AlfredHealth

Guideline Title: Medical Record Access, Borrowing and Return

Campus	**Alfred Health**	**Guideline Number:**
Category	**Information Management**	**Related to Policy number:**
Responsibility for Review	**Director of Health Information Services**	
Date Approved: June 2009		**Review Date: March 2010**

PURPOSE/EXPECTED OUTCOME:
It is the intent of this document to provide guidelines for the access and return of medical records at The Alfred, Caulfield and Sandringham. This guideline should be read in conjunction with the Medical Record Access, Borrowing and Return Policy 2009.

STAFF RESPONSIBILITIES:
Staff responsible for a medical record(s) must either:-

a. Report any subsequent movement of the medical record(s) from their area or from their possession immediately to Health Information Services (HIS).
b. Update the computerised medical record tracking system for subsequent movement of the medical record(s) from their area or from their possession. Access to the computerised medical record tracking system can be arranged though HIS.

DEFINITIONS:

1. Direct Patient Care

For the purposes of this policy, direct patient care is defined as:-

a. any event in which the patient is in attendance; or
b. occasions where the patient is not in attendance, but the medical record is required to provide information to another health care provider for the specific purpose of ongoing patient care;or
c. any event in which the patient is in transit to or within Alfred Health.

2. Indirect Patient Care

For the purposes of this policy, indirect patient care is defined as:-

a. any event where the medical record is required to facilitate necessary communication and follow-up of the patient for ongoing care. Examples of this are where the record is required for typing of correspondence, completion of notes, follow-up on investigation results or complaints management.
b. Requests required or permitted by law. Examples of this Freedom of Information (FOI), subpoena, court order, search warrant, medico-legal request by a legal representative and the State Coroner.

3. Missing medical record

A "missing" medical record is defined as any medical record that cannot be located by the date and time that it is required for direct or indirect patient care.

4. "Day only" loan privileges

A maximum of 5 medical records (current and previous volumes are counted separately) may be taken from HIS between the hours of 8am – 5pm Monday to Friday (excluding Public Holidays). This is limited to staff whose role includes clinical research. Requests for "day only" loan privileges must be made directly to the Director or Manager of HIS who reserves the right to accept or reject such applications.

1. ACCESS & RECORD TRACKING

1.1 Only staff employed by Alfred Health are permitted to have access to medical records. The purposes of such access and any exceptions to this are in accordance with the Alfred Health Information Privacy Policy and Guideline and the Medical Record Transport Guideline.

1.2 To facilitate rapid and urgent transport of medical records, staff employed through Contracted Services (only Ward Support or Distribution) and Volunteers will be permitted access to medical records specifically for the purpose of record transport. These staff are not permitted to open or read the medical record.

1.3 Medical records that are released for patient attendance will be tracked to the department, clinic or ward the patient attends. At all times, such records are the responsibility of staff working within the area, but are ultimately the responsibility of the Department or Nurse Manager in charge of the area. If a record is in the possession of a department, clinic, or ward for longer than the time permitted, HIS staff have the right to retrieve the record.

1.4 Medical records that are released for purposes other than patient attendance will be tracked to the individual staff member. At all times, such records are the responsibility of the individual staff member.

1.5 Original patient records may only leave Alfred Health under the following circumstances:

(i) If they are required for court or the Coroner's Office or are required by search warrant via the police. Only HIS or the Mortuary are authorised to make arrangements for patient records to be sent to court or the Coroner's Office.

(ii) If they are required for patient attendance at a satellite clinic or service. In such instances HIS must be given prior notice and the records are to be returned to the Hospital on the same or following day. Sub-acute services arranged by Caulfield are able to retain records for longer periods of time as determined by the Manager of HIS.

1.6 Prior to release of a medical record for purposes other than patient attendance, the following information will be recorded by HIS:-

a. Staff member's name
b. Staff members contact telephone number and/or pager number
c. The purpose of the request (indirect patient care, clinical audit or another purpose)
d. Precise location that record will be taken or within HIS if the record is to be viewed internally
e. The date and time the record is required.

Medical records will not be released without this information being provided.

1.7 HIS staff shall, at all times, be allowed access to any department, office or other area where medical records are tracked or located. Such access may be via provided keypad code, key or alternatively through Hospital Security.

