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Policy***Patient health record system (C 6.2 A - B)***Accreditation link: [C 6.2 \(A - B\)](#)**Patient health record system (C6.2)**

Our practice uses an electronic patient health record system, Best Practice.

Managing health information (C6.2A)

Our practice uses the Best Practice clinical software program to manage all our patient's health information. Our orientation and induction program for all new practice team members includes training in the use of Best Practice; ongoing, refresher and software program update training is provided during the term of their employment/engagement.

Creating a new medical record

Once patient name, address, date of birth and related demographic details are received by reception, enter this information into the patient record and then scan the new patient registration form into the patients file.

Retrieving a medical record for a current patient

Computerised patient records are only accessed by authorised doctors and staff via secure login/password.

Filing reports (pathology, x-ray, consultants, etc.)**Paper based reports:**

- Paper based diagnostic test results and other incoming patient correspondence must be dated and passed on to the patient's treating doctor or the Practice Principal, if the doctor is not in on the day, for follow-up.
- Once the doctor has actioned and initialled the document it should be followed up accordingly.
- This practice scans all patient paper based correspondence with copies of this data securely stored.
- Original copies are not retained.

Digital reports

- If results are received electronically, they are to be checked by the referring doctor or Clinical Handover Doctor or Practice Principal daily, and the appropriate action box marked.
- The doctor will ensure that the action is completed.

Errors in medical records

Corrections in the electronic record should be recorded by referring to the date of the original entry and the associated amendment.

Refer to NPP6/HPP6 Access & Correction, which refers to the patient's rights to have their personal health information amended if he/she can establish that it is not accurate, complete, misleading or up to date.

Allergies and alerts

Alert notification may be required for allergic responses, drug reactions, and previous aggressive behaviour (*see attached fact sheet*) or guardianship/custody arrangements.

It is practice policy to ensure that all patients have their allergic status recorded especially any allergies to medications to facilitate safer prescribing.

In computer based records "no known allergies" is recorded in the absence of any allergies to note.

Alert notifications are documented in the electronic medical record Health Summary.

Back up of electronic medical records

In order to avoid lengthy down time, disruption, and medico-legal issues frequent backups are essential and form a critical component of the practice disaster recovery plan.

A formal policy for the backup of the practice computer systems must be in place.

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