Policy and Procedure for Handling Newly Received Patient Notes

1 SUMMARY

- All incoming notes need to be summarised within 10 days of receipt
- Medications Reconciliation needs to be done within 2-7 working days
- Check both electronic and hard copy notes (if any). Always import electronic notes prior to manually inputting notes from hard copy to reduce workload and multiple data entries
- Electronic notes include GP2GP, specialist reports and test results
- It is the role of the nurse assigned to "Paperwork" in any given session to ensure that the incoming notes are summarised in the PMS and that the receptionist assigned to acknowledging incoming notes responds to the Medical Centre from which the notes have come from.

2 POLICY STATEMENT

2.1 Purpose

Patient records are essential for managing and auditing patient information. Continuity of care requires that information is robust and available when needed so that practice teams can manage and track conditions. Effective patient data is up to date, readily accessible, safely stored, and has an audit trail to meet Health Sector, Health and Disability Commission or other legal requirements.

This policy outlines the protocols and processes that will be followed by staff working in this practice to in the handling of newly received patient notes.

2.2 Background

The Health Information Privacy Code 1994, Rule 5 – Storage and Security of Health Information, directs that the Practice has the role of responsible custodian of health and patient information and will therefore promote and help protect the privacy of personal information received.

Most health related information is collected in a situation of confidence and trust, is generally highly sensitive and may include particularly sensitive personal details which must be protected at all times.

2.3 Scope

This policy applies to all staff engaged in any activity carried out at this practice including those not directly employed by the practice eg Mental Health professionals.

2.4 Responsibilities

All staff are responsible for ensuring this policy is followed.

2.5 Definitions & Abbreviations

HIPC	Health Information Privacy Code 2000
Health information:	is any information, such as medical history, disabilities, daily notes, classifications and screening results, dispensing record, discharge

	summaries, and test results, that can be associated to the patient the information relates to. Also includes any information of a personal nature such as contact details, next of kin etc.

2.6 Related Policies

- Privacy Policy
- Complaints Policy
- Security of Electronic Health Information

3 POLICY DETAIL AND PROCEDURES

3.1 Importing electronic GP2GP notes

GP2GP notes that have been electronically imported will appear in the Provider Inbox under the subject line "Patient Transfer In.

- Click on "Patient Transfer In" message to upload the file.
- Click on the "Import' buttom on the bottom right to bring you to the notes categories screen.
- For each highlighted category (other than "demographics" which we would have already entered when the patient first registered and/or enrolled), click on the blue "Next" button to import the patient data. Keep clicking on this until the orange message "save all section changes and close" appears. Select this. (If a message that says "please select screening template against each vital group" appears then the lines in pink need to be matched somewhere in Indici. There are 2 places to look. Click on "Template" and if there is no template to file them against select Add and they will be added into the patient notes.)
- Select yes you want to save changes. Once saved, the PMS will take you back to the Inbox screen
- Type IMPORTED into rectangular box at the top that is for clinical field comments to record that the task is completed.
- Select OK

For large patient files, there can be more than one inbox document to import. Ignore double up of patient data as the PMS will recognise this and only enter data in once.

- Check imported fields and enter details that may be missing e.g. ensure problem list and allergies are up to date.
- Do medications reconciliation by checking what patient may have already been prescribed with what their imported notes inform us and check with HealthOne database. Enter that this has been done using the keyword ..medrev (this part of the process will be audited every 1-2 months. See Medications Review and Reconciliation Policy).
- The hard copy notes will also be checked within the next 10 days.

Remember that we may not actually receive all the relevant notes as it depends what the person sending them has chosen.

3.2 Summarising hard copy notes

Hard copy of patient notes are put into a box in the Nurses' room and the day they arrived is recorded on the front page of the notes. Please record when they are summarised and when the medication is reviewed on the spreadsheet on the front of the box. Once summarised, the hard copy of notes can be filed.

Use the keyword ..nn as prompts to summarise the new notes as below:

- Check the front page of the hard copy notes for anything useful e.g. family and/or patient history, allergies etc. Put this info into relevant areas i.e. classifications
- Vaccination history / Immunisation status

  For all children under 18 perform an NIR search. Task yourself to follow this up and obtain a vaccination record from families if there is no record. Follow the overseas vaccination catch up procedure.

  For those not on the NIR and under 27 check the vaccination status and put into the immunisation screen (see procedure for recording immunisations given overseas). If the patient has not had a HPV and is under 27 enter a recall for this.

  For older people enter any known immunisation or disease history.
- Enter the following into diagnosis / coding:
  - Family history
  - Personal history / conditions / procedures
  - Social history including current work or how they spend their time (enter occupation in patient details screen).
  - Recreational drug use / No drug use
  - Disabilities /Impairment eg hard of hearing or mobility issues
  - Domestic violence – enter under social / living
  - Smoking status: Enter smoking status into dashboard remembering we need a b and c code. If smoking status unknown txt (txtsm). If a smoker txt (txtcsm). The replies to these will be seen by Lynne in her email.
  - Alcohol use

  Once the above have been entered into diagnosis/coding go to the diagnosis part and select (where appropriate)
  L = long term P = Problem List H = highlight to add these to the Problem List under the patient palette
- Enter Allergies / Adverse reactions
- Medication reconciliation:

  Look through recent hospital, specialist and other correspondence to ensure medications are reconciled (i.e. there are no discrepancies with what a specialist has prescribed and what DOR has prescribed). If there is a discrepancy alert the GP provider. Document. See Medications Reconciliation Policy.
- Screening Recall
  - Cervical Smear for women:

    look for smear or results and put in the recall date in Recall menu. If there is no evidence of them having had any, look on Health One or send a letter to the National Cervical Screening Programme in the 'Outbox'.
  - Mammogram for women:

    Check that all women over 45 years have a Breast Screen status and enter in Tab 3 of Patient Details.

Enter any other information that could be useful to know. Then put a note in the Patient Timeline to to state that the old notes have been summarised.

If there is anything that needs attention, bring it to the notice of a doctor.

IF ANY OF THE ABOVE INFORMATION IS MISSING PLEASE ADD AN ALERT IN THE PATIENTS NOTES ASKING FOR THIS.

REFERENCES

- Privacy Act 2000
- Health information Privacy Code 2000
- Health (Retention of Health Information) Regulations 1996