SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

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EXECUTIVE SPONSOR	Director, Clinical Governance and Medical Services
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KEY TERMS	Medical record, healthcare record, hybrid record, scanning, indexing, importing, single document capture, eMR, health record, system integration
SUMMARY	Addresses processes around importing documents into the electronic medical record (eMR). Documents may be imported manually or via interface. Procedure outlines application processes, implementation, training, document retention post importing, and quality assurance requirements.

Documentation Import Requests for the Electronic Medical Record (Manual and System Integration)

SESLHDPR/513

1. PROCEDURE STATEMENT

This procedure aims to provide a consistent and clear process for management of requests and processes for importing documents into the electronic medical record (eMR) either by manual import or automatic system integration. This ensures that:

- Imported documentation meets South Eastern Sydney Local Health District (SESLHD) / Illawarra Shoalhaven Local Health District (ISLHD) requirements
- Documentation that is imported into the eMR is accessible, clear and complete, and supports ongoing patient care and safety
- Allocation of existing or new note types are fit for purpose and meet approved standards and syntax within the eMR Event Set Hierarchy to support accessibility
- Integration with eMR from other electronic health record systems is fit for purpose and meets approved standards and policies

Further, this procedure aims to outline requirements for documentation imported into eMR, such as auditing and retention periods.

The procedure supports local, district and state legislation and policy, whilst ensuring efficient and effective health record management. The process outlined in this procedure is governed by the SESLHD Health Records & Medico Legal Committee.

2. BACKGROUND

The majority of health records within SESLHD are hybrid by nature – meaning that health information is stored in both paper and electronic formats. The main electronic health record system used by SESLHD and ISLHD is Cerner eMR.

The importing of health information to an electronic health record provides clinicians with up-to-date patient information without having to access the paper health record.

The importing of documents into Cerner eMR can be completed by manually importing a single document or automatic import through a developed integration with another system/electronic health record.

All documents that are imported into the eMR must be imported against an encounter and note type to ensure accessibility. If an appropriate note type does not exist within the eMR, then a new note type within the existing eMR Event Set Hierarchy must be developed.

To ensure consistency within the eMR, all requests for importing documents into Cerner eMR must be approved by the SESLHD/ISLHD Electronic Clinical Forms Committee. This requires an application and review process so that updates within the eMR are done in a measured, clear, and consistent way to ensure accessibility, and ultimately, assist in patient care and safety.

SESLHD requirements for importing:

- Single documents only. Bulk importing of whole encounters or medical records (including satellite records) is generally not supported unless otherwise approved by SESLHD Clinical Forms Committee.
- Clinical forms for importing must be approved by either the State Clinical Forms Committee or the SESLHD Clinical Forms Committee. Exception to this includes diagnostics and external documents (such as referrals).
- Documents must have sufficient patient identification for import either through use of a patient label or four identifiers.
- All diagnostics should be endorsed on the source document with the author's printed/typed name, designation, signature (electronic or hand written), and date/time.
- Only specific eMR positions are approved for the document import functionality. In community health, all users are approved but, in the hospital setting, access is restricted to specific administrative eMR positions.

2.1 DEFINITIONS

Term / Abbreviation	Definition
Attendance	The period of admission to discharge of a patient who attends a facility to receive treatment. Includes inpatient, outpatient, emergency, and community encounter/treatment types.
Client/patient	Any person to whom a health care provider owes a duty of care in respect of provision of health care services.
Electronic Health Record	Includes all electronic health record systems such as eMR Cerner, eMaternity, eRIC, MOSAIQ, ARIA, or any other electronic medical record application/system
Encounter	A single patient/client interaction and/or a series of interactions with a service within a health organisation for the purpose of providing healthcare services or assessing their health status. Includes inpatient, outpatient, emergency, and community treatment.
Event Set Hierarchy	Hierarchy of note types within eMR that governs how documentation and information is stored and subsequently retrieved/viewed.
eMR	Refers to Cerner Electronic Medical Record (eMR), the main electronic health record utilised by SESLHD/ISLHD
Health Information	(a) personal information that is information or an opinion about: (i) the physical or mental health or a disability (at any time) of an individual, or (ii) an individual's express wishes about the future

