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ACKNOWLEDGEMENTS

The following staff were involved in the preparation of this Handbook and corresponding District Policy Directive:

Amy Jones - Author of Discussion Paper - Data Coordinator, Community Health, Southern Hospital Network October 2005
Dr Tony Sara – Director Clinical Information Systems
Jennifer Holmes Clinical Nurse Consultant, Informatics
Shane Simpson and Julie Hider - CHIME Team
NSW HEALTH CHIME Steering Committee
1. INTRODUCTION

This Handbook sets out available guidance about the management of different types of patient/client information in either electronic or paper records for SESLHD community-based services using CHIME.

This practical information will be used as a SESLHD CHIME users training resource for staff to review their current work practices in line with the recent:

- Legislative Requirements
- Ministry of Health Policy Directives
- SESLHD Policy Directives

Please note: this document must be read in conjunction with the SESLHD Policy Directive CHIME– confidentiality and information management – SELHDPD/188

NSW Health policy on information management in the recent past has pulled back from the labelling of certain types of information as “sensitive”. For example, the new version of the Privacy Manual no longer has a section devoted to the treatment of sensitive information. The reason given for this is that all personal health information should be considered sensitive, because it all deals with personal matters that patients/clients would generally expect to be used only for purposes relating to their health care or legislative matters.

In addition, the Centre for Mental Health has issued an Information Bulletin (IB2005_026) notifying NSW Health staff that mental health information is no longer to be considered “sensitive”, and is to be treated according to the same principles as general “health information” under the Health Records and Information Privacy Act (HRIPA) 2002. The reasons for this are two-fold: firstly, there is no legal basis in the privacy law for the separation of mental health information; and secondly, the Centre for Mental Health considers this a move towards the de-stigmatisation of mental health issues in the community.

There are very few types of information described in HRIPA and the Privacy Manual that are subject to special or heightened confidentiality requirements. Exceptions are HIV-related information, as well as information held by specialist sexual assault and child protection services. All other types of information are subject to the general Health Privacy Principles spelled out in HRIPA.

The Act does, however, require that services use and disclose information in accordance with patients/clients’ expectations. This provision dictates two important features of care under the new law:

- Services need to be open and effective in communicating their information management practices to patients/clients – thus setting up client expectations of what the service will do with their information
- Services need to be as flexible as possible in accommodating requests for increased confidentiality provisions that arise as a result of open discussions with patients/clients about their information.

In general, SESLHD community based services using CHIME will adopt Ministry of Health policy on the standard treatment of formerly “sensitive” information and its integration with general health information.

There are services whose client groups are particularly concerned with protecting their information from wide access. Local examples include Drug and Alcohol services, and Homeless Outreach and other counselling-type services, where constructive therapy cannot take place.
without client-clinician trust that is facilitated by assurances of high levels of confidentiality. For these services, a CHIME confidentiality setting of partial may be of benefit, because it provides extra protection for information whilst allowing controlled access by relevant health service providers. Staff should approach the Service manager who will have the permissions in CHIME to change the confidentiality setting to partial.

In adopting the above approaches, it is important that resources and staff capacity are developed to effectively communicate confidentiality provisions to patients/clients. It will also be necessary to develop procedures for decision-making about special requests from patients/clients to increase the confidentiality level of their own record.

Staff duties of confidentiality also need to be continually emphasised, and processes developed to audit compliance with these duties. Every member of staff should be able to trust that other members of staff are scrupulous about confidentiality, and that staff will only access information that is relevant to their work.
2. WHAT IS A HEALTH RECORD

The health record provides:

- a means of communication between health care providers
- a basis for planning continuity of care
- data for research, study and education
- a basis for review, study and evaluation of care given to the client
- data to assist in protecting the medico legal and other interests of the client, health care centre and health care providers

The primary purpose and principle is that the health record contains sufficient understandable and relevant information about the client and their care to ensure the safe care of the client including, if necessary, the sharing of care with other disciplines, and the transfer of care to other clinicians.

All persons receiving care in a health centre must be registered and a record created. The record must have entries for each episode of care. There are no restrictions on the use of the information in the record for the purposes for which the information was collected or for which the record was established, that is, the provision of care.

