**Sherbourne Road Medical Clinic**

**7.2 Policy on Managing Patient Health Information**

Patients at our practice have their own individual patient health record containing all the health information held by our practice about that patient.

All patients that have attended the practice/service in the last 2 years should have essential information in their health summary and active patients i.e. those attending 3 or more times in 2 years should have a comprehensive health summary.

All staff endeavour to keep the information in patients’ health records up to date and where possible data is entered using accepted coding or drop down selections rather than free text to assist with practice audits and chronic disease registers. Care is taken when entering sound alike or look alike medicines, particularly when using the “drop down” boxes in electronic prescribing programs.

Medical records are essential to provide evidence of all services billed under the Medical Benefits Schedule (Medicare) and the continuing care of our patients. The contents are confidential and covered by privacy legislation. Doctors and staff have a responsibility to maintain the confidentiality of every medical record, which is each patient’s right.

Recording of patient health information should be to the standard that a locum or another doctor could easily and efficiently take over the care of the patient. As a key component for the continuing management of our patients, contemporaneous, legible, accurate and complete records are kept.

To ensure optimum documentation of medical care and to meet our legal risk obligations all staff involved in clinical care are able to document their care activities in the medical records logging in using their own password. Training appropriate to their level of access should be provided to all staff recording clinical management in the medical records or utilising the records for clinical management activities e.g. reminder/recall.

Our staff are also well aware of the importance of recording the cultural background of patients since this background can be an important indication of clinical risk factors and can assist GPs and other staff in providing relevant and culturally appropriate care. (Refer Section 5 Culturally Appropriate Care).

An active patient health record is defined as the record of a patient that has attended the practice/service three or more times in the last two years.

To assist in the provision of optimum care to patients, our practice integrates with other services. Information, including referral arrangements for these public and private providers, and contact details are maintained on a central register which is accessible to all practice staff. Details of referrals are documented in the patient medical record.

The patient health records contain evidence of a system to review and follow up test results.

We are working towards a systematic approach to the entry of patient data in the medical records to facilitate the search, extraction and utilisation of patient information for our prevention and screening activities. This includes comprehensive patient health summaries and documentation of preventative activities in the patient’s medical records.