	provision of health services to him or her, or (iii) a health service provided, or to be provided, to an individual, or (b) other personal information collected to provide, or in providing, a health service, or (c) other personal information about an individual collected in connection with the donation, or intended donation, of an individual's body parts, organs or body substances, or (d) other personal information that is genetic information about an individual arising from a health service provided to the individual in a form that is or could be predictive of the health (at any time) of the individual or of any sibling, relative or descendant of the individual, or (e) healthcare identifiers, but does not include health information, or a class of health information or health information contained in a class of documents, that is prescribed as exempt health information for the purposes of the *Health Records and Information Privacy Act 2002* (NSW) (HRIP Act) generally or for the purposes of specified provisions of the HRIP Act
Health Record	A documented account, whether in hard copy or electronic form, of a client/patient's health, illness, and treatment during each visit or stay at a public health organisation. Note: holds the same meaning as "health care record", "medical record", "clinical record", "clinical notes", "patient record", "patient notes", "patient file", etc.
HIM	Health Information Manager
MRM	Medical Record Manager
SARA	State-wide service desk/portal for IT services and support. "Search And Request Anything"
SESLHD Health Records and Medico-Legal Committee (SESLHD HR&ML)	District committee which provides advice and leadership with regards to health information principles and practices. Consists of members from all sites/services within SESLHD.
Single Document Capture (SDC)	Process for manual import of documents into Cerner eMR
System integration	Integration or interfaces with between another electronic health record system and eMR to ensure all health information is available in one system to support a complete

	health record.

3. RESPONSIBILITIES

3.1 End Users will:

- Submit a complete application to the SESLHD/ISLHD Electronic Clinical Forms Committee for (includes both manual and system integration imports):
- Requests from a new service/unit/facility to import specific documents into Cerner eMR
- Addition of new document for import into Cerner eMR
- Ensure appropriate approval has been granted from the SESLHD/ISLHD Electronic Clinical Forms Committee and, if applicable, system updates (such as new note types) have been completed prior to implementing requested importing
- Adhere to importing process within the eMR quick reference guides: Single Document Capture Quick Reference Guide – Importing and Single Document Capture (SDC): Troubleshooting and Data Fixes for Errors
- Liaise with site Health Information Managers/Medical Record Managers for data and error correction where required
- Log jobs within SARA for any technical requirements or issues
- Ensure adequate confidential destruction of any imported paper documents after compliance with auditing processes outlined in this procedure

3.2 Line Managers will:

- Oversee compliance to this procedure
- Ensure staff are provided adequate training and guides in importing processes
- Ensure quality assurance processes are undertaken prior to the destruction of paper documents that have been imported
- Ensure any errors picked up in auditing are escalated to the site Health Information Managers/Records Managers to be marked “in error”

3.3 District Managers/ Service Managers will:

- Review and, where appropriate, approve the SESLHD/ISLHD Electronic Clinical Forms Committee Application Form

3.4 Health Information Managers/Medical Record Managers (Hospital and Community Health) will:

- Receive and review applications SESLHD/ISLHD Electronic Clinical Forms Committee. Approve and submit applications where appropriate.
- Provide expertise and support with regards to the Forms Committee application and processes
- Assign (or if required, submit new) document types for each importing request

- Raise tickets/jobs in SARA and liaise with Digital Health where required for new note types
- Provide advice to managers on whether changes to eMR user access is required and direct them to the Digital Health page
- Liaise with eMR trainers where necessary to provide end user support
- Liaise with departments/services/staff to resolve queries or issues related to the application, build, use, or auditing.
- Remain the point of contact for data fixes when errors are identified by end users to ensure for the maintenance of data integrity
- Ensure scanning staff are aware of their quality/auditing obligations under this procedure
- Test new note types in XR charting to ensure printing correctly
- Assist in integration testing where required

3.5 SESLHD/ISLHD Electronic Clinical Forms Committee will:

- Review application and determine whether request is appropriate and within scope
- Assign all documents required to be scanned/imported to document types within the eMR event set hierarchy or submit new naming
- Approve applications where appropriate
- Maintain a register of applications submitted and documents approved for scanning/importing.
- Sign off on approved application

3.6 Digital Health / eMR Application Support Manager and their team will:

- Build new note types within eMR
- Test any builds to ensure they are working correctly in Powerchart and XR Charting/Printing.
- Liaise with requesting HIM/MRM to complete validation testing prior to release
- Inform Site HIM/MRM of the completion of their request.
- Update the default note type list within eMR where applicable
- Update the eMR Single Document Capture Import and Scanning Appendix.
- Update eMR access levels for users who require the addition of scanning/importing functionality (if applicable)
- Provide technical support and advice for integration/interface requests

3.7 eMR Trainers will:

- Develop, update and maintain the relevant eMR quick reference guides
- Train and support end users in how to manually import documents into eMR (i.e. single document capture)
- Ensure the end user is trained in how to locate and use the appropriate note type in the eMR

4. APPLICATION PROCEDURE

4.1 Application

Services intending to import documentation in to eMR either manually or through an existing/developed system integration/interface must seek approval from the SESLHD/ISLHD Electronic Clinical Forms Committee by completing the SESLHD & ISLHD Application for Paper and Electronic Forms, eMR Auto-Text, Single Document Capture, and eMR Note Types.

