SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Single Document Capture in eMR: Scanning and Importing
TYPE OF DOCUMENT	Procedure
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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director Clinical Governance and Medical Services
AUTHOR	SESLHD Health Records and Medico Legal Working Group (HR&MLWG)
POSITION RESPONSIBLE FOR THE DOCUMENT	Chair, SESLHD HR&MLWG
KEY TERMS	Medical record, healthcare record, hybrid record, scanning, indexing, importing, single page documents
SUMMARY	To outline the approval process and procedure to follow when a SESLHD service intends to commence single document capture in eMR for the first time or when approved services require additional single page documents to be captured. The scope of this procedure is limited to the capturing of single page documents that are to form part of the patient health care record.

Feedback about this document can be sent to seslhd-executiveservices@health.nsw.gov.au

Single Document Capture in eMR: Scanning and Importing

SESLHDPR/513

1. POLICY STATEMENT

SESLHD has identified the need to develop a consistent and clear approval process and procedure in order to ensure that single document capture into the eMR via scanning and importing is conducted in accordance with statutory requirements and supports patient safety. This procedure supports local, district and state legislation and policy, whilst ensuring efficient and effective health record management.

Single document capture should not be used to scan/import:

- entire medical records or bulk documentation
- clinical forms not approved by either the State Clinical Forms Committee or the SESLHD Clinical Forms Committee.

2. BACKGROUND

Single document capture provides clinicians with additional patient information available in one place, to support a complete patient record. It reduces the requirement to create and store paper records when low volume documents can be included as part of the electronic record.

The aim of the procedure is to provide a framework to support the control of scanned/imported documents into the eMR. The procedure provides the Local Health District with assurance that there are processes in place to protect information assets in line with policy.

The procedure applies to all SESLHD services with a defined use for single document capture. This includes eMR for Community (CHOC), Non Admitted and Diagnostics Services.

3. DEFINITIONS AND ABBREVIATIONS

eMR	Electronic medical record
SDC	Single Document Capture: the scanning or importing of singular documents into the electronic medical record against a predefined record type
CHOC	Community Health Outpatient Care
SESLHD	South East Sydney Local Health District
SESLHD HR&MLWG	SESLHD Health Records and Medico-Legal Working Group
SESLHD HRSC	SESLHD Health Record Steering Committee
SFMC	State Forms Management Committee

4. RESPONSIBILITIES

4.1 End Users will:

- Adhere to this procedure by scanning/importing documents against the correct client, correct encounter and correct document type
- Liaise with the site Health Information Manager for data fixes
- Log a call with the Statewide Service Desk to eMR Support for any technical requirements/concerns

- Ensure the adequate destruction of scanned/imported paper documents by placing documents for destruction in confidential bins or shredding machines
- Adhere to the eMR quick reference guides: Single Document Capture Quick Reference Guide - Importing and Single Document Capture Quick Reference Guide - Scanning
- Adhere to the eMR quick reference guide: Single Document Capture (SDC): Troubleshooting and Data Fixes for Errors

4.2 Line Managers will:

- Oversee compliance to this procedure.
- Ensure quality assurance processes are undertaken prior to destruction of paper documents, once documents have been scanned/imported into the EMR
- Ensure documents scanned to the incorrect patient are escalated to the Site Health Information Managers/Record Managers to be marked 'in error' in the eMR

4.3 District Managers/ Service Managers will:

- Complete the referenced electronic application form - Request for Single Document Capture in eMR
- Submit the completed electronic application form, attaching copies of each document required to be scanned/imported to the site Health Information Manager for submission to the SESLHD HR&MLWG for approval.

4.4 Site Health Information Managers/Record Managers will:

- Receive all applications and submit to the SESLHD HR&MLWG for initial approval
- Provide expertise and support with regards to clinical forms creation/revision processes
- Assign document types to each clinical form required to be captured in the eMR
- Contact the requestor on approval, once obtained from the SESLHD HRSC
- Liaise with the relevant eMR trainer, once approval is obtained from the SESLHD HRSC, to advise of the required training to end users
- Remain the point of contact for data fixes when errors are identified by end users to ensure for the maintenance of data integrity
- Ensure quality audits are conducted to confirm adherence to the procedure.

4.5 SESLHD Health Records and Medico-Legal Working Group will:

- Determine appropriate scope of scanned/imported documents
- Map all documents required to be scanned/imported to document types within the eMR event set hierarchy
- Approve new document types within eMR
- Submit the application form to the SESLHD HRSC for final approval
- Maintain a register of applications submitted on application form Request for Single Document Capture in eMR and documents approved for scanning/importing.

4.6 SESLHD Health Record Steering Committee will:

- Remain the governance committee to have final approval on all requests.

4.7 eMR Application Support Manager will:

- Develop, update and maintain the relevant eMR quick reference guides.

4.8 eMR Trainers will:

- Train and support all end users utilising single document capture via scanning/importing into the EMR.

5. PROCEDURE

5.1 Approval Process

- Services required or intending to implement single document capture in eMR must seek approval from the SESLHD HRSC through the SESLHD HR&MLWG
- Managers of the above services are to complete the referenced application form and submit to the SESLHD HR&MLWG via the site/stream Health Information Manager.
- The application form requires the applicant to demonstrate that the required record management processes meet the statutory requirements as outlined in the NSW General Retention and Disposal Authority 45 (GA45).

5.2 Approved clinical forms

- Only clinical forms approved by the State Forms Management Committee or the SESLHD Clinical Forms Committee are eligible to be scanned/imported into the eMR (with the exception of external correspondence).