References:

- NSW Health Patient Matters Manual, NSW Health
- Privacy and Personal Information Protection Act 1998
- NSW Health Policy Directive PD2007_094 Client Registration
3. PRIVACY PRINCIPLES

3.1 Duties of confidentiality of health service employees
The Privacy Manual regulates that staff should sign a privacy undertaking at the beginning of their employment. This covers both electronic and paper records, and should be used by SESIH services, using an electronic medical records system.

References:
- Health Records and Information Privacy Act 2002
- NSW Health Policy Directive PD2012_018 Code of Conduct

Ministry of Health Code of Conduct
It is also very important to emphasise the importance of staff duties of confidentiality and to continue to develop a culture of respect for confidentiality. Every member of staff should be able to trust that other members of staff are scrupulous about confidentiality, and that staff will only access information that is relevant to their work. It should be emphasised to patients/clients that all Health Service employees are bound by this duty.

CHIME provides additional surveillance capacity to review staff access to information. Reports can be generated to demonstrate staff access to particular records, enabling the service to identify where duties of confidentiality have been breached.

3.2 Setting up client expectations of confidentiality and sharing of information for ongoing care

Under the requirements of the Privacy Act Services are required to:
- Be open about what they will do with the information they collect from their patients/patients/clients.
- The privacy law enables health workers to share information with other health providers inside and outside the Area Health Service for ongoing care without express client consent, on the condition that patients/patients/clients would reasonably expect them to do this.
- The best way to be sure of a client’s expectation is to tell them about how the service will manage their information at the outset of their care.
- This includes being clear that it is common practice for health providers to share information in providing coordinated and multidisciplinary client care.
- Patients/patients/clients need to be reassured, however, that only relevant information will be shared in this way, and that all Health Service employees are bound by duties of confidentiality and the Health Records and Information Privacy Act 2002.

3.3 Client decision making about the confidentiality of their own record
While SESLHD has implement a standardised procedures for the treatment of information, we need to acknowledge that individual patients/patients/clients may specifically request a level of confidentiality over and above that provided as standard in a particular service.

The Privacy Manual recommends that these requests be considered on an individual basis and decisions made using professional judgement according to the circumstances.

The guiding principle here is that where possible, services should attempt to comply with client requests to restrict access to their information (over and above existing provisions). However, they can only do so if restricting access to information does not put the client, staff member or organisation at risk.
The flexibility of the service in accommodating these kinds of requests will depend on the type of service provided and the client group that accesses the service.

3.4 Anonymity under the privacy law and the Client Registration Standard
The privacy law allows patients/patients/clients to access health services anonymously if their anonymity doesn’t:
- compromise their care
- increase the health service’s liability or
- breach of any law.

It is recommended, however, that we counsel patients/patients/clients who wish to be anonymous as to the reasons that identifying information is collected, the confidentiality provisions that are in place to protect this information, and the possible implications of remaining anonymous.

Factors to consider in deciding whether to provide a service to an anonymous person include:
- whether the client requires follow-up and whether this will be possible
- whether the client is being seen by a multidisciplinary team, making it difficult to refer and coordinate the care
- whether the information being withheld is substantial enough to compromise the safety of the client in care
- whether Health Service liability may be increased
- whether identification must be provided in order to access services (eg Medicare Card, Department of Veterans Affairs services)
- whether a prescription for a restricted substance requires the name of the recipient
- whether the client has been diagnosed with a scheduled medical condition under the Public Health Act 2010 that must be reported

In any of the above circumstances, it is inappropriate that patients/patients/clients be registered on an anonymous basis.

The Client Registration Standard states that patients/patients/clients who wish to remain anonymous (subject to the above conditions being met) may use an alias, but the service needs to record this name as an alias name type so that it is clear that this is not the person’s true identity. Using an alias should be a last resort in accommodating the client’s concerns about confidentiality.

