

# HEALTHCARE RECORDS MANAGEMENT PROCEDURES 2020

Issued by: Pro Vice Chancellor and Executive Dean, Faculty of Medicine and Health]

Dated: 17 December 2020 (commencing 13 January 2021)]  
24 April 2024 (administrative amendments)

Last amended:

Signature:

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## 1 Purpose and application

- (1) These procedures are to give effect to the:
  - (a) [Recordkeeping Policy](#); and
  - (b) [Health Clinics and Clinical Services Policy](#). (“the policies”)
- (2) These procedures apply to:
  - (a) the University, staff, students and affiliates;
  - (b) health care records that are the property of, and maintained by, or on behalf of, any of:
    - (i) the University;
    - (ii) a category 1 - 4 health clinic; or
    - (iii) a University clinical facility;

**Note:** See the [Health Clinics and Clinical Services Policy](#).
  - (c) all activities undertaken on behalf of the University within health clinics or clinical facilities; and
  - (d) any other health clinic which is contractually bound to follow these procedures, or particular clauses within these procedures.
- (3) These procedures do not apply to:
  - (a) health clinics that are operated by external entities from premises that are not University lands (category 5 health clinics);

**Note:** See the [Health Clinics and Clinical Services Policy](#).
  - (b) health care or other records maintained by external clinicians providing services to patients seen in private rooms;
  - (c) affiliates undertaking clinical work outside their University engagement; or
  - (d) veterinary services.

## 2 Commencement

These procedures commence on 13 January 2021.

## 3 Interpretation

- (1) Words and phrases used in these procedures and not otherwise defined in this document have the meanings they have in the policies.
- (2) In this document:

**health care record** means a documented account of each health service interaction or intervention with a particular individual, providing details of the individual's:

- history of illness;
- health care plans;
- health investigation and evaluation;
- diagnosis;
- care;
- treatment; and
- progress and health outcome.

**Proper Officer** means the person appointed to receive subpoenas on behalf of the University. At the time of these procedures' commencement, it is the University's Records Manager.

## 4 Purpose and function of health care records

- (1) A health care record is the primary repository of information including medical and therapeutic treatment and intervention for the health and wellbeing of an individual during an episode of care, and it informs future episodes of care.
- (2) A health care record may also be used for:
  - (a) communicating with external health care providers, and statutory and regulatory bodies;
  - (b) facilitating patient safety improvements;
  - (c) investigating complaints;
  - (d) planning;
  - (e) audit activities;
  - (f) research (subject to ethics committee approval, as required);
  - (g) education;
  - (h) financial reimbursement; and
  - (i) public health purposes.



- (3) Health care records include, but are not limited to:
  - (a) information about any or all of the patient, participant or carer;
  - (b) information relating to:
    - (i) assessment;
    - (ii) diagnosis;
    - (iii) care planning; and
    - (iv) management;of the patient or participant;
  - (c) details of the care, treatment or services provided to the patient or participant, and the responses or outcomes;
  - (d) details of professional advice sought and provided;
  - (e) records of observations taken and results.
- (4) Health care records do not include records of complaints.

**Note:** See clause 7.

## 5 Recordkeeping principles

- (1) The requirements of the [Recordkeeping Policy](#) apply to all health care records. These procedures apply in addition to those requirements.
- (2) A health care record may be kept on paper, in electronic form or both. Where health care records are maintained in both forms, the relevant managers must provide health care personnel with access to the information that is included in each part.
- (3) All clinicians and students must accurately record their interactions with patients, participants and their carers, consistently with the requirements of these procedures.
- (4) All information contained in a health care record is confidential and subject to:
  - (a) the [Privacy Policy](#);
  - (b) the [Privacy Procedures](#);
  - (c) the [Health Records and Information Privacy Act 2002 \(NSW\)](#).
- (5) The staff member responsible for supervising students in a clinic must:
  - (a) obtain from each student a written undertaking to comply with the requirements of the [Health Records and Information Privacy Act \(2002\)](#) before the student is permitted to participate in any activity at the clinic; and
  - (b) file copies of the signed undertakings in appropriate clinic and University files.
- (6) Attending clinicians and clinic managers must provide patients, participants and their carers with information about the collection of their health information, and the uses to which it may be put. This may occur:
  - (a) at the time of intake or consultation;
  - (b) through information displayed in public areas;



- (c) during discussion and signing of consent forms before a consultation or intervention; or
- (d) at other times as required (for example, where a change in scope of consent is requested).

