- Develop checklists for the various tasks involved in the management of health information from other sources by different members of the team.
- Focus on the accurate matching of information from other sources with the correct patient health record.
- Review your system for the follow-up of tests and results to make sure key information is being properly incorporated in the correct health records.
- Identify near misses and mistakes in the incorporation of health information from other sources, and implement solutions to prevent their recurrence.
- Develop a policy that describes what, when and how information from other sources is scanned into health records and invest in a scanner that is easy to use and provides good quality images.
- Invest in Secure Message Delivery to receive and send health information electronically (e.g. prescriptions, pathology reports, referrals and discharge summaries).



Clinical examples

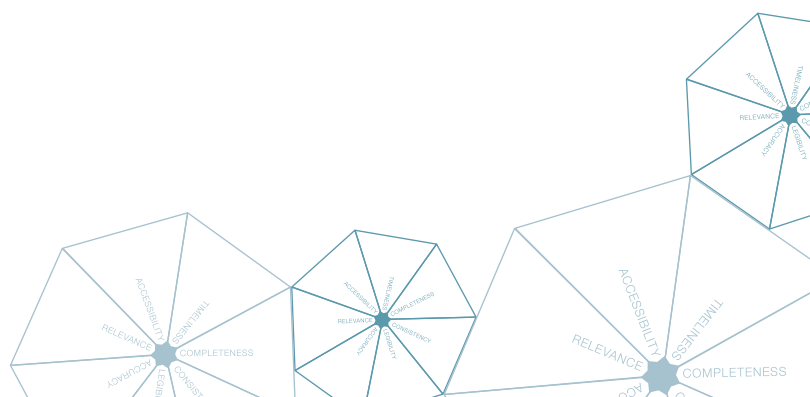
These clinical examples are designed to illustrate a typical day in a practice that keeps quality health records. The examples are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- The practice has a day-to-day system for receiving, reviewing and incorporating into the correct health records a large volume of information from other sources, such as external correspondence including pathology and radiology test results, letters from specialists, letters from allied health providers, hospital discharge summaries and outpatient correspondence, significant phone communication from patients/carers, letters from insurers, letters from Centrelink, photos and video recordings.
- The receptionist is responsible for receiving health information from other sources and is allowed uninterrupted time to undertake this responsibility. To minimise risk, the receptionist has a checklist for the tasks involved in receiving information from other sources (e.g. check patient identity, identify the information, check the information has been reviewed by the relevant health professional before it is incorporated in the health record, and keep originals for a designated time before destroying them).
- The practice has invested in Secure Message Delivery to receive health information (including pathology results) electronically.
- The practice reviews its system for the follow-up of tests and results and identifies the following instances: a highly abnormal test result filed in the wrong health record, a health professional wasting time on the review of unsorted letters and test results, several letters from specialists that were scanned but not identified and incorporated into the correct health record. The practice implements changes to its system for the follow-up of tests and results to prevent comparable instances happening again.

Further information

Also check the General Resources section for further information.

- For further information on follow-up see RACGP *Standards for general practices* (4th edition) Criterion 1.5.3 System for follow up of tests and results (www.racgp.org.au/your-practice/standards/standards4thedition/practice-services/1-5/system-for-follow-up-of-tests-and-results).
- Also see the Department of Health, Royal College of General Practitioners, British Medical Association, *The good practice guidelines for GP electronic patient records* Version 4 (2011) p. 73 Section 6.4.1.1 Handling of letters incoming to the practice at (www.gov.uk/government/publications/the-good-practice-guidelines-for-gp-electronic-patient-records-version-4-2011).
- For further information on clinical risk management systems see RACGP *Standards for general practices* (4th edition) Criterion 3.1.2 (www.racgp.org.au/your-practice/standards/standards4thedition/safety,-quality-improvement-and-education/3-1/clinical-risk-management-systems).
- Further information on Secure Message Delivery is available from NEHTA (www.nehta.gov.au/our-work/secure-messaging).



Section 5: System-specific issues

Australians have a recognised right to receive safe and high-quality healthcare. Safe and high-quality healthcare depends on the sharing of health information from quality health records.

Explanatory notes

Quality health records depend on a health record system (whether paper, hybrid or electronic) that has the right capacity and the right capabilities for the practice.