It is accordingly SESLHD District Policy that in it will not be appropriate to register patients/patients/clients on a completely anonymous basis.
4. OPERATIONAL FACTOR WITHIN CHIME

4.1 CHIME confidentiality settings
CHIME has the capacity to restrict the availability of information contained in client records. These levels are preset in within CHIME by the System Administrators based on the direction of the CHIME steering committee and in line with NSW Health Documentation. Individual service requests (or referrals) are currently set at one of three confidentiality levels as listed below:

<table>
<thead>
<tr>
<th>Level of Confidentiality</th>
<th>Definition of Confidentiality level</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>The service request is visible in the client record to all CHIME users and can be opened by any CHIME user</td>
<td>Child and Family, Community Nursing, Heart Failure, Cardiac, Continence, Rehabilitation, Oncology, Stomal Therapy, Spinal, Asthma, Physiotherapy, SAFTE, Occupational Therapy, Diabetes, Health Promotion, CAPAC, ACAT, Aboriginal Health, Womens Health, Multicultural Health, Aged Day Care, Chronic Obstructive Pulmonary Disease (COPD), Dementia, Palliative Care, Psycho-geriatrics, Transitional Aged Care.</td>
</tr>
<tr>
<td>Partial</td>
<td>The titles of the episode (eg Child and Family) and service request (eg Family Care Cottage Nursing) are visible to all CHIME users but the referral can only be opened by staff in the same organisational unit as the clinician to whom the referral was sent</td>
<td>Youth Health, Mental Health, Drug and Alcohol, Counselling Services, Homeless Outreach</td>
</tr>
<tr>
<td>Full</td>
<td>Both the title and the contents of the referral are invisible to all CHIME users except those in the organisational unit to which the referral has been sent. This means that to those CHIME users outside that particular organisational unit, there is no evidence that the client has accessed a particular service</td>
<td>PANOC (Child Protection), Sexual Health, Sexual Assault, HIV/AIDS,</td>
</tr>
</tbody>
</table>

4.2 Restrict Information Alerts in CHIME
Alerts are pop-up messages in CHIME that act as reminders about aspects of patients/patients/clients’ care, behaviour, clinical information, or administrative requirements. There is a Restrict information alert in CHIME that can be used to notify staff of a client’s special needs with regard to confidentiality. Alerts can be placed in the client demographic details section to open whenever the client record is opened, or at the service request level, where they will only open in relation to a particular referral.
4.3 Consistency between electronic and paper records
Decisions about confidentiality requirements for individual services and types of information will need to apply equally to electronic and paper records.

Restricting or facilitating access to paper records is more difficult to achieve than in an electronic system. Logistical issues involved in separating parts of paper records may create additional risk for the service or client.

As a general rule, separating of records is not supported.
5. LEGISLATION AND POLICY GOVERNING THE MANAGEMENT OF SPECIFIC TYPES OF INFORMATION

5.1 Information collected by Sexual Assault Services

This section refers to information collected by specialist sexual assault services. There are specific NSW Health guidelines about the management of information collected by specialist sexual assault services.

These guidelines and the privacy law dictate that:

- Information collected by a sexual assault service can be separated from general health information.
- Sexual assault service records can be linked to general health records, but not by any system that identifies the service provided to the client (e.g., the sexual assault service name should not appear in any general record).
- Access by other health providers to the content of the sexual assault component of the record is restricted and should only be granted through a “gatekeeper” in the sexual assault service who must seek client consent.

Practical implications

According to the above, sexual assault service records are able to be integrated with general electronic records (and use the general client/patient identifier (i.e., MRN, UI etc)), as long as there is capacity for the sexual assault service component of the record to be completely blocked from sight and access for all except authorised users.

CHIME records

In CHIME, sexual assault services should exist as independent organisational units, with all service requests set to full confidentiality. This means that the sexual assault service request will be invisible in the record to any CHIME user outside the sexual assault service.

Paper records

Paper records of sexual assault services should be kept separately to any general health record. Area identifying number systems can be used on these records.

Sexual assault information in general records

Disclosures about sexual assault occasionally occur in general service provision, and more commonly in counselling services. Some services also actively screen for this type of history.

What to record when a client discloses sexual assault in general service provision

General advice is that sexual assault disclosures should be documented in general records, but that the detail of the notes should reflect the care that the clinician is providing to the client and not focus on the detail of the sexual assault.

