SESLHD PROCEDURE COVER SHEET

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
AUTHOR	SESLHD District Clinical Forms Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Dr Tony Sara on behalf of the SESLHD Clinical Forms Subcommittee
FUNCTIONAL GROUP(S)	Clinical Forms Records Management - Health
KEY TERMS	Clinical form, medical record, healthcare record form, order of forms, healthcare record.
SUMMARY	Outlines the process to follow when a SESLHD clinical form (paper or electronic) is to be created or an existing form requires revision. The scope of this procedure only includes forms that are: • to form part of the Patient Health Care Record • developed within SESLHD

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1. POLICY STATEMENT

South Eastern Sydney Local Health District (SESLHD) has identified the need to develop a consistent procedure in order to manage the appropriate development, revision and, if applicable, printing of Clinical Forms to be included in the Patient's Health Care Record. The scope of this procedure only relates to clinical forms that are:

a) to form part of the Patient Health Care Record (applies for both paper and some electronic – including Cerner Millennium – forms, most electronic forms are dealt with by the joint SESLHD/ISLHD forms committee)
b) developed within SESLHD.

2. BACKGROUND

All SESLHD clinical forms forming part of the Patient Health Care Record are to be trialled and approved for development/revision according to the processes detailed within this procedure, including review and approval by:

- the Clinical Stream/Service/Site Manager who is responsible for considering/evaluating the financial resources required for printing, photocopying and training
- the SESLHD Clinical Forms Committee.

All clinical forms should be reviewed regularly to ensure that the content remains appropriate and reflects best practice. Should this not be the case, revision should be undertaken as soon as possible.

The impact of creating new clinical forms is to be considered. This may include:

- increased staff workload for staff completing the form (paper-based or electronic) and Medical Record Staff filing the form (paper-based)
- increased size of paper-based medical records, which may impact on storage space and have potential WH&S issues due to the weight
- costs (paper based) - double-sided printing increases the printing costs, so instructions should not generally be included on the back of clinical forms but be laminated and placed in an obvious area when introducing the form and be included in a procedure/policy document
- costs (electronic) – form build costs.

All paper-based unofficial/unapproved clinical forms filed in the Patient Health Care Record will be followed up with the Ward/Department/Service by the Medical Record Department and should cease to be used.

Revised paper clinical forms, once approved, will be printed as soon as the current supply is depleted. Alternatively, existing stock can be bought out to allow for the immediate printing of the amended form.

No photocopying of non-completed Patient Health Care Record clinical forms is to be conducted, unless permission is obtained (See below).

In the instance of the supply of clinical forms being depleted even though print orders were timely, approval is to be obtained from the site Medical Record Manager by the relevant

Stream Senior Nurse Manager/Allied Health Manager, to photocopy a small supply of good quality clinical forms until the order is filled.

The relevant Ward/Department Manager will liaise with the District Print Manager to determine the delay in filling the printing order.

Poor quality photocopied blank clinical forms will be followed up with the Ward/Department/Service by the Medical Record Department.

2.1 DEFINITIONS

- **Custodian:** is responsible for the overseeing of the consultation process in the development and revision of the clinical form prior to approval by the SESLHD Clinical Forms Committee.

- **Health Care Record:** a Health Care Record is a documented account of a patient's/client's health evaluation, diagnosis, illness, treatment, care, progress and health outcome that provides a means of communication for all health care personnel during each visit or stay at a health service. It is the primary repository of all information regarding patient/client care, and may be in paper or electronic form or both.

  The record is used to document care provided to the patient/client during an episode of care but may also be used for future episodes of care, communication with external health care providers and regulatory bodies, planning, research, education, financial reimbursement, quality improvement and public health. The health care record may also become an important piece of evidence in protecting the legal interests of a patient/client, clinician or Health Service.

- **Author:** the individual and/or Committee, with the overall responsibility for the development and consultative process involved in the preparation of the clinical form.

- **Unofficial form:** a form included in the Patient Health Care record that has not followed this approval process.

3. RESPONSIBILITIES

General Managers, Clinical Stream Directors, Service Directors, Clinical Department Managers, Medical Staff, Nursing Staff, Allied Health Staff, Clinical Information/Medical Record Managers and Staff and Ward Clerks.

