The Rowley Road Clinic

Patient Health Record Policy

May 2025

A medical record is a detailed, confidential document compiled by a health professional, over a period of time, on a particular person. Its primary purpose is to:

- Identify a person accurately
- Record symptoms and signs
- Support diagnosis and treatment
- Justify management decisions.

Record all information fully and accurately including (but not limited to):

- Medications
- Allergies
- Vaccinations
- Cultural background
- Lifestyle risk factors

This Rowley Road clinic uses an electronic record system being Best Practice Version Orchid SP1 Revision Addition

Medical records are integral to the provisions of effective ongoing care. This practice has an obligation to maintain records in a form that facilitates this.

All significant contacts with the patient, regardless of whether they are face-to-face or via the telephone will be recorded in the patient's medical record. This is to enhance continuity of care.

An alert notification for allergic responses and drug reactions is marked in the patient's medical record.

Creating a New Patient File

- Collect patient name, address, date of birth, related demographic details and emergency contact details.
- Enter Medicare and concession details then run confirmation check.
- Update HI number and enable SMS consent unless the patient has opted out.
- Enter information on the computer or copy and paste from Hot Doc New patient form.
- Notate as new patient on the GP appointment.

Content of Health Record

Our practice ensures that at least 50% of active health records contain a health summary including:

- Adverse medicines events
- Current medicines list
- Current health problems
- Past health history
- Risk factors
- Immunisations
- Relevant family history
- Relevant social history

Our practice also ensures that:

90% of active health records contain a record of allergies in the health summary

'Active health records' are considered to be records of a patient who has attended our practice 3 or more times in the past 2 years.

Significant face-to-face, telephone or electronic communication is recorded in the patient record

Health records are updated to show recent important events including immunisations, births and family history changes

Consultation Notes

Our practice documents all consultations including those outside normal opening hours, home or other visits and clinically significant telephone or electronic consultations.

Consultation must include the following:

- Date of consultation
- Reason for consultation
- Relevant clinical findings
- Diagnosis
- Recommended management plan and where appropriate expected process of review
- Prescribed medicine (including medicine name, strength, directions for use/dose frequency, number of repeats, and date medicine started/ceased/changed)
- Any relevant preventive care undertaken
- Documentation of referral to other health care providers or health service
- Any special advice or other instructions
- Identification of who conducted the consultation, e.g. by initial in the notes, or audit trail in electronic record
- Evidence that problems raised in previous consultations are followed up

Our patient health records show evidence that problems raised in previous consultations are followed up.

Results, Reports and Clinical Correspondence

All tests and results including pathology results, diagnostic imaging reports, investigation reports and clinical correspondence received are scanned in or downloaded via HealthLink under the patient's name, in the treating doctors inbox. Once the information has been viewed and/or actioned it moves into the patient health record

Our practice has a system in place to follow up tests and results, reports and clinical correspondence where there is a concern about the significance of the test or result. This also includes tests or referrals ordered for the patient. **This forms part of our Recall and Reminder system.**

This system is managed jointly by the doctor, practice nurse and administration. It is however the GP's responsibility to identify and flag patients of concern.

Scanning

In our practice, we scan patient correspondence received into the patient's electronic record.

Our scanning processes consist of the following steps:

Once scanned moved to confidential storage bin which is emptied every 3 months. Theses documents remain un shredded so can be retrieved if required during this time.