General service providers will generally not explore sexual assault disclosures in any detail with their patients/patients/clients – they are likely to refer the client on to a specialist provider. The general service clinician should not probe the client’s history in a setting in which these issues cannot be addressed. For example, if a client disclosed past sexual assault in a Child and Family nursing consultation, the nurse would document the disclosure, then document the actions taken in relation to this – support given, referral or information offered etc. There may be concerns stemming from the past assault that relate to the current care of the child – in this case, document the current issues and actions taken.
Detail of documentation
Problems can arise for the client when sexual assault is documented in excessive detail (including dates, times etc) by multiple services. If the matter goes to court and accounts differ between records, the client may be discredited.
Therefore, details about the assault should only be recorded in the record when they form part of the care or therapy of the client. This is most likely to occur in specialist sexual assault services.

Confidentiality level of the record
All patients/patients/clients should be aware at the outset of their care that information will be made available to health professionals involved in ongoing care and where applicable, released in accordance with legislative requirements.

In order for this to occur, the default setting for general records in CHIME must be standard. In individual circumstances, the clinician could have an open discussion with the client about what will be written in the record about the disclosure, and the people who will access that information. The client can then indicate whether they are satisfied with these provisions. If not, the service may be able to accommodate increased confidentiality provisions for the record.

Services where this type of information is more regularly disclosed, for example counselling type services, may consider using a confidentiality setting of partial to reflect a perceived client expectation that these types of disclosures will be protected more comprehensively. Staff should approach the Service manager who will have the permissions in CHIME to change the confidentiality setting to partial.

5.2 PANOC service information
This section refers to information collected by specialist child protection services. It does not necessarily apply to information about child abuse and neglect collected in the provision of general services.

There are NSW Health guidelines about the management of information collected by PANOC services. These guidelines and the privacy law dictate that:

- Information collected by PANOC can be kept separately from general health information.
- PANOC records can be linked to general health records, but information within a PANOC record and the existence of that record should remain undetectable to health professionals accessing the general record, EXCEPT:
  - Where there is judged to be a serious and imminent threat to the safety, health or life of a child, alerts must be placed in the general record and accessed by all health professionals providing a service to the child.
- PANOC service information in CHIME will have the confidentiality setting of full.

Reference:
- NSW Health 2005_299 Protection of Children and Young People

Child protection information in general service records
This section relates to information about child at risk concerns or child protection issues identified in general service delivery and recorded in general records (i.e. not PANOC services – see 4.3 for this).

What to write in the general record when there are child at risk concerns?
All information relating to child protection concerns and resulting action taken by health workers must be documented in the child’s medical record.
When documenting a child at risk concern, include the following (full guidance available in section 10 of the Frontline Procedures for the Protection of Children and Young People):

- social, emotional developmental and nutritional assessment of child and family
- history given by child and/or family
- clinical observations and whether these are consistent with the history given by the child and the family

It is also necessary to document all reports made to Community Services as well as instances where making a report to Community Services has been considered but decided against.

In this case the record should:

- identified risk factors for the child or young person and preventative factors that might mitigate against risk of harm
- any consultation undertaken with either the DoCS helpline or staff member’s line manager
- any supports put in place for the child or their family

Confidentiality of child protection information

In the interests of child protection, any child at risk concerns contained in a general record should remain accessible to staff involved in the client’s care. It is therefore necessary that there be no increased confidentiality provisions for general records containing child at risk information in the main (over and above existing provisions for a particular service), with the usual CHIME confidentiality setting to be **standard**. There may be circumstances in general service provision in which the service decides to negotiate with the client if there are particular concerns about confidentiality, but, in view of the potential risks to the child arising from inadequate communication to staff, it would be unusual to have any other confidentiality setting in CHIME. Child counselling-type services may choose to adopt a confidentiality setting of **partial** to reflect client expectations about confidentiality in this type of service, however, where child at risk concerns are evident, an alert **must** be placed in CHIME to ensure that health workers can work in a coordinated way to protect the child. Staff should approach the Service manager who will have the permissions in CHIME to change the confidentiality setting to **partial**.

Child at risk alerts

Where there are current child protection concerns for a client, it is essential that an alert be placed in CHIME by a manager at the green level, according to the **HTROS Birth Alerts at Risk unborn baby procedure**.

The privacy law allows that this type of information be disclosed in this way to try to lessen or prevent a serious and imminent threat to the safety, health or life of the child.

5.3 Domestic Violence Information

Many health services are required by NSW Health to actively screen for domestic violence.