3.1 Custodians and Authors of Clinical Forms are responsible for the following during the Development Phase:

- Contact their relevant District clinical forms representative and request an application package
- Source relevant best practice evidence
- Involve staff with expertise and knowledge in the development of the clinical form
- Ensure there is endorsement from the relevant District/Stream Committees and the document is compliant with current guidelines and policies (NSW Health, SESLHD)
- Ensure wide consultation with consumers to obtain feedback

- Ensure the clinical form is consistent with the District Clinical Forms template and satisfies AS-2828.1:2019 as well as NSW Ministry of Health Policy Directive - PD2012_069 - Health Care Records – Documentation and Management
- Send electronic version of the form with completed application package to the District Clinical Forms representative for submission to the SESLHD Clinical Forms Committee for approval/trial.

Clinical Forms should be based on best practice, legislative requirements, Ministry of Health policy directives, Australian Standard 2828.1, specific industry requirements, regulatory and professional body requirements.

3.2 SESLHD Clinical Forms Committee is responsible for the following during the approval of a form for trial:

- Ensuring all clinical forms meet AS-2828.1 Standard requirements and NSW Ministry of Health Policy Directive - PD2009_072 - State Health Forms and NSW Ministry of Health Policy Directive - PD2012_069 - Health Care Records – Documentation and Management
- Determining the trial length based on the application, the nature, scope and current or anticipated usage of the clinical form
- Organising print work in District template
- Informing the Author/Custodian of clinical forms approval
- Updating the clinical forms register and clinical forms website.

3.3 Custodians and Authors are responsible for the following during the Trial Phase:

- Selecting the trial site
- Organising the printing of the clinical form by liaising with the SESLHD Print Manager.
- Coordinating any bulk ordering for various sites
- Ensuring all relevant stakeholders are alerted to the trial clinical form
- Prior to closure of the trial stage, the author is to ensure the final clinical form has had corrections made and has completed the trial form evaluation or notify the District Clinical Forms representative if trial extension is required
- Submitting the final copy of the clinical form and evaluation to the SESLHD Clinical Forms Committee for final printing approval.

3.4 SESLHD Clinical Forms Committee is responsible for the following during the Final Printing Approval:

All clinical forms to be filed in the patient healthcare record must be approved by the SESLHD Clinical Forms Committee unless directed by Ministry of Health Policy Directives or Information Bulletins.

- Organise the clinical form to be formatted professionally into the District template, ensuring it meets AS2828.1:2019
- Assign a SESLHD form number and barcode
- Referring finalised clinical forms or pathways involving medicines use to the SESLHD Drugs and Therapeutic Committee (DTC) for approval prior to use, in line with NSW Ministry of Health Policy Directive PD2022_032 - Medication Handling
- Determine the stock levels based on usage

- Contact the Author/Custodian on approval of clinical form
- Update forms register and website
- Escalate high usage and relevant forms to the State Forms Management Committee.
- Liaise with the State Forms Management Committee to ensure implementation and application of the State Health Forms Policy Directive
- Communicate the availability of all new/revised clinical forms with relevant site/sector staff
- For clinical forms that are to be included in the Cerner eMR, liaising with the eMR Team to ensure that what is built meets the clinical purpose.

3.5 Custodians and Authors are responsible for the following when the clinical form is finalised for printing approval

- Liaising with the SESLHD Print Manager for printing of the clinical form, bulk ordering and buying out of existing stock (if applicable)
- Notifying relevant stakeholders of the ordering process
- Education and implementation of clinical form
- Removing superseded clinical form/s from circulation (if applicable); including the provision of a cost centre number in the instance that stock is not used/in excess
- Regularly reviewing clinical forms to ensure content is both appropriate and reflects best practice, if found not to be the case, instigation of revision of the clinical form.

4. PROCEDURE

4.1 Identification of the need for new and/or revision to clinical forms included in the Patient's Health Care Record

Sources for identifying the need for the development or revision of an SESLHD clinical form include, but are not limited to:

- Internal and External Audit Reports (National Standards, Internal Audit and Risk Management Department Audit, Numerical Profile and professional College Standards)
- Service reviews, the Incident Information Management System, Complaints, Root Cause Analysis and Process Improvement Teams and Peer review
- Executive sources include (but not limited to) External Regulations relating to Legislative requirements, Ministry of Health Policy Directives, Guidelines, Australian Standards and specific industry requirements, better practice or research evidence
- The need for a working party, identification of Author/Custodian is determined and the site or District Clinical Forms representative is contacted for an application package.