Getting the best out of any health record system requires appropriate policies and procedures for record making and record keeping and risk management, and appropriate staff training to ensure the system is used to its maximum capability and upgraded as circumstances require.

Principles

5.1 Policies and procedures

Practices should establish, implement and review documented policies and procedures to optimise the operation of their health record systems.

5.2 Managing risk

Practices should establish, implement and review documented policies and procedures for managing risk in their health record systems.

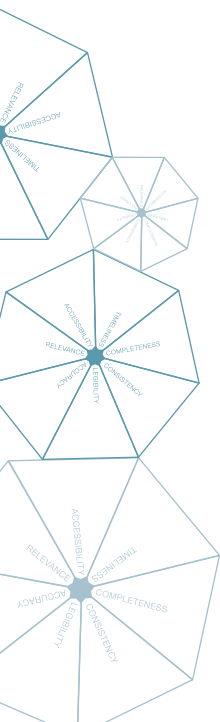
5.3 Education and training

Practices should provide appropriate education and training for clinical and administrative staff on the importance of quality health records, the essential attributes of quality health records and the successful operation of health record systems.

Tips for compliance

These tips for compliance are designed to illustrate the application of the principles in day-to-day clinical practice. The tips are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- Review the strengths and weaknesses of your health record system, and design related policies and procedures to act on these strengths and weaknesses.
- If your practice has a paper-based health record system, develop particular risk management procedures for information recovery and for ensuring your health records are capable of serving a range of recognised purposes (e.g. use standardised ways to record information such as 'boxing' diagnoses or using a chronic disease/allergy/medication register to enable another health professional to become quickly familiar with a patient's health status or to allow a health summary to be quickly produced for another health professional).
- If your practice has a hybrid health record system, develop particular risk management procedures for information recovery, information consistency and for ensuring your health records are capable of serving a range of recognised purposes (e.g. cross-reference health information in your paper and electronic subsystems to reduce the risk of important information being overlooked when needed during a consultation).



- If your practice has an electronic health record system, capitalise on its decision support features (e.g. an allergy alert for penicillin prescriptions, pregnancy status for contraceptive prescriptions, asthma status for beta blocker prescriptions, and suicide risk for patients with a mental health diagnosis).
- If your practice has an electronic health record system, capitalise on its automated features (e.g. prompt for a diagnosis before a record can be closed or prompt for a prescription that is contraindicated for a particular diagnosis).
- If your practice has an electronic health record system, make sure each health professional in the team (whether single-discipline or multidisciplinary) has protected access to the system so that each member of the team can exercise their individual professional obligation to produce and maintain quality health records.
- Where you import a health record, make it your policy to check the imported information with the patient present and correct mistakes as required.
- If your practice has an electronic health record system, join an independent 'software users group' to share knowledge about the capabilities and limitations of the system.
- If your practice has an electronic health record system, make sure you meet accepted standards for information security (e.g. the RACGP *Computer and information security standards*).
- Organise initial and ongoing training for clinical and administrative members of the team to get the most out of your health record system (e.g. the optimal use of clinical software and the correct linkage with compatible management software).
- Develop a checklist for your practice that identifies areas for improvement in your health record systems (e.g. the use of decision support features or upgrading to an electronic health record system).

Clinical examples

These clinical examples are designed to illustrate a typical day in a practice that keeps quality health records. The examples are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

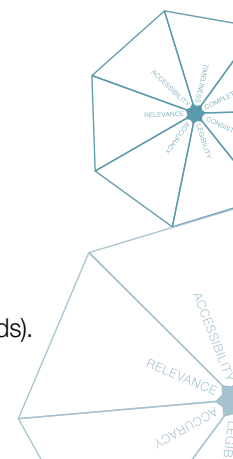
- The practice engages professional support to oversee the secure and reliable operation of its electronic health record system.
- The practice has correctly set the automated link between its 'management' software and its compatible 'clinical' software so that when the receptionist clicks on the patient's appointment for patient identification purposes, this opens the correct health record.
- The health record champion has undertaken training on the optimal use of the practice's clinical software and is now running inhouse training for all the health professionals in the team.
- The practice manager has undertaken training on the optimal use of the practice's management software and is now running inhouse training for all the administrative staff in the team.