For a system integration/interface, the requestor should log a job through SARA for Digital Health to review the request from a technical viewpoint. If HealthICT approves the request/takes on the job, then this is when an application to the SESLHD/ISLHD Electronic Clinical Forms Committee should be made.

4.2 Submission Process

The application package must be submitted to the site/service HIM/MRM or, if part of a wider project, to Digital Health for review then to the site/service HIM/MRM. The application will be reviewed to ensure that:

- It has been completed clearly and correctly
- The request is within scope
- Samples of documents have been provided where applicable
- The appropriate management approvals have been obtained

The HIM/MRM/Digital Health will also review and record whether the documents for import (manual or integration/interface) fits into an existing note type within the event set hierarchy or whether a new note type will need to be created. If a new note type needs to be created, the existing event set hierarchy should be consulted for consistency in format/syntax.
Note: In the Cerner Discern Reporting Portal running the report "Event Set Hierarchy" will produce the entire event set to assist in review.

When the site/service HIM/MRM is satisfied with the application, they will sign and submit the application along with any other relevant documents to the chair of SESLHD/ISLHD Electronic Clinical Forms Committee for addition to the agenda for the next meeting.

4.3 Review of Application by SESLHD/ISLHD Electronic Clinical Forms Committee

The application is reviewed during the committee meeting and a decision is made to approve or not approve the request. For urgent applications, this may be done outside of session by email.
Note: Additional approval may be required from the Clinical Council or SESLHD Drug Committee depending on the nature of the request. This will be processed by the Forms Committee.

The "Outcome" section of the application package is then completed by the chair of the committee and returned to the HIM/MRM or Digital Health for notification to the requesting party and follow-up where required.

4.4 Completion of approved requests

4.4.1 New/amended eMR note type (If required)

A new note may need to be added to the eMR event set hierarchy for manual or system integration/interface document importing.

1. HIM/MRM log a request through SARA for a new/amended note type be added to the eMR event set hierarchy. Either the signed application or the meeting minutes indicating approval should be attached to the request.
2. Digital Health builds/amends the note type
3. Digital Health tests functionality, including ensuring appropriate printing in XR Charting
4. Digital Health will liaise with requesting HIM/MRM to complete validation testing prior to release. This will include testing for Release of Information / Medico-Legal requirements.
5. Digital Health adds to the eMR Single Document Capture Import and Scanning Appendix *(if applicable)*
6. Digital Health adds to the default admin note list *(if applicable)*
7. Digital Health informs HIM/MRM of new/amended note completion and proposed date of release
8. HIM/MRM notifies applicant and assists in implementation where required

4.5 Implementation/Training – Integration/interfaces

Digital Health will continue with steps required for an integration/interface with another system, ensuring testing and auditing of information and note types where required.

4.6 Implementation/Training – Manual import / Single Document Capture

4.6.1 eMR User Access Level

If a staff member's eMR position does not allow for the document import functionality then a Digital Health application to Modify an Existing Computer Network Account must be submitted to change their access. This must be submitted by the staff member's supervisor/manager.
Note: Not all positions are approved for scanning/importing. See the eMR User Account Position List for more information.

4.6.2 Training / Implementation

Staff who are importing approved documents into the eMR must receive training from the eMR Trainers and/or a HIM/MRM prior to implementation. *Note: Where an approved super-user has been identified, they may also provide training*.

As part of training, users should be provided with:

- A list of note types relevant to the types of documents that were included in the application, including any new note types
- The relevant eMR QRGs
- Contacts for data fixes
- Relevant information including:
  - Storage, retention, and destruction of imported documents (see Section 4.7.1 and 4.7.2)
  - Quality assurance requirements (see Section 5)

4.7 Document retention and destruction (Manual import only)

4.7.1 Storage/retention of imported documents

Once imported documents have been checked to ensure they were successfully imported, the original documents are to be retained and indexed either by the captured date or alphabetically. Documents must not be destroyed until a minimum of one month after they were captured and may only be destroyed once an audit is undertaken to ensure compliance.

4.7.2 Destruction of imported documents

The destruction of original or source records after copying is only permitted under NSW State Health Records Legislation - Original or source records that have been copied (GA45) after auditing of the scanned documents (refer to section 5) and where the following conditions are met:

- The records aren't classified as excluded records
- The records are covered by an approved retention and disposal authority
- Authentic, complete and accessible copies have been made

Quality and auditing will support this (see Section 5 of this document)

- The copies become the official record of the business of the agency and are kept for the authorised minimum retention period
- The original or source records are kept for quality control purposes for an appropriate length of time

Original clinical documents must be retained for a minimum period of one month or until audited as per Section 5 of this procedure, whichever is longer, after which they may be destroyed. This includes both paper documents scanned and imported as well as documents received digitally and subsequently imported. Paper documents must be destroyed in a confidential manner either by shredding or disposing in a confidential bin. Note that original documents that must be retained as per GA45 must not be destroyed as part the destruction process.