5.3 Mapping against the event set hierarchy

- To ensure that scanned/imported documents are readily accessible, all scanned/imported documents must be assigned to a document type within the eMR event set hierarchy by the SESLHDHR&MLWG.

5.4 Training

- Staff required to undertake the scanning/importing of documents must receive training from the eMR trainers or nominated Super User prior to commencing.

5.5 Approved Hardware/technical specifications

- Ensure approved hardware is procured and use recommended settings to support network and performance stability, whilst maintaining visual quality of images.

5.7 Storage/retention of scanned documents prior to destruction

- Once scanned/imported documents have been checked to ensure they were successfully uploaded (refer section 5.1), 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 for data integrity.

5.8 Destruction of scanned 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 section 5) and where the following conditions are met:
    - *The records aren't classified as excluded records*
      Excluded records are records subject to a legislative or Government policy requirement that the original record not be destroyed e.g. 2.2.4 out of home care documents.
    - *The records are covered by an approved retention and disposal authority*
    - *Authentic, complete and accessible copies have been made*
      Documents scanned or imported are to be quality checked at the time of uploading into the eMR to ensure that they are assigned to the correct patient, encounter and document type. Remedial action is to be taken to correct any incorrect posting of documents. Quality audits are also to be undertaken to ensure that images are of sufficient quality within the eMR and that each document has been uploaded
    - *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*
      Refer to 4.9 Quality assurance processes at the time of capture
- Original clinical documents will be kept onsite for a minimum period of one month. Prior to destruction, 10% of each scanned/imported box of documents is to be quality checked against the eMR to ensure that documents are scanned and imported to 100% accuracy, with no possibility of corruption or manipulation of images
- If all 10% of audited documents meet the quality standards as per GA45, the destruction process for that box may proceed. If not, all pages remaining in the box need to be checked for accuracy and rescanned/imported if necessary
- Original documents which have been retained for a minimum of one month and audited to be scanned/imported successfully, may be destroyed by being placed in confidential bins or shredded, excluding documents as per section 5.8 above which must be retained.

5.9 Identification/endorsement of documents for upload/import

- All documents imported must be patient identifiable through either the use of a patient label or four identifiers for the patient. Diagnostics should be endorsed on the source document with the following criteria: author's printed name, designation and signature (electronic or hand written) and date and time of entry

6. QUALITY ASSURANCE

6.1 Quality assurance processes at the time of capture

- 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 and that the copies are complete, accurate and legible reproductions of the original or source record.

6.2 Reporting of Errors and Data Fixes

- Upon identification of an error where an uploaded document was either scanned/imported against the incorrect patient, encounter or document type, refer to Appendix A for the contact details of the Site Health Information Manager the errors are to be reported to
- The Site Health Information Manager will locate the document, and convert this to an in-error document. An in error comment is to be entered.
- The end user will re-scan the document to the correct patient record, encounter or document type. (refer to the referenced quick reference guide: Trouble Shooting and Data Fixes for SDC)

6.3 Monthly Auditing

- Ensure that all documents have been captured against the correct patient, encounter and document type (to ensure for accessibility)
- Verify that the copies are accurate, legible reproductions of the original or source record in its entirety
- Verify that all documents have been captured
- Ensure that only approved clinical forms are approved for scanning/importing into the eMR
- Prior to destruction of captured documents, 10% of captured records per patient are to be audited to ensure for the integrity of data (refer section 4.8)

7. DOCUMENTATION

- SESLHD Application Form – Request for Single Document Capture in eMR
- Single Document Capture Quick Reference Guide - Importing
- Single Document Capture Quick Reference Guide - Scanning
- Troubleshooting and Data Fixes for Single Document Capture

8. REFERENCES

8.1 External references

- State Records Authority of NSW GA 45: Original or source records that have been copied
- Australian Standard 2828.2 (Int) – 2012 Health Records – Digitized (scanned) health record system requirements
- Ministry of Health PD2012_069 Health Care Records - Documentation and Management

8.2 Internal references

- SESLHDPR/335 Clinical forms - creation and / or revision of
- SESLHDPR/292 Hybrid HealthCare Record

9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
August 2015	1	Author: SESLHD Health Records and Medico-Legal Working Group
September 2015	1	Reviewed and Approved: SESLHD Health Records and Medico legal Working Party
November 2015	1	Reviewed and Approved: Anne OConnor, Wendy Cotter, Belinda Lee
November 2015	1	Reviewed and Approved: SESLHD Health Records Steering Committee
May 2016	1	Reviewed and Approved: SESLHD Health Records and Medico legal Working Party (removed Community Health and opened to all non-admitted and diagnostics)
December 2016	1	Endorsed by DET
September 2020	2	Executive Sponsor updated from Patricia Bradd to Director Clinical Governance and Medical Services. Review date amended to be in line with a Medium Risk rating.

Appendix A – Site Health Information Managers/Record Managers for data fixes

Site	Contact Name	Contact
Drug and Alcohol	Therese Finch	933208757
Mental Health	Vinessa Lo / Frank Zivkovic	9113 1335
Calvary Hospital	Jennifer O'Hearn	9553 3591
St George Hospital	Rachel Kelloway / Vivienne Rowlands	9113 2087 / 9113 3484
Sutherland Hospital	Jacqueline (Jackie) Kozman / Vivienne Rowlands	95407154 / 9113 3484
Prince of Wales / Royal Hospital for Women	Sophia Adamo	9382 3706
Sydney/Sydney Eye Hospitals	Lyudmila Nikolenko	9382 7338
War Memorial Hospital	Nisveta Hasanbegovic	9369 0242