

Leschenault Medical Centre

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PRACTICE POLICY FOR THE MANAGEMENT OF HEALTH INFORMATION

Nature and scope of this practice policy

This practice policy primarily addresses the management of “personal health information” in the practice.

This practice policy covers the following areas:

1. Privacy
2. Third party access to the medical record
3. Access to the medical record by a new treating GP
4. Patient access to medical records
5. Security
6. Staff training
7. Informing new patients

Personal health information is defined as information which concerns a patient’s health, medical history or past or present medical care; and which is in a form that enables or could enable the patient to be identified.

This policy is based on the 1998 RACGP *Code of Practice for the Management of Health Information in General Practice*. The code is consistent with the National Principles for the Fair Handling of Personal Information. This practice policy is also consistent with the 1996 RACGP *Entry Standards for General Practices*.

While the policy focuses on the management of the patient’s medical record, it also relates to information recorded, for example, in billing and accounting records, pathology and radiology results, medical certificates and letters to and from hospitals and other doctors.

The practice policy is not about the quality and content of medical records. (Section 2 of the 1998 RACGP *Code of Practice for the Management of Health Information* and the 1996 RACGP *Entry Standards for General Practices* both deal with these issues.)

1. Privacy

All GPs and staff will take steps to ensure that patients can discuss issues relating to their health, and that the GP can record relevant personal health information, in a private setting where unauthorised people cannot access the information.

For example: GPs will ensure that consultations are conducted in a manner that prevents conversation from being overheard. Staff will not enter a consultation room during a consultation without knocking or otherwise communicating with the GP. Staff, registrars and students should not be present during the consultation without the prior permission of the patient.

2. Third party access to the medical record and to personal health information by practice staff and for practice research and Quality Assurance

Patients new to the practice will be informed by the GP at the first consultation that the practice normally allows access to patient records by other GPs in the practice, by GP locums and by general practice Registrars attached to the practice for training for the purpose of patient care and teaching.

The GP will give the patient the opportunity to limit access to their record and to have this noted in red ink in the front of the record or in the “alert” section of the computerised record.

New patients will also be informed that the practice undertakes research and quality improvement activities, from time to time, to improve individual and community health care and practice management. Patients will be informed when such activities are being conducted and given the opportunity to “opt out” of any involvement in the activities. The GP responsible for the activity will ensure that appropriate information is available from the reception staff for patients.

When research projects are conducted in the practice under the approval of an institutional ethics committee, staff must be aware of the requirements to obtain consent specified in the research protocol and ensure that consent is properly obtained.

Where possible identifying information will be removed from personal health information being used for research and QA activities. Where this is not possible, internal staff accessing the personal health information should be aware that they are under an obligation of confidentiality not to disclose the information. Breaches of that obligation may result in instant dismissal. The responsible practice GP will ensure that any external researchers are also under an explicit written obligation of confidentiality with appropriate penalties for disclosure.

Other disclosure

GPs and staff will ensure that personal health information is disclosed to third parties only where consent of the patient has been obtained. Exceptions to this rule occur when the disclosure is necessary to manage a serious and imminent threat to the patient’s health or welfare, or is required by law.

GPs will explain the nature of any information to be provided to others about the patient, for example, in letters of referral to hospitals or specialists. If appropriate the letter may be shown to the patient. In terms of a referral letter, patient consent is implicit in their agreement to take the letter to the hospital or specialist.

GPs and staff will only disclose to third parties that information which is required to fulfil the needs of the recipient.

These principles also apply to the personal information provided to a treating team and available, eg, via an Intranet.

Information disclosed to Medicare or other health insurers would be limited to the minimum required to obtain insurance rebates. Information supplied in response to a court order will be limited to the matter under consideration by the court.

Information classified by a GP or patient as restricted will not be disclosed without the explicit consent of the patient and/or GP.

3. Access to the medical record by a new treating GP

Access to accurate and up to date information about the patient by a new treating GP is integral to the GP providing high quality health care. If a patient transfers away from the practice to another GP, and the patient requests that the medical record is transferred, the existing GP will provide the record, a summary or a photocopy to the new treating GP.

4. Patient access to medical records

It is practice policy that all patients have access to the health information contained on their file. The treating GP will provide an up to date and accurate summary of their health information on request or whenever appropriate.

The treating GP will consider any request made by a patient for access to the medical record itself. In doing so he/she will need to consider the risk of any physical or mental harm resulting from the disclosure of health information and will protect any information provided by others on a confidential basis.

If the GP is satisfied that the patient may safely see the record then he/she will either show the patient the record, or arrange for provision of a photocopy, and explain the contents to the patient. A charge of 10c per sheet will be requested from the patient for any photocopying.

5. Security

GPs and staff will protect personal health information against unauthorised access while it is being stored and transmitted.

Staff will ensure that patients and other visitors to the practice will not have access to the medical record storage area and that records, pathology test results and any other papers containing personal health information are not left where they may be accessed by unauthorised persons.

Non clinical staff will limit their access to personal health information to the minimum necessary for the performance of their duties.

Fax, e-mail and telephone messages will be treated with security equal to that applying to medical records.

Computer screens will be positioned in a way which prevents unauthorised viewing of a patient's personal health information. Staff will ensure that computers left unattended cannot be accessed by unauthorised persons.

GPs and staff will ensure that personal health information held in the practice is secured against loss or alteration of data.

Patient records will not be taken away from the practice except when required by clinical staff for the care of a patient and kept securely during this time. The responsible clinician will ensure that the record is returned to the practice and left in an appropriate place for filing.

Medical records and other papers containing personal health information will be filed promptly after each patient contact.

Staff will ensure that the record and filing areas are secured at the end of each day and that the building is locked when leaving.

The data on the computer system will be backed up daily and a duplicate backup tape given to the nominated staff member for storage off site.

6. Retention of medical records

It is the policy of the practice that individual patient medical records be retained until the patient has reached the age of 25 or for a minimum of 7 years from the time of last contact, whichever is the longer. No record will be destroyed at any time without the permission of the treating GP or of another GP if the treating GP is no longer involved in the practice.

In the event of a GP being deceased or transferring out of the practice, the practice will post a notice in the practice waiting room, or a GP who is leaving may choose to write individually to each patient, asking the patient to nominate a practitioner to whom the record should be transferred.

If the practice closes, either patients will be contacted individually or, if this is not practical, a public notice will be placed in the local newspaper indicating the way in which patients should arrange for the transfer of their record to another GP.

It has been arranged that any medical records not transferred will be stored securely under the supervision of Leschenault Medical Centre.