The NSW Health domestic violence screening tool requires the health worker to explain before the screen is commenced that any disclosures of domestic violence will be kept confidential within the health service (Local Health District) unless there are serious safety concerns for the client or children.

The purpose of this preamble is to reassure the client of confidentiality but also give a realistic expectation that information disclosed will be able to be accessed by SESLHD staff involved in the client’s care. We should verbally broaden this preamble to include all health providers involved in the client’s care, in accordance with the new privacy law.
What to write in the record when domestic violence is disclosed
Where domestic violence is disclosed it must be documented in the client’s medical record. If domestic violence is suspected but not disclosed, the reasons for the suspicion should also be documented.

The NSW Health Domestic Violence screening tool provides a good framework for recording domestic violence disclosures against a structured set of questions. Action taken by the health worker in response to the disclosure can also be documented on this form. This will only be useful for the services that actively screen for domestic violence (Child and Family nursing, Drug and Alcohol and Mental Health).

When documenting domestic violence in the progress notes, use the client’s words, or objective statements like "the client states…" or “injuries are consistent with…”

The NSW Health Policies and Procedures for Identifying and Responding to Domestic Violence state that we should document in the record (if disclosed):
- the name of the perpetrator and their relationship to the victim
- dates and times when abuse occurred
- any clinical observations consistent with the history given by the client.

Reference:
- NSW Health Directive 2006_084 Policies and Procedures for Identifying and Responding to Domestic Violence

Confidentiality level of the record
All patients/patients/clients should be aware at the outset of the care that information will be made available to health professionals involved in ongoing care and where applicable, released in accordance with legislative requirements. Accordingly, the usual confidentiality setting for these records should be standard. In individual circumstances, the clinician could have an open discussion with the client about what will be written in the client record about the disclosure, and who may access that information, however, a DV disclosure in general service provision should not generally warrant allocation of a higher level of confidentiality.

Counselling type services may consider using a default confidentiality setting of partial to reflect client expectation that information disclosed in these settings will be protected more comprehensively. Staff should approach the Service manager who will have the permissions in CHIME to change the confidentiality setting to partial.

Any decisions about the confidentiality level of domestic violence information should consider the purpose of domestic violence screening as expounded by NSW Health – to bring the issue into the open and provide appropriate information and services for affected patients/patients/clients.

5.4 Drug & Alcohol Information
There is no specific policy guidance available on the management of information about drug and alcohol use, either collected by a stand-alone drug and alcohol service or in the provision of a general service. Drug and alcohol services are often stand-alone services that keep separate client records to other community-based services. This separation has been in keeping with perceptions that drug and alcohol information can be stigmatising.

However, the dearth of specific advice about management of this type of information necessitates that the general privacy principles of the HRIP Act be used. An information management approach facilitating multidisciplinary care is in keeping with the major focus of the Interagency
guidelines for the Early Intervention, Response and Management of Drug and Alcohol Misuse, which highlight the extent to which drug and alcohol problems are both a cause and a symptom of problems in many spheres of life and health.

Reference:
- NSW Health, Interagency guidelines for the Early Intervention, Response and Management of Drug and Alcohol Misuse, May 2005

Confidentiality level of the record
All patients/patients/clients should be aware at the outset of the care that information will be made available to health professionals involved in ongoing care and where applicable, released in accordance to legislative requirements. In individual circumstances, the clinician could have an open discussion with the client about what will be written in the record about the disclosure, and who may access that information.

Where patients/patients/clients request increased levels of confidentiality for their information, we should try to accommodate their concerns as outlined in section 2.3 of this document.

5.5 Sexual Health Information
This section refers to sexual health information in general. For HIV-specific information refer to the section below.

Sexual Health Services are often stand-alone services which keep separate records from general Community Health records. Other than HIV-related information (see below), there is no policy guidance available on sexual health information. Sexual Health services usually have policies in place requiring client consent for the release of this information. Where a stand-alone Sexual Health Service uses CHIME for its record keeping, a confidentiality setting of partial may be used.

Where sexual health information is collected in general service provision (ie not by a designated sexual health service), it is subject to the general rules on use and disclosure as outlined in the Privacy Manual. However, services should be mindful that when sharing information for ongoing care without express client consent, the client needs to reasonably expect this. Open communication with the client is vital in setting up accurate expectations about how information will be used and disclosed. Where patients/patients/clients request increased levels of confidentiality for their information, we should try to accommodate their concerns as outlined in section 2.3 of this document, but the usual CHIME confidentiality setting for general service provision should be standard.

