

Private Health Facilities (Standards) Notice

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| **Information management standard (version 5)** | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. Information management systems meet the needs of patient care delivery and the organisation**.** |  | Provide name of information management system used at facility e.g. Simday, Meditech. |  |
| 1. The health facility’s medical records comply with Australian Standard 2828.1 - 2012 (Health records - Paper-based health records) and/or AS 2828.2(Int)-2012 Health records - Digitized (scanned) health record system requirements. |  | Names of relevant policies / procedures that demonstrate requirements for medical records, include version number and date of most recent review. |  |
| 1. Each patient, including each infant born or treated at the health facility, has a complete **medical record** which includes the following:  * information required for the provision of reports to the Chief Health Officer under section 144 of *the Private Health Facilities Act 1999*; * progress notes which include the patient’s medical history, the nature of the principal condition of the patient and the nature of any other condition, including adverse events, treated during the patient’s stay in the health facility; * the nature of any surgical/diagnostic procedure performed on the patient during an episode of care; * a daily record of all medical and nursing care given in relation to the patient’s medical, physical, psychological and social needs and responses; * detail of all medication; and medication plan * record of informed consent for the performance of any surgical and/or potentially harmful diagnostic procedures and/or treatment regime. |  |  |  |
| 1. The minimum period for the **retention and storage** of medical records is:  * for clinical records – 10 years after the last clinical attendance or last medico-legal action, whichever is later; * for minors’ clinical records and obstetric records – 10 years from the child attaining adulthood (18 years); * for patients with a condition affecting their decision-making capacity (e.g. intellectually disabled relating to traumatic brain injury, dementia, or severe mental illness) – 10 years from the date the patient’s decision-making capacity is no longer limited, or 80 years from the date of birth of the patient. |  | Provide names of policy documents about healthcare record management, including access, storage, security, consent and sharing of patient information, including version numbers and date of most recent review. |  |
| 1. All records of Assisted Reproductive Technology procedures are retained according to National Health and Medical Research Council guidelines. |  | N/A |  |
| 1. The following **registers** are available where relevant: |  |  |  |
| * Admission and Discharge register: * Birth Register * Operating theatre and/or procedure register: |  | Name of system |  |
| * Mental health register:  1. information required under the relevant Mental Health legislation. |  | N/A |  |
| 1. Security of records complies with:  * AS ISO/IEC 27001:2015 Information technology – Security techniques – Information security management systems – Requirements. * AS ISO/IEC 27002:2015 Information technology – Security techniques – Code of practice for information security controls. |  | Provide names of relevant policy documents, including version numbers and date of most recent review. |  |