1.8 Where large volumes of records are stored outside of HIS indefinitely for frequent, ongoing patient treatment (please refer to section 2.1), HIS staff shall be provided access via swipecard, keypad code or key. This is to allow fast and efficient access to records 24 hours per day, particularly for direct patient care.

1.9 HIS shall provide a suitable medical record viewing area with access to the Alfred Health Information Technology network for staff who wish to access to records that are not permitted to leave HIS (please refer to section 2.1).

2. BORROWING MEDICAL RECORDS

2.1 Borrowing Limits

The following table specifies the borrowing limits for medical records.

PURPOSE OF RECORD REQUEST	BORROWING LIMIT	**Record permitted to leave HIS?**
Non-Admitted Patient attendance	48 hours after patient attendance	Yes
Admitted patient attendance	48 hours after patient discharge	Yes
Pre-admission attendance	Up to 48 hours prior to booked patient admission or 48 hours after patient attendance, whichever is sooner.	Yes
Other direct patient care (as defined in this policy)	24 hours after record provision.	Yes
Cross-campus request	As per non-admitted or admitted patient Attendance borrowing limits (24 hours and 48 hours respectively).	Yes
Administrative (includes scheduling appointments or elective admission, typing of correspondence,	48 hours after record provision.	Yes
FOI requests, subpoena, search warrant, court order, Coroner	7 days from date that record is required (excluding Coroner requirements).	Yes
Completion of documentation, completion of discharge summary, follow-up with patient via telephone, etc.	24 hours after record provision.	Yes
Direct patient care – frequent Alfred patient attendance areas. Limited to: • Heart Transplant Unit, • 5th Floor MWB Cystic Fibrosis • Renal Dialysis Ward • Haematology/Oncology Ward • Junction and Waiora Clinics and CCU Frequent Caulfield areas. Limited to: • Allied health hub • Pain clinic • Podiatry • TITH	May retain medical record until patient has completed treatment or until patient dies	Yes
Complaints Management	7 days after record provision	Yes
Sentinel Event audit/monitoring	7 days after record provision	Yes (with Unit Head or above authorisation)
Audit	7 days after record provision	Yes (with Unit Head or above authorisation)
Review of notes		Yes (with Unit Head or above authorisation)
Research & data management*	7 days after record provision	No
Clinical Trial (except for patient attendance)	7 days after record provision	No
Student access (authorised case study,etc.)	7 days after record provision	No
All other purposes	7 days after record provision	No

Note: Where records are not permitted to leave HIS, access to Alfred records will be available within the medical record viewing rooms, HIS, Basement, Main Ward Block. 24 hour access is available. Caulfield records can be viewed in the HIS Meeting Room/Audit area during office hours. Sandringham records can be viewed in the HIS doctors' area during office hours.

*Where "day only" loan privileges have been authorised, only up to 5 records can be removed from HIS between 8am-5pm Monday – Friday (excluding Public Holidays).

2.2 Staff responsible for a medical record(s) must report any subsequent movement of the medical record(s) from their possession immediately to HIS. This can be done in person or by telephoning the Alfred HIS on 62644 or 63289, CGMC HIS on 77643 or SDMH HIS on 11249, or by directly updating the electronic medical record tracking system. For access to this system, please contact the Manager of HIS.

2.3 Until the medical record is returned to HIS or subsequent movements of the record are reported, the record remains the responsibility of the individual staff member who requested it or in the event of a patient attendance, the Manager of the ward, department or clinic the patient has attended.

3. RETURN OF MEDICAL RECORDS

3.1 Medical records are to be returned to HIS in accordance with the time lines specified in 2.1.

3.2 The return of medical records is the responsibility of individual staff members, wards, departments or clinics that the records are tracked to.

3.3 At the request of HIS staff, the staff member, ward, department or clinic in possession of the record is responsible for its return to HIS immediately, or at a time specifically requested by HIS.

3.4 Medical records must not be sent in the internal mail at any time. When medical records are being returned, this must be done in person. Contracted Services (Ward Support and Distribution only) and Alfred Volunteers are permitted to transport medical records where the record is required immediately AND it is impracticable for an individual member of staff to leave the work area to do so themselves.

3.5 Records transported by support staff must be placed in a sealed envelope as per the Medical Record Transport Guideline.

4. INCIDENT REPORTING

All incidents involving a missing medical record that have direct patient care implications are reported electronically via Riskman. Failures to return records to HIS within the specified timelines in section 2.1 may also be reported on Riskman.