5.6 HIV related information
HIV-related information is any information that confirms or indicates that a person is infected with HIV or AIDS. This could include details of AIDS defining illnesses or treatment. Also included is information indicating that a person has been tested for HIV, is required to be tested for HIV or will be tested for HIV.

There are special legal requirements for confidentiality of HIV-related information, contained in the Public Health Act 2010. These were put in place in 1991 because of the stigmatisation and discrimination that can occur if this information about individuals is disclosed without authorisation. They were also intended to promote trust and cooperation in care and treatment for people who are HIV infected, so that the public health risk could be minimised. The Public Health
Act is due for review in the coming years, and it is possible that changed societal views about HIV may loosen the strict regulation of HIV information in the new version of the Act.

HIV information can only be disclosed:
- to a person involved in providing care to the person infected with or being tested for HIV, if that information is relevant to the care
- for purposes authorised by other laws (eg notification required by the Public Health Act, court subpoena, disclosures to the Director General authorised under the Public Health Regulations etc (see Policy Directive referenced below for details))
- or where the individual gives written consent for the release of the information.

Reference:
National HIV Testing Policy 2006
The policy directive above also outlines the procedures to follow when ordering HIV tests, giving HIV test results and undertaking contact tracing.

**Practical implications for records management:**
Any health record containing HIV-related information in a general record needs to be protected against access by health staff to whom the HIV information is not relevant.
For CHIME records, this means raising the confidentiality level to **Full**.

### 5.7 Mental Health Information

The Centre for Mental Health (NSW Health) has released an Information Bulletin notifying health system staff that mental health information is to be dealt with in accordance with the requirements of the Health Records and Information Privacy Act 2002:

“All personal health information is considered sensitive personal information, dealing as it does with matters that are extremely personal and which a client/patient will expect to be shielded from public disclosure. As such, the Act does not contain special provisions for mental health information as the requirements of the Act already apply.”

Specifically, this allows mental health information to be shared between health service providers in and outside of the AHS for ongoing care without express consent (as long as the client would reasonably expect this). Accordingly, the usual CHIME confidentiality setting for this type of information in general records would be **standard**.

Client expectation is key in setting confidentiality standards for services. Services need to be open at the outset of care about the way information is routinely used and disclosed by the service. Satisfying client expectations of confidentiality is crucial for counselling services in building therapeutic alliance or the client-clinician relationship so that constructive therapy can occur. Counselling type services may thus consider using a default confidentiality setting of **partial** to reflect client expectation that information disclosed in these settings will be protected more comprehensively. A **partial** confidentiality setting allows for controlled sharing of relevant information with other service providers through the service to whom the client has disclosed the information. Staff should approach the Service manager who will have the permissions in CHIME to change the confidentiality setting to **partial**.

Reference:
- NSW Health Information Bulletin IB2012_044 Mental Health Information and the Health Records & Information Privacy Act 2002
- NSW Health 2004 Review of the Mental Health Act 1990: Discussion Paper 1; Carers and Information Sharing
6. INFORMATION ABOUT A PATIENTS/CLIENTS LEGAL HISTORY

Legal information about patients/clients can be important to their case management, and can often surface in counselling. Criminal histories may affect the suitability of a person for certain types of residential or respite care, and may thus need to be documented in client records.

Generally, information about legal or criminal history is subject to the Privacy and Personal Information Protection Act (PPIPA) (non-health, public sector privacy law). However, when this information is collected in the provision of a health service, it becomes personal health information and is hence governed by the health privacy law.

In practical terms, this means that legal information should be treated in the same way as any other health information, and the usual CHIME confidentiality setting would be standard. As with all health information, client expectation about its use and disclosure must guide our practice. It should be recognised that some patients/clients may have greater sensitivity to the use or disclosure of their personal health information than others with the same type of information, and that individual expectations should be taken into consideration when using and disclosing information about a client.

This highlights the importance of open discussion at the outset of care about the way information will be managed by services. If patients/clients have concerns about the level of confidentiality offered by a service, services should attempt to accommodate their requests as outlined in section 2.3 of this document.

