WHAT YOU NEED TO KNOW

HEALTH CARE RECORDS

AMA
NEW SOUTH WALES

What you need to know

As doctors you have a professional and legal duty to maintain accurate records about your patients.

In the busy hospital setting you may not necessarily consider patient information or health care records as a key part of your work however you have specific obligations under the Medical Board of Australia's **Good medical practice: a code of conduct for doctors in Australia** and NSW **Health Policy Directive – Health Care Records – Documentation and Management** relating to this information.

Does everyone in NSW have a health care record?

Every patient who receives care in a NSW public health organisation will have a health care record created for them with a unique identifier (e.g. Unique Patient Identifier or Medical Record Number).

What needs to be included in a patient's health care record?

The Code of Conduct and Policy Directive require you to keep accurate, up-to-date and legible records for all patients.

In addition to basic information (name, date of birth etc), these need to include the patient's medical history, any clinical findings (e.g. results), investigations, information about medication and any other patient management plans or relevant information.

Records should be in English using only approved abbreviations and symbols.

In addition to the requirements of your employer, all registered medical practitioners in NSW have a professional obligation to make contemporaneous and sufficiently detailed medical records to ensure continuity of the patient's care under **Health Practitioner Regulation (New South Wales) Regulation 2016** and the Code of Conduct.

While I was taking a patient's history they told me something in confidence and asked me not to record it in their notes. What should I do?

If the information provided by the patient is clinically relevant then it must be included in your notes. Reassure your patient that all information recorded is kept confidential.

I have made some notes in a patient's health care record but after talking with a colleague I have changed my thinking, can I go back in and change my notes?

You must not delete any information you have already recorded for your patient. You can 'strikethrough' any incorrect information although it must still be legible. It is better to flag your original note as "written in error" and make a contemporaneous note that reflects the change in your thought process and/or subsequent care plan.

If you have any questions with regards to the information contained in this document or related to Health Care Records, please contact our Workplace Relations team on 9439 8822 or via workplace@amansw.com.au

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I have just finished my shift and remembered that I didn't make any notes on a patient I saw earlier. Can I just wait and write them when I am next in the hospital?

As you know, a lot can happen to a patient's health status in a very short period of time. Ideally all patient notes should be made at the time the information is given (or observed) or as soon as possible thereafter to meet your obligations under the Code of Conduct and Policy Directive. If you are adding notes after the fact, you need to distinguish between the time of writing and the time of the event or observation.

I am worried that some things I wrote about a patient may be seen as inflammatory or even rude, can the patient gain access to their notes and read what I wrote?

Yes. Patients have a right to access information contained in their medical record. Your records must show respect to your patients and must not include any demeaning or derogatory remarks.

Who has ownership of a patient's health care record?

In the public hospital setting, the health care record is the property of the public health organisation providing care to the patient. The record is not the property of individual medical practitioners or the patient.

Are the notes I make on a patient in the hospital's system automatically loaded onto their My Health Record assuming they have one?

My Health Record is intended to be a summary of a patient's health information only and does not constitute the entire medical record. If your patient has a My Health Record then the hospital discharge summary only will be uploaded.

I have seen others sharing patient information or discussing a patient via social media platforms such as WhatsApp. Is that a good idea?

No. If you need to communicate with a colleague about a patient, check if there is a platform endorsed by your hospital/employer.

For more information please refer to our guide **What you need to know - Social Media.**

I make notes on patients for my own learning/study and keep them, is that ok?

Beware of keeping your own notes on specific patients. You must completely de-identify any information kept about patients. If your notebook was picked up in the street could someone figure out who your patient was? Remember it's a small world and a rare disease or symptom could be identified by a family member or friend.

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I have just seen that a friend has been admitted as a patient in the hospital where I work. They said they are having trouble getting information from their treating medical practitioner and they have asked me to find out what it says in their record. Should I do it?

No. A patient's health care record is only accessible to the medical practitioners who are currently providing treatment or care to that patient. If you do access a patient's health care record when you are not involved in the patient's care, it may be considered a data breach.

Also keep in mind that the hospital is your place of work. You must maintain a professional boundary in the workplace.

What is a data breach?

A data breach occurs when personal information is accessed or disclosed without authorisation or is lost.

What can I do to prevent a data breach?

There are some simple steps you can take to ensure the security of patient information, these include:

- Always lock a PC before walking away,
- Don't share your log in details with anyone,
- Double check you have the correct recipient before hitting send on an email,
- Familiarise yourself with the procedure if you think you have been involved with a data breach

A patient has made a complaint. Is this recorded in their health care record?

No. Records of complaints are not kept with the patient's health care record.

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MORE INFORMATION

NSW Health Policy Directive **PD2012_069 - Health Care Records – Documentation and Management**

Medical Board of Australia **Good medical practice: a code of conduct for doctors in Australia**

Health Practitioner (New South Wales) Regulation 2016

This information is for general guidance only and should not be used as a substitute for obtaining specific assistance or advice. The information included in this document was collated citing NSW Health Policy Directive PD2012_069 – Health Care Records and guidelines provided by the Medical Board of Australia.

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