<table>
<thead>
<tr>
<th>NAME OF DOCUMENT</th>
<th>Hybrid Health Care Record Procedure</th>
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<td>Procedure</td>
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<td>National Standards 1.9.1 and 1.19.1</td>
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<td>SESIAHS PD 217</td>
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<td>EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR</td>
<td>Patricia Bradd Chair, SESLHD Health Records Steering Committee</td>
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<tr>
<td>AUTHOR</td>
<td>SESLHD Health Records and Medicolegal Working Group</td>
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<td>POSITION RESPONSIBLE FOR THE DOCUMENT</td>
<td>Chair, Health Records and Medicolegal Working Group</td>
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<tr>
<td>KEY TERMS</td>
<td>eMR, Health care record, medical record, clinical notes, electronic information</td>
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<tr>
<td>SUMMARY</td>
<td>This document outlines processes about the storage of electronic and paper based information in the health care record.</td>
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1. **POLICY STATEMENT**

This document has been written to support the ongoing integration of electronic health information systems (both core and satellite) and paper-based medical records. Electronic systems include the core system (eMR electronic Medical Record) and numerous satellite systems (e.g. CHIME, ARIA, MOSAIQ). It guides staff on how to handle paper-based, electronic and hybrid health records to ensure effective and timely access to accurate and complete health information.

This procedure applies to all settings and sites within SESLHD, including Sydney Children’s Hospital which operates under the Randwick Campus Medical Record Service Shared Service Level Agreement.

2. **BACKGROUND**

SESLHD continues to develop and implement clinical information systems to support patient care. Increasingly, there are clinical services where clinical documentation is either produced and/or stored electronically. Consequently, SESLHD has a hybrid health care record and requires a procedure to define and manage the hybrid health care record. The introduction of eMR, and various satellite electronic systems, has resulted in a significant increase in electronic clinical documentation.

**Satellite electronic systems** are those containing clinical information not integrated with the core system, examples include, but are not limited to, CHIME, ARIA, MOSAIQ and GE RIS/PACS.

This document defines the **Source of Truth** in the event that a section of clinical documentation is available in both electronic and hard copy version. It also seeks to prevent or limit the frequency of this situation occurring.

A **hybrid health care record** comprises patient information that is a combination of information stored in an electronic format and in traditional paper format. It is a system with functional components that:

- Include both paper and electronic documents
- Uses both manual and electronic processes.

For example, laboratory results, some operating theatre documentation and x-ray reports may be available electronically, whereas progress notes, observation charts and referrals may remain documented on paper. Please refer to Appendix 1 – Components of the Hybrid Health Care Record.

A **transitional health record** is a health record with both computer readable and fully computable components. This type of health record is often representative of a system in transition from digitised format to a fully electronic health record. It is not anticipated that SESLHD will move to a full electronic health record in the foreseeable future.
3. RESPONSIBILITIES

3.1. Medical, Nursing and Allied Health Staff will:
- Adhere to all procedures relating to Hybrid Health Care Records listed below.
- Be aware of the accepted Source of Truth for the sections of the record for which they are responsible.

3.2. Medical Record / Clinical Information Staff / Managers will:
- Adhere to all procedures relating to Hybrid Health Care Records listed below.
- Audit compliance of Hybrid Record management principles on a regular basis.

3.3. Ward Clerks will:
- Adhere to all procedures relating to Hybrid Health Care Records listed below.

3.4. Medical Administration / Clinical Practice Improvement staff will:
- Adhere to all Procedures relating to Hybrid Health Care Records listed below.
- Audit compliance of Hybrid Record management principles on a regular basis.

4. PROCEDURE

4.1. Defining the Source of Truth
- Appendix 1 defines the Source of Truth in the event the clinical documentation is available in both electronic and hard copy version.
- When patient information is solely available in electronic format, the Source of Truth is to be interpreted from the electronic system which holds that information.
- When patient information is solely available in paper format, the Source of Truth is to be interpreted from the paper records alone.
- When hard copy information has been digitised (scanned), the Source of Truth is to be interpreted from the scanned image.
- When identical information is available in paper and electronic format (e.g. Operation Report) and there is an inconsistency between the sources of information, the Source of Truth is to be defined as per Appendix 1.
- In the event an electronic Source of Truth document is printed and a hand written clinical notation is added to this document, both the electronic document and the hand written notation must be integrated as the Source of Truth.

4.2. Communication of the Source of Truth
- A reference to any existing electronic information must be flagged on the cover of a patient’s paper based health care record in line with Australian Standard – Paper based Health Records 2828.1.
- A reference to electronic information allows relevant staff to identify that there is more than one source of information and the Source of Truth for specific information may vary.
4.3. Updates and Corrections

- Whenever possible, amendments to patient information must be completed in both the paper and electronic record management systems (if archived in both formats) for consistency of data between systems.