7. REVISION & APPROVAL HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2006</td>
<td>0</td>
<td>Shane Simpson and Julie Hider - CHIME Team</td>
</tr>
<tr>
<td>February 2013</td>
<td>1</td>
<td>Reviewed by Shane Simpson Operations Manager Primary &amp; Community Health Information Systems. References updated and rebadged in SESLHD template Approved by Tish Brice Deputy Director Ambulatory and Primary Health Care</td>
</tr>
</tbody>
</table>
ATTACHMENT A – REFERENCES

Legislative
- Criminal Records Act 1991
- Privacy and Personal Information Protection Act 1998
- Health Records and Information Privacy Act 2002
- Public Health Act 2010

External
- National HIV Testing Policy 2006
- NSW Health Policy Directive PD2007_094 Client Registration
- NSW Health Information Bulletin IB2012_044 Mental Health Information and the Health Records & Information Privacy Act 2002
- NSW Health Policy Directive PD2012_018 Code of Conduct
- NSW Health Patient Matters Manual, NSW Health
- NSW Health 2005_299 Protection of Children and Young People
- NSW Health Directive 2006 064 Policies and Procedures for Identifying and Responding to Domestic Violence
- NSW Health 2004 Review of the Mental Health Act 1990: Discussion Paper 1: Carers and Information Sharing
- NSW Health, Interagency guidelines for the Early Intervention, Response and Management of Drug and Alcohol Misuse, May 2005
- NSW Health 2005 CHIME User Manuals
- NSW Health 2005 CHIME System Administrator Manual

Internal
- SESLHDPD/196- Records Management Policy
ATTACHMENT B - DEFINITIONS

Availability: The characteristic of data, information and information systems being accessible and useable on a timely basis in the required manner.

CHIME: Community Health Information Management Enterprise. A NSW Health state mandated electronic medical record for all community-based services.

Confidentiality: The characteristic of data and information being disclosed only to authorised persons, entities and processes with a right to know at authorised times and in an authorised manner.

Data: A representation of facts, concepts, or instructions in a formalised manner suitable for communication, interpretation or processing by electronic or manual mean.

Information: The meaning assigned to the data by means of conventions applied to that data.

Information systems: Computers, communication facilities, networks, data and information that may be stored, processed, retrieved or transmitted by them, including programs, specifications and procedures for their operation, use and maintenance.

Integrity: The characteristic of data and being accurate and complete and the preservation of and completeness.

Systems Manager: The person responsible for managing user related activities in support of users and the UPI. They are in regular contact with the database administrator.

Security processes: The measures, practices and procedures relating to the security of information systems including both logical and physical security.

User: An authorised person having access to or placing reliance on information.

SESLHD: South Eastern Sydney Local Health District

UI: Universal Index – an Area-wide index that contains patient demographic and episode data

UPI: Unique Patient Identifier

UE: Universal Encounters

WebUE: viewing of UE via a web browser
ATTACHMENT C - CONFIDENTIALITY SCRIPT FOR COMMUNITY HEALTH STAFF

- I need to talk with you briefly about confidentiality in this service and the way we will manage the information that you give us. Your information is protected by privacy laws and we are committed to treating your information in accordance with these laws.

- The team of health professionals caring for you will keep a record of the care that we provide to you. In this service (state which service), records are kept in paper files/in a computerised information system/a combination of these. The purpose of this record is to provide up-to-date, accurate information about your health and care, so that health professionals caring for you can provide the best care possible.

- Your health record will be kept strictly confidential by the health professionals caring for you. This means that no one will access your record unless they are involved in your care or you have given your consent.

- When you consent to be referred to another health professional or health provider, either in this service or outside it (eg GP or specialist), you are also consenting to the sharing of relevant information with that person or service so that they are better able to treat you or care for you.

- There are also legal requirements that require us to disclose some information to relevant authorities if yours or another person’s safety is at risk.

- You are entitled to request to read or make copies of the information in your record. Please speak to a clinician or manager if you wish to do this at any time.

- Our guiding principle at all times is that we are holding your information for the purposes of your care and in strict confidence.

- Do you have any questions?

- Give out “Privacy Leaflet” and note in the client’s record that this leaflet has been given out and explained (NSW Health privacy Leaflet, available to order form on Salmat).