Further information

Also check the General Resources section for further information.

Refer to:

- Australian Standard 2828.1-2012 *Health records – Paper-based health records*.
- the eCollaborative handbook *21st century patient care and self management* (November 2012) published by the Improvement Foundation and the National E-Health Transition Authority, especially Section 4.3 Develop systems to improve and maintain data quality across your clinical system (www.ecollaborative.com.au/w/images/2/21/ECollaborative_Handbook_2012.pdf)
- RACGP *Computer and information security standards* (2nd edition) (www.racgp.org.au/ehealth)
- RACGP *Standards for general practices* (4th edition) Criterion 1.7.1 Patient health records (www.racgp.org.au/your-practice/standards/standards4thedition/practice-services/1-7/patient-health-records).



Section 6: Information sharing and a national e-health record system

Australians have a recognised right to receive safe and high-quality healthcare. Safe and high-quality healthcare depends on the sharing of health information from quality health records.

Explanatory notes

The potential benefits of shared health information are acknowledged, even though it is inherently difficult for clinicians to interpret and rely on information entered by others.¹⁰

The quality of information shared within a national e-health record system is visible to patients and health professionals alike, and depends on a shared professional commitment to quality health records at the practice level.

A national e-health record system provides an important tool for patients to become more active partners in their own healthcare by enabling individuals to access an online summary of their health record and to share that summary information with a range of treating health professionals.

Principle

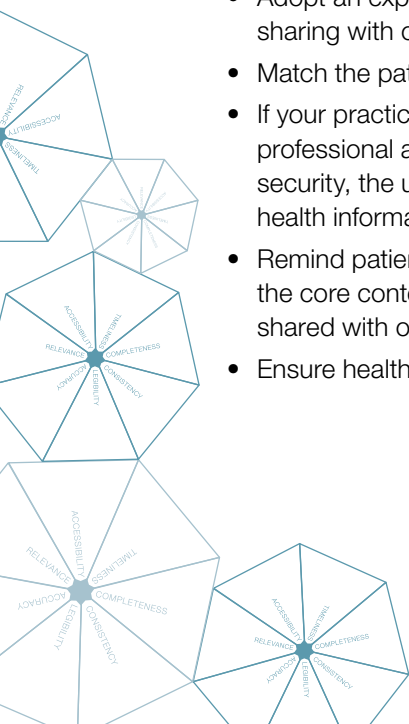
6.1 Shared professional obligation

Health professionals have an obligation to capture and record information in ways that support accurate patient identification and that produce quality health information fit for sharing with colleagues and patients.

Tips for compliance

These tips for compliance are designed to illustrate the application of the principles in day-to-day clinical practice. The tips are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- Adopt an expect-to-share mindset as a self-fulfilling driver of quality health information fit for sharing with colleagues and patients.
- Match the patient's identity with the correct health record before sharing health information.
- If your practice participates in a national e-health record system, make sure you meet your professional and contractual obligations (e.g. obligations on quality health records, information security, the use of healthcare identifiers, uploading health information and restrictions on sharing health information).
- Remind patients that a summary of key health information from their local health record will form the core content of their record in a national e-health record system and this information may be shared with other health professionals to enhance the continuity of their healthcare.
- Ensure health professionals have scheduled time to produce and maintain quality health records.



Clinical examples

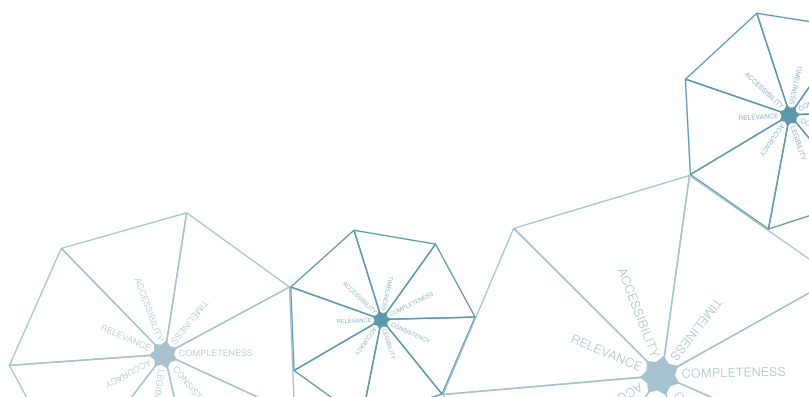
These clinical examples are designed to illustrate a typical day in a practice that keeps quality health records. The examples are of a general nature only and are not exhaustive – they may or may not be relevant to particular circumstances.