4.2 Design/Formatting requirements

Before designing or redesigning a clinical form the following questions should be considered:

- What is the main purpose of the clinical form, in terms of the work practice to be described and the information it is intended to collect?
- Who will be responsible for completing the clinical form?
- Is it intended that this form replaces an existing clinical form?
- Is the information to be collected on this clinical form already captured on another form, or documented elsewhere within the health care record?

- Why is it necessary for patient care that this clinical form exists?
- Has there been wide consultation?
- Does the clinical form satisfy the formatting requirements AS-2828.1?
- Will the clinical form be on paper or the eMR, or will it be in the eMR and only be a down time paper form?

Paper clinical forms for inclusion in the Patient Health Care Record must meet the formatting requirements, as per AS-2828.1; 2019.

A template that embodies these requirements is available on the Clinical Forms intranet page on the SESLHD intranet and is to be used for the design of all clinical forms covered by this procedure.

The draft clinical form will require approval and allocation of a form number by the SESLHD Clinical Forms Committee prior to trialling of the form.

4.3 Proposed use of clinical form

A comprehensive consultation process is to be conducted by the author/custodian of the clinical form, with relevant stakeholders i.e. wards, departments, clinicians who would utilise the form. For clinical forms or pathways involving medicines use, the finalised form must be forwarded to the SESLHD Drugs and Therapeutics Committee (DTC) for approval prior to use, in line with NSW Ministry of Health Policy Directive PD2022_032 - Medication Handling.

Proposed usage of clinical forms is to be considered prior to ordering the printing of the form.

4.4 Trialling of Clinical Forms

All newly created clinical forms or major revisions to existing forms are to be trialled for a period of up to two months. If further major revisions are made to the clinical form during or after the trial period, a further trial period may need to be undertaken.

The revised clinical form is to include the updated trial review dates or version number.

4.5 Printing/Ordering requirements

- **Existing Stock Clinical Forms:** Notification of any changes required to stock clinical forms must be sent as soon as possible to the District Print Manager to ensure forms are not reprinted in large quantities when changes are pending.

  Once changes are finalised, they are to be sent to the District Print Manager to arrange for new artwork.

  Unless otherwise specified, old stock will be used first then the new version will be printed.

  If old stock is to be destroyed, and the revised version printed immediately, a cost centre must be supplied to the District Print Manager for it to be costed to.

- **New Stock Clinical Forms:** The District Print Manager to organise artwork and stock number.

4.6 Supply/Storage of Clinical Forms

Stock clinical forms will be made available via Stream Solutions and dispatched to the Ward/Department.

4.7 Inter-District Clinical Forms

Clinical Forms that were previously developed as SESIAHS clinical forms may be transitioned into SESLHD clinical forms when possible, e.g. upon re-order. Due to the nature of some clinical forms, content will remain the same for inter-district clinical forms if they are based on best clinical practice or clinical information systems, e.g. eMR/iPM downtime forms.

SESLHD and ISLHD Clinical Forms Committees will liaise directly to ensure consistency of these forms and seamless transition for users.

5. DOCUMENTATION

- Clinical Form template
- New/Revised Clinical Form Application Package
- Clinical Forms Process flow sheet

6. REFERENCES

External references

- AS 2828.1: 2019 Paper Based Health Records
- NSW Ministry of Health Policy Directive - PD2009_072 - State Health Forms
- NSW Ministry of Health Policy Directive - PD2012_069 - Health Care Records – Documentation and Management
- NSW Ministry of Health IB2023_012 - Privacy Management Plan
- Privacy Manual for Health Information
- NSW Ministry of Health Policy Directive PD2022_032 - Medication Handling

Internal references

- SESLHDPR/292 - Hybrid Health Care Record

7. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
August 2012	3	Former SESIAHS PD108 'Clinical Forms – Creation of' Reviewed by SESLHD Forms Committee
February 2014	4	Endorsed by Patricia Bradd on behalf of the SESLHD Health Records and Information Steering Committee
November 2015	5	Reviewed and revised by the SESLHD Clinical Forms Committee to incorporate forms created in electronic format. Document endorsed by Executive Sponsor

November 2016	6	Minor revision at the request of the SESLHD Policy & Procedure Governance Committee
December 2016	6	Endorsed by Executive Sponsor
October 2019	7	Minor Revision. Executive Sponsor updated to Director of Medical Services and Clinical Governance. Endorsed by Executive Sponsor. Formatted by Executive Services prior to publishing.
31 October 2023	7.1	Minor revision. Reviewed and revised by the SESLHD Clinical paper Forms Committee Updated QUMC to SESLHD Drug and Therapeutics Committee. Updated references and Standards.