## **6 Documentation requirements**

- (1) Every page or screen of a health care record must show:
  - (a) a unique identifier (for example, a patient or participant identifier or a medical record number);
  - (b) the patient or participant's:
    - (i) family name and given names;
    - (ii) date of birth;
    - (iii) sex; and
    - (iv) allergies, sensitivities or adverse reactions, and the known consequences.
- (2) The attending clinician or student must confirm the details specified in subclause 6(2) with the patient or participant at each presentation, to ensure accuracy and allow for corrections to personal information where required.
- (3) Health care records must be:
  - (a) in the English language;
  - (b) clear, accurate and legible; and
  - (c) factual and objective, with no demeaning or derogatory remarks.
- (4) Only abbreviations approved by the clinic or clinical service may be used in health care records.
- (5) The attending clinician or student must make an entry in the health care record for each patient or participant attendance where individual care is provided, including video conference sessions or other electronic consultations or group sessions where individual care is provided.
  - (a) The supervising clinician must co-sign all entries made by students involved in the care and treatment of a patient or participant.
- (6) Health care records must consist of sequential, contemporaneous entries each of which records:
  - (a) the date and time of the recorded interaction;
  - (b) the date and time the record was made, if different to the time of the interaction;
  - (c) the author and their designation;
  - (d) the author's electronic signature, for electronic records.
- (7) If it is necessary to correct or add to an entry in a health care record, the original entry must be retained, and the addition or correction clearly identified. Changes must be retained, and the nature of the correction must be evident.
  - (a) If an entry omits details, any additional details must be documented next to the heading "Addendum", including the date and time of the omitted information and the date and time of the addendum.



- (b) All errors must be corrected.
  - (i) Incorrect entries must not be overwritten, erased or deleted and correction fluid must not be used.
  - (ii) If an entry is incorrect, a line must be drawn through it (manually or using “strikethrough” in electronic records) and the annotation “written in error” added immediately after the incorrect text.
  - (iii) The author of a correction must add their name (printed), signature, designation and the date and time of the correction.
  - (iv) Student corrections must be countersigned by the relevant supervising clinician.
- (8) The following matters must be recorded in a patient’s or participant’s health care record where applicable.
  - (a) Changes in a patient’s or participant’s condition or status. Entries must include:
    - (i) the time of the change and the entry;
    - (ii) the actions taken;
    - (iii) notifications made to supervising clinicians; and  
the record number or other identifying information from the applicable entry in the relevant incident management system.
  - (b) Infection prevention and control risks.
  - (c) Behaviour issues that may pose a risk to the patient or participant, or to others.
  - (d) Child protection or wellbeing concerns.
- (9) Medical practitioners must record, for each patient or participant:
  - (a) their medical history;
  - (b) their diagnoses (as a minimum a provisional diagnosis);
  - (c) investigations, treatment, procedures and interventions, including details of tests ordered and results received;
  - (d) their progress for each treatment episode;
  - (e) a medical treatment plan, for conventional health care clinics;
  - (f) a record of each invasive procedure performed, or anaesthetic administered, including completion of all required procedural checklists; and
  - (g) copies of any relevant forms or certificates provided to the patient or participant.
- (10) Where documentation or care is delegated to another medical practitioner, such as a fellow or registrar, the primary medical practitioner is responsible for the care and quality of the clinical documentation and is required to countersign each entry on the health care record.
- (11) Electronic consultations (whether by telephone or audio visual link) must be included in the patient or participant’s health care record and must include, in addition to other requirements:
  - (a) the identification and designation of the attending clinician and any student present;
  - (b) details of the supervising clinician where contact is made by a student;

- (c) the means by which the consultation was conducted (e.g., telephone, Zoom link); and
  - (d) the purpose of the call and its outcome;
- (12) Procedural or research consent forms must be added to the patient's or participant's medical or research record by the clinician responsible for the procedure or research.
- (a) Clinical supervisors must also add consent forms for student-led clinics or consultations to the student's record on the University's recordkeeping system.

**Note:** See the [Recordkeeping Policy](#).

- (13) The attending clinician must record any notice received from a patient or participant, or their carer where appropriate, that an individual is leaving a clinic in the manner required by the clinic or clinical service management.