- Health professionals in the team appreciate the attributes of quality health records and the importance of health information that is fit for sharing with a range of health professionals in a range of diverse settings within the Australian primary healthcare sector.
- Health professionals in the team understand that as the uptake of a national e-health record system becomes more widespread, the quality of the practice's health records will become more visible to patients and other health professionals, and there is the potential for more complaints about poor-quality health records that do not support good continuity of care.

Further information

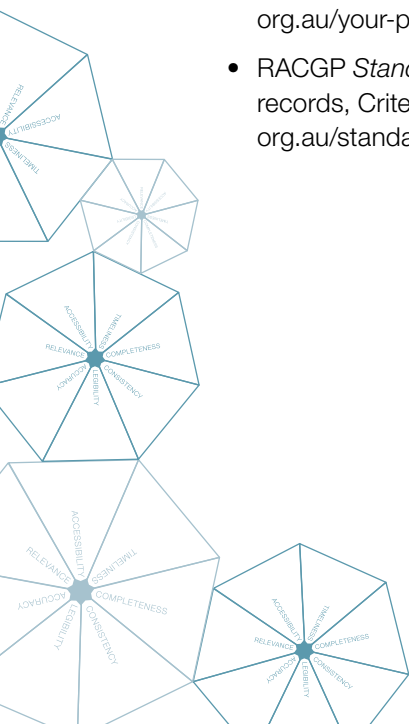
Also check the General Resources section for further information.

- See www.ehealth.gov.au for further information about a national e-health record system.
- Information on some of the key requirements for participating in a national e-health record system is contained in RACGP *Computer and information security standards* (2nd edition) (www.racgp.org.au/ehealth).



General resources

- *Australian charter of healthcare rights* from the Australian Commission on Safety and Quality in Health Care at www.safetyandquality.gov.au/our-work/
- Australian Nursing Federation *Policy on information management and information technology* (reviewed 2011) at http://anf.org.au/documents/policies/P_Information_Management.pdf
- Australian Physiotherapy Association *Standards for physiotherapy practices* (8th edition: 2011 update), especially Standard 2.1 Client health record at www.physiotherapy.asn.au/DocumentsFolder/Resources_Private_Practice_Standards_for_physiotherapy_practices_2011.pdf
- Australian Physiotherapy Association *Code of conduct* at www.physiotherapy.asn.au/DocumentsFolder/Membership_Code_of_Conduct_2008.pdf
- Australian Physiotherapy Association *Position statement on health records* at www.physiotherapy.asn.au/DocumentsFolder/Advocacy_Position_Health_Records_2010.pdf
- Australian Primary Care Collaboratives at www.apcc.org.au/
- Australian Psychological Society *Professional practice management standards* at www.psychology.org.au/practitioner/essential/PPMS
- *Australian safety and quality framework for health care* from the Australian Commission on Safety and Quality in Health Care at www.safetyandquality.gov.au/our-work/
- Codes of Conduct endorsed by the National Boards for Australian registered health professionals available from the Australian Health Professional Regulation Agency at www.ahpra.gov.au/
- eCollaborative Handbook *21st century patient care and self management* (November 2012) published by the Improvement Foundation and the National E-Health Transition Authority at www.ecollaborative.com.au/w/images/2/21/ECollaborative_Handbook_2012.pdf
- *Guidelines on privacy in the private health sector* (2001) available from the Office of the Australian Information Commissioner at www.oaic.gov.au/privacy/privacy-resources/privacy-guides/privacy-in-the-private-health-sector-november-2001
- RACGP *Computer and information security standards* at www.racgp.org.au/your-practice/standards/ciss/
- RACGP *Handbook for the management of health information in general practice* at www.racgp.org.au/your-practice/business/tools/safetyprivacy/privacy/
- RACGP *Standards for general practices* (4th edition), especially Criterion 1.7.1 Patient health records, Criterion 1.7.2 Health summaries and Criterion 1.7.3 Consultation notes at www.racgp.org.au/standards