5. QUALITY ASSURANCE

5.1 Quality assurance at the time of importing

Complete quality checks are to be performed on all documents which have been scanned /imported at the time of uploading to ensure that the captured documents have been assigned against:

- the correct patient
- the correct encounter
- the correct document type

Audits must also ensure that all documents have been captured in that they are complete, accurate and legible reproductions of the original or source record.

5.2 Monthly Auditing

Prior to destruction of imported documents, 10% of imported documents are to be audited to ensure compliance with importing standards. This includes both paper documents scanned and imported as well as documents received digitally and subsequently imported.

This may be done monthly by ensuring that all documents:

- have been captured against the correct patient, encounter and document type (to ensure for accessibility)
- the digital documents are accurate, legible reproductions of the original or source record in its entirety
- that have been imported have been approved

If the audited 10% of documents meet the quality standards, the destruction process may proceed.

If there are any errors within the 10% of documents audited, all the documents retained for quality assurance must be audited to against the quality standards. Care should be taken to correct the errors as part of the quality process. Where required, documents may need to be re-scanned/imported.

5.3 Errors and Data Fixes

Upon identification of an error where an uploaded document was either imported against the incorrect patient, encounter or document type, the site Health Information/Medical Record Managers must be notified.

Upon notification, the site Health Information/Medical Record Manager will locate the document and change the document status to “in-error”. When marking a document as “in error” a relevant note should be included (i.e. “incorrect patient”, “incorrect note type”, etc).

Upon completion of marking the document "in error" the Health Information/Medical Record Manager will inform the end user. The end-user will then re-import the document to the correct place.
Note: Refer Troubleshooting and Data Fixes for Single Document Capture QRG

Where the HIM/MRM identifies that changing the status of a document to "in error" is insufficient to ensure patient safety and documentation standards, they should follow SESLHDPR/718 - Inactivating Encounters or Documents in the eMR.

6. SUPPORTING DOCUMENTATION

- SESLHD & ISLHD Application for Paper and Electronic Forms, eMR Auto-Text, Single Document Capture, and eMR Note Types
- Single Document Capture (SDC): Importing QRG
- Troubleshooting and Data Fixes for Single Document Capture
- eMR Single Document Capture Import and Scanning Appendix

7. REFERENCES

7.1 SESLHD References

- SESLHDPR/292 - Hybrid Health Care Record Procedure
- SESLHDPR/335 - Clinical Forms – Creation and Revision
- SESLHDPR/336 - Documentation in the Health Care Record
- SESLHDPR/718 - Inactivating Encounters or Documents in the eMR

7.2 NSW Health References

- NSW Health Policy Directive PD2012_069 - Health Care Records – Documentation and Management
- NSW Health Policy Directive PD2009_072 - State Health Forms

7.3 External References

- NSW State Archives and Records. Original or Source Records That Have Been Copied (GA45) 2015 (2023)
- Australian Standard. AS2828.2 (Int) –Health Records – Digitized (scanned) Health Record System Requirements. 2012

8. VERSION AND APPROVAL HISTORY

Date	Version	Version and approval notes
17/08/2015	0.1	Author: SESLHD Health Records and Medico-Legal Working Group
23/09/2015	0.2	Reviewed and Approved: SESLHD Health Records and Medico legal Working Party
18/11/2015	0.3	Reviewed and Approved: Anne OConnor, Wendy Cotter, Belinda Lee
19/10/2015	0.4	Reviewed and Approved: SESLHD Health Records Steering Committee

25/05/2016	0.5	Reviewed and Approved: SESLHD Health Records and Medico legal Working Party (removed Community Health and opened to all non-admitted and diagnostics)
23/11/2016	0.6	Reviewed and Approved: SESLHD Health Records and Medico legal Working Party - reviewed and condensed
12/12/2019	0.7	Reviewed by the Health Records and Medico Legal Committee
August 2021	1	Review by the Health Records and Medico-Legal Committee. Updated to reflect change in Forms Committee processes. Change of name from SESLHDPR/513 - Single Document Capture in eMR: Scanning and Importing.
March 2022	1	Draft for comment period. Approved by Executive Sponsor
May 2022	1	Approved at Clinical and Quality Council meeting.
18 June 2025	1.1	Minor review. Approved by the Health Records and Medico-Legal Committee and Executive Sponsor.