## 7 Incidents and complaints

- (1) The attending or witnessing staff member or student must record clinical incidents (including near misses) in:
- (a) the patient's or participant's health care record;
  - (b) the University's [Riskware](#) incident management system; and
  - (c) any other required incident management system (for example, those operated by a Local Health District).

- (2) The recipient of a complaint (staff or student) must record complaints:
- (a) in the University's [Riskware](#) incident management system; and
  - (b) any other required incident management systems as.

**Note:** See the [Resolution of Complaints Policy](#); [Faculty of Medicine and Health – Professionalism Provisions](#); [Faculty of Medicine and Health – Professionalism Requirements Provisions](#).

- (3) The clinic supervisor or other individual responsible for investigating the complaint or incident must record details of all information provided to patients, participants or their carers in relation to incidents or complaints.

## 8 Access to information and records

- (1) Health care records must be managed at the point of care or service delivery. The supervising clinician or Head of Discipline is responsible for managing access to these records in University clinics or clinical facilities.
- (2) Except as required by law, or with the consent of the person to whom they relate, health care records will only be provided to:
- (a) the relevant patient or participant;
  - (b) the authorised agent of the relevant patient or participant; and
  - (c) in accordance with University policy and procedures.

**Note:** See the [Privacy Policy](#); [Privacy Procedures](#); [Resolution of Complaints Policy](#); [Recordkeeping Policy](#).



- (3) All requests from external parties (i.e., not from, or with the authorisation of, the relevant patient or participant) for information contained in an individual's health care records must be provided to the University's Proper Officer as soon as possible after receipt.
  - (a) No information from a health care record may be provided to an external party without prior consultation with the Proper Officer.
- (4) For the purposes of subclause 7(2)(b), an authorised agent is any of:
  - (a) the parent or guardian of a minor;
  - (b) the appointed guardian or custodian of an adult who is not competent to manage their own affairs;
  - (c) the holder of a relevant power of attorney given by the patient or participant; or
  - (d) if the patient or participant:
    - (i) is deceased;
    - (ii) is otherwise unable to consent due to illness or incapacity; and
    - (iii) has no other formally appointed personal representative;the next-of-kin.
- (5) Health care records, and the systems for managing them, may be audited on the direction of:
  - (a) the Clinical Governance and Support Office; or
  - (b) the Senate Audit & Risk Committee;

## 8 Retention and disposal of records

- (1) All health care records must be retained and disposed of consistently with the requirements of the NSW State Records Authority [General Retention and Disposal Authority 17](#).
- (2) Generally, the retention period for health care records is:
  - (a) for adults, seven years from the date of the last health interaction; and
  - (b) for children, until the individual is aged 25 years.
- (3) Records may only be disposed of consistently with the requirements of the [Recordkeeping Policy](#). In particular:
  - (a) records may only be disposed of (including but not limited to destroyed) with the prior approval of the Records Manager, Archives and Records Management Services; and
  - (b) records may only be destroyed in a manner approved by the University's Archives and Records Management Services Unit.

**Note:** See the [Recordkeeping Manual](#).

## NOTES

### Health Care Records Management Procedures 2020

Date adopted: 17 December 2020

Date commenced: 13 January 2021

Date amended: 24 April 2024 (administrative amendments)

Administrator: Executive Dean, Faculty of Medicine and Health

Review date: 17 December 2025

Rescinded documents:

Related documents: Health Records and Information Privacy Act 2002

State Records Act 1998 (NSW)

State Records Regulation 2015 (NSW)

NSW Health - Health Care Records – Documentation and Management Policy PD2012\_069

NSW Health – Privacy Manual (Version 2) PD2005\_593

[State Archives and Records Authority of New South Wales General Disposal Authority 17 \(GDA17\)](#)

State Records Standard No 1, Standard on records management, 2014

University of Sydney (Delegations of Authority) Rule

Health Clinics and Clinical Services Policy

Privacy Policy

Recordkeeping Policy

Risk Management Policy

Faculty of Medicine and Health – Professionalism Requirements Provisions

Health Clinic and Clinical Services Procedures

Privacy Procedures

Recordkeeping Manual



## AMENDMENT HISTORY

<b>Provision</b>	<b>Amendment</b>	<b>Commencing</b>
Throughout	Administrative amendments to remove the year in policy references	24 April 2024