Appendix A: Sharing health information

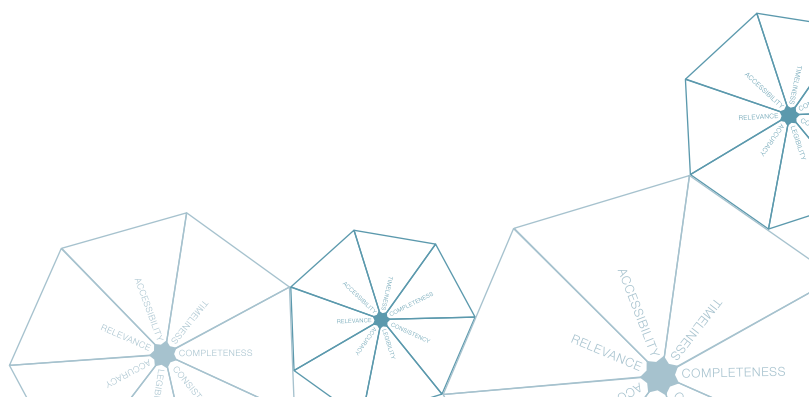
This is a sample list of health information generally shared with other health professionals, patients and third parties. In day-to-day clinical practice, health professionals need to exercise their own professional judgement on the proper sharing of health information on a case-by-case basis, in accordance with privacy legislation, other relevant legislation and patient confidentiality. It is assumed practices will customise this sample list to suit their own particular circumstances.

Generally, you could share this health information:

- health information constituting sufficient information to enable continuity of care
- a summary of presenting problem, assessment and diagnosis (including provisional and/or differential diagnosis)
- a summary of treatment, including treatment approach, progress and any barriers to treatment
- prognosis and suggestions for future treatment
- results of any risk evaluation (e.g. known allergies, adverse drug reactions, health risk factors, immunisations, suicide risk)
- relevant family or social history (where clinically relevant)
- matters covered by mandatory reporting.

Generally, you would not share this health information:

- sensitive health information not relevant to the presenting problem
- information provided in confidence by or about third parties
- information the patient specifically asks to be kept confidential
- detailed raw test data/scores (unless clinically relevant or specifically requested by another health professional).



Glossary

Audit tool: A tool used by health professionals to evaluate and improve clinical management (e.g. the efficacy of different treatment approaches for patients with a particular diagnosis) or clinical systems (e.g. the practice's health record system).

Capturing information: Recording information collected in a consultation in the correct health record or incorporating information from other sources in the correct health record.

Clinical situation: A scenario where there is no suitable diagnosis for a patient's presenting problem.

Clinical tool: A standardised tool used by health professionals to assess a patient's condition.

Coding system: A data coding system is designed to achieve the consistent classification of clinical diagnoses for safe and effective healthcare, the standardised transfer of health information, clinical audit purposes and chronic disease registers.

Consultation: A consultation is an interaction between a health practice and a patient in relation to the patient's health issues, where the interaction may take a number of formats including but not limited to a face-to-face appointment, an informal conversation, telephone or email communication, or telehealth options such as a videoconference.

Differential diagnosis: A diagnosis that is distinct from other possible diagnoses.

Electronic health record: A health record produced and maintained in electronic format.

Essential attributes: There are seven attributes which collectively distinguish high-quality health records. These attributes are **(CCLARAT)**:

- **Completeness:** Sufficient information collected in a consultation is then recorded in the health record, to reliably serve a range of purposes.
- **Consistency:** Standardised terminology and a recognised coding system are used to complement free text narrative.
- **Legibility:** Recorded health information is clear enough for others to read, where the recording system includes factors such as the identity of the person recording health information, handwriting, document scanning, the layout of forms and the selection of suitable typefaces.
- **Accuracy:** The record of a consultation in the patient health record correctly reflects the information captured in that consultation.
- **Relevance:** The information in health records is meaningful and sufficient for a range of purposes including the provision of safe and effective healthcare for individual patients and practice populations.
- **Accessibility:** Health information is recorded and arranged in ways that make it readily retrievable as well as respectful, unambiguous and meaningful to others.
- **Timeliness:** Information captured in a consultation is recorded in the patient health record at the time of the consultation or as soon as practicable afterwards, and information from other sources (e.g. the results of a diagnostic procedure) is incorporated in the patient health record within a reasonable timeframe.