4.4. Printing

- Printing of information stored within electronic information systems should be avoided whenever possible unless the information is required for medico-legal purposes or there is a strict requirement to file the particular information in the health care record.
- If there is a lack of workstations in a particular clinical area, the electronic Source of Truth documents may be printed in order to accompany the patient and reduce clinical risks.
- Any printout of an electronic Source of Truth document should be destroyed once the document is no longer required, unless there is a hand written clinical notation added to this document.
- Radiology images/reports stored on GE RIS/PACS must NOT be printed and filed within the health care record.
- Information in eMR that is entered directly on screen is not required to be signed by clinical staff as there is a date and time stamp which has been generated by the electronic system at the point of data entry. Similarly, information subsequently printed out as below does not require a physical signature.
- All staff must adhere to printing requirements as outlined in SESLHDPR/335 Clinical Forms – Creation and Revision, at times it is necessary for partial or complete publishing (ie. printing) of the patient’s health care record. This functionality within eMR is referred to as the Medical Record Publishing Tool (MRP). Similar principles apply to other information systems.
  - All pages in the MRP include the SESLHD logo and patient identifiers within the page header, and a confidentiality disclaimer as a standard footer.
  - All pages in the MRP include a print date/time stamp, and identifier for the staff member printing the document.
  - The MRP will be restricted to authorised personnel only.
  - The section order of printing will be based on the results hierarchy.
  - The MRP should only be used for appropriate situations such as medico-legal requests and patient transfers.

4.5. Filing

- Where the Source of Truth is a paper document, it should be filed in the patient record as soon as possible after the presentation/visit.
- If a paper version of a document exists and its Source of Truth is electronic, it should be destroyed and not filed, unless there is a hand written clinical notation added to this document.
- All paper-based information must be filed within the health care record of the patient. This will include electronic Source of Truth documents which have an additional hand written notation added to the printout. This is particularly relevant for forms with signatures or written consent as these are the primary document/ Source of Truth.
- Detailed guidance in relation to loose leaf filing is contained below:
<table>
<thead>
<tr>
<th>Category of Loose Sheets</th>
<th>Includes, but is not limited to</th>
<th>Retention</th>
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</table>
| Internal diagnostic and investigative reports | o SEALS reports  
| | o Medical Imaging (SESAIMI) reports  
| | o EEG  
| | o Urology  
| | o Audiology  
| | o Cardiac reports | Retain only if:  
| | o Not accessible electronically  
| | and/or  
| | o Available electronically, but with handwritten notations  
| | Otherwise destroy  
| | Includes those with signatures only |
| External diagnostic reports | o External Medical Imaging reports  
| | o External pathology reports  
| | o External correspondence | Retain only if:  
| | o Pertains to a current/recent patient  
| Destroy if:  
| | o No evidence of recent or planned attendance (after investigation)  
| | and/or  
| | o No facility MRN assigned |
| Fax confirmations / internal administrative paperwork | o Fax confirmations  
| | o Paper-based requests for information | Retain if:  
| | o Request is more than 3 months after discharge of the patient  
| | o Request includes written patient consent  
| Destroy if:  
| | o Printed / sent electronically from the eMR and audit trail is maintained  
| | or  
| | o Electronic register of the request and the information sent is maintained |
5. **DOCUMENTATION**
Not required

6. **AUDIT**
As per NSW Health [PD2012_069 Health Care Records – Documentation and Management](#) and the SESLHD Documentation Audit Policy/Audit tool, Medical Administration/Clinical Practice Improvement Units and/or Health Information Managers, will audit compliance of Hybrid Records Management on a regular basis with particular focus on documentation, amendments to hybrid record information and compliance in printing practices of electronic patient information.

This procedure is to be reviewed and updated on a regular basis by the SESLHD Health Records and Medicolegal Working Group

7. **REFERENCES**
- [NSW Health PD2012_069 Health Care Records – Documentation and Management](#)
- [SESLHDPR/335 Clinical Forms – Creation and Revision](#)
- AS 2828.1 Paper based health care records
- AS2828.2 Digitised (scanned) health record system requirements

8. **REVISION AND APPROVAL HISTORY**

<table>
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<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
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<tr>
<td>22/04/2009</td>
<td>0.1</td>
<td>Ivan Koprivic, UPI Systems Officer – SESIH (Endorsed by SESIH HIM Committee). Approved by Area Clinical Council 22/04/2009</td>
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<td>01/05/2009</td>
<td>0.2</td>
<td>D. Martin – inclusion of definition – Source of Truth</td>
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<td>04/09/2012</td>
<td>1.0</td>
<td>D. Martin on behalf of the SESLHD Health Information Managers</td>
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<td>26/03/2013</td>
<td>1.1</td>
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<td>May 2016</td>
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<tr>
<td>June 2016</td>
<td>2.0</td>
<td>Updates endorsed by Executive Sponsor</td>
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## APPENDIX 1

<table>
<thead>
<tr>
<th>SECTION OF HEALTH CARE RECORD</th>
<th>SOURCE OF TRUTH</th>
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| **1) EMERGENCY DIVIDER**<br>(Non admitted patient attendances only) | ➢ Front Sheet for Emergency Attendance – Printed from iPM System and filed in health care record.  
➢ ED Electronic Clinical Documentation when implemented. (Note that some sites have chosen to implement electronic documentation as a phased approach). **Not** to be printed and filed within the health care record  
➢ Paper based ED Documents – To be filed within health care record behind the ED Attendance front sheet (e.g. Medication Charts/Ambulance Report) |
| **2) INVESTIGATIONS DIVIDER** | ➢ eMR Pathology Results/Reports (Histopathology, Microbiology etc) - eMR electronic document. **Not** to be printed and filed within the health care record  
➢ GE RIS/PACS Radiology Reports – eMR electronic document. **Not** to be printed and filed within the health care record  
➢ GE RIS/PACS Radiology Images & Films – **Not** to be printed and filed within the health care record  
➢ Diagnostic Reports from External Providers – To be filed within the health care record |
| **3) OUTPATIENTS DIVIDER** | ➢ Paper based documents (eg. Outpatient progress notes) – To be filed  
➢ Community Health documents – **Not** to be printed from CHIME and filed in the health care record.  
➢ Satellite systems – Electronic information **not** to be printed. Paper-based forms will be filed in the satellite record or amalgamated with the main health care record. |
| **4) CORRESPONDENCE DIVIDER** | ➢ Paper based documents only (eg. Correspondence letters) |
| **5) ADMISSION DIVIDER** | ➢ Front Sheet  
➢ Discharge Forms  
➢ Consent Forms  
➢ Mental Health Forms  
➢ Pre-Admission | ➢ Paper based document only - Printed from iPM System  
➢ eMR Electronic Discharge Summary – **Not** to be printed and filed within the health care record.  
➢ Paper based documents (eg. Patient Transfer Summary)  
➢ Paper based documents only (eg. Request consent for medical procedure/treatment)  
➢ All forms requiring a physical signature must be retained and filed eg. guardianship forms, No CPR order.  
➢ Paper based documents only (eg. DOH A1 Assessment of current presentation)  
➢ Paper based documents only (eg. External Referrals)  
➢ eMR Pre-admission clinic nursing notes – Electronic document **Not** to be printed and filed within the health care record |
### SECTION OF HEALTH CARE RECORD | SOURCE OF TRUTH
---|---
Emergency Admission Notes | - ED Electronic Clinical Documentation when implemented. (Note that some sites have chosen to implement electronic documentation as a phased approach). **Not** to be printed and filed within the health care record.
| - Paper based ED Documents – To be filed within health care record behind the admission divider (eg. Medication Charts/Ambulance Report)
ICU Summary (Intensive Care Units) | - Paper based documents (eg. ICU Flow Charts)
| - ICU Marquette System – Electronic information to be printed and filed within the health care record
Progress Notes | - Paper based document only
Nursing Assessment and Care Plans | - Paper based documents only (eg. Chest Pain Assessment Form)
Allied Health | - Paper based documents only (eg. Physiotherapy assessment form)
Cardiac Forms | - Paper based documents (eg. Echocardiography Report)
Operation Notes | - eMR SurgiNet Operation Report – **Not** to be printed and filed within the health care record.
| - Other Operation Notes – Paper Based Documents only (eg. Count Sheet, Recovery Notes, Anaesthetic Chart)
Diagnostic Results | - eMR Pathology Results/Reports (Histopathology, Microbiology etc) - eMR electronic document. **Not** to be printed and filed within the health care record
| - GE RIS/PACS Radiology Reports – eMR electronic document. **Not** to be printed and filed within the health care record
| - GE RIS/PACS Radiology Images and Films – **Not** to be printed and filed within the health care record
| - Diagnostic Reports from External Providers – To be filed within the health care record
Renal Dialysis | - Paper based documents only (eg. haemodialysis care plan)
Observation Charts | - Paper based documents only (eg. Standard Observation Chart)
Fluid Balance | - Paper based documents only (eg. NSW Health Daily Fluid balance summary)
Medications | - Paper based documents only (eg. NSW Health Inpatient Medication Chart)