Free text narrative: A means of recording health information using plain language.

Governance: A framework through which members of health practice teams and health organisations in the primary healthcare sector are accountable for patient safety and quality care including quality health records.



Health information from other sources: Health information from another practitioner in the practice/organisation or from a source external to the practice/organisation.

Healthcare identifiers: Unique identification numbers for healthcare professionals and organisations that provide healthcare and for individuals who seek healthcare.

Mistake: An error or adverse event that results in harm.

National e-health record: A secure electronic health record within a national e-health record system containing a summary of important health information about an individual, where access to such information is controlled by that individual.

National e-health record system: A voluntary system that enables an individual to initiate a secure electronic health record designed to contain a summary of important health information about them, where access to such information is controlled by that individual.

Near miss: An incident that did not cause harm but could have.

Organisation: Any healthcare organisation operating in the Australian primary healthcare sector.

Patient: A patient of a practice/organisation in the Australian primary healthcare sector.

Presenting problem: The reason given by a patient for their visit to a health professional.

Primary contact status: Health professionals with primary contact status are able to see patients directly without the need for a referral from another health professional.

Primary healthcare: In Australia, primary healthcare is largely delivered through two parallel systems: primary care delivered by fee-for-service health professionals (with some fees offset by Medicare rebates), and state-funded and managed community health services.

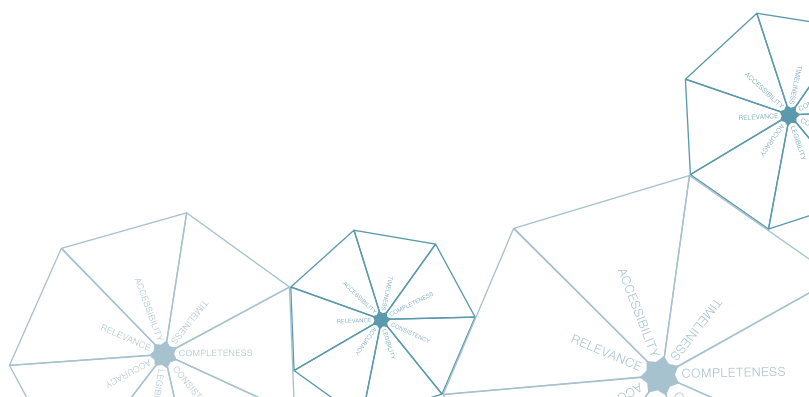
Reasonable timeframe: A length of time that might reasonably be expected by professional peers for a defined situation.

Secure Message Delivery: A secure and reliable way for healthcare organisations in Australia to safely receive and send health information in accordance with a national standard.

Standardised medical terminology: Medical terminology accepted by a group of health professionals as having agreed meaning and agreed usage.

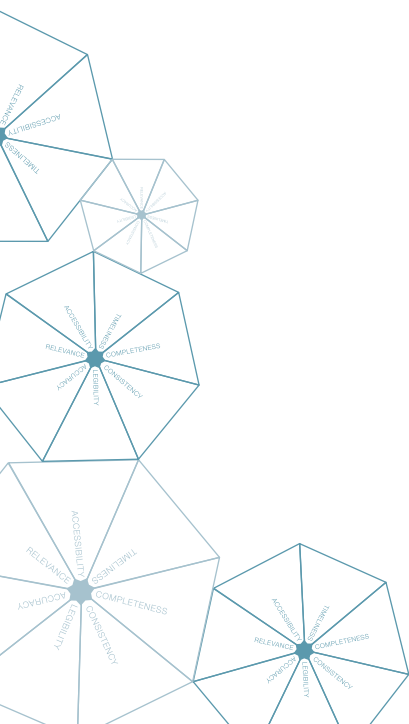
Structured data: A means of recording health data using structured options within a health record software system.

System: An organised and coordinated method or procedure comprising manual and/or technological elements.



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