CCC EXHIBIT

Gold Coast Health

General Business Rules

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Version 1.0

ieMR

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Contents

General Business Rules

1. Introduction

For the purposes of this document, all staff are required to work within their professional scope of practice for access, use and documentation into ieMR.

Where appropriate, localised departmental documentation should be developed or amended to align with the requirements outlined in this document.

Refer to the following supporting documents together with these business rules:

- Code of Conduct for the Queensland Public Service.
- PRO0688 Death of a patient – Care and management of the deceased patient (coronial and non-coronial deaths).
- PRO0971 Clinical Documentation – Patient / Client Record.
- PRO1165 EMR - Requesting Electronic Medical Record (EMR) Audit Trails.
- PRO1218 Alerts and Adverse Reactions Management and Documentation.
- PRO51011 Information Management: Confidentiality Request.
- PRO51001 Sub and Non-Acute Patient (SNAP) Management and Episode of Care Type Changes for Clinicians and Administration Staff.

2. Confidentiality

General principles

Patient information that is available within electronic and paper-based clinical records is to remain confidential at all times in accordance with legislative and policy requirements. ieMR is classified as “Clinical-In-Confidence”.

The following key points relate to the use of ieMR:

- All information contained in ieMR is strictly confidential. Access to the ieMR is based on an individual’s need to access the patient's medical record information.
- Access to an individual’s own patient record, family member’s patent records and friends / colleague’s patient records is strictly prohibited and monitored daily. Instances identified where patient records of the same family name accessed will be routinely investigated and actioned by HR.

- Individuals who access patient records when not involved in patient's treatment or care or when it is not a requirement of their role, may be liable for disciplinary action.
- Prior to viewing and printing clinical information from the ieMR, consider your obligations / limitations under the:
  - Code of Conduct
  - *Hospital and Health Boards Act* (2011)
  - *Mental Health Act* (2000)
  - *Privacy Act* (1988)
  - *Public Health Act* (2005).
- Individuals are personally accountable for their use of the system/s and must be defensible. Never share logins or passwords with others and do not leave computers unattended while logged on.
- ieMR retains an audit trail of individuals accessing each patient record which can be used to investigate alleged inappropriate access. Health Informatics and Business Analytics and Human Resource Services work together to routinely audit information access across the health service, identifying and investigating any potential breaches.

Consequences of a patient confidentiality breach

Consequences are severe:

You could lose your job.

- Inappropriate access to patient information may amount to suspected corrupt conduct, which requires mandatory reporting to the Crime and Corruption Commission (CCC).

You could have your professional registration revoked.

- Agencies such as Office of the Health Ombudsman (OHO) may be notified of your conduct.

You could face large financial penalties.

- You may receive a heavy fine.
- You may be held personally liable for compensation resulting from inappropriate access or disclosure of information.

Patients with increased confidentiality needs

- Refer to *PRO51011 Information Management: Confidentiality Request and* Confidentiality Request form.
- Increasing the confidentiality levels in HBCIS does not flow through to ieMR.

- HBCIS is the source of truth for increased inpatient confidentiality levels.
- Staff may add and maintain a relevant ieMR alert where a patient has requested increased confidentiality. This may include alerts from the Home Environment, Safety and Security or Special Mental Health folder.

3. Access to ieMR

GCHHS staff

The following principles apply when considering if a GCHHS clinical or administrative staff member should have access to the ieMR:

- Managers will determine if access to ieMR is required, based on the need for the staff member to access a patient's medical record.
- Access will be appropriate to the staff member's current role and acknowledgement that they will work within their scope of practice and adhere to privacy and confidentiality policies.
- Access will only be provided to staff who have attended training and are deemed proficient.
- An active personal Novell account is a pre-requisite for access to ieMR.
- Line Managers will request ieMR access via the IT Support Online Provisioning System by selecting ieMR – Release 4 (Digital/MARS) from the 'Applications to add' drop down menu. The following components are to be completed:
    - Facility – GCUH or Robina Hospital.
    - Access Type - to be matched to discipline.
    - Credential – to be matched to discipline.
    - Physician Indicator – set to Yes for staff that order medication, pathology or radiology and No for other staff.
    - AHPRA number is mandatory for certain clinical roles and the request will be rejected if one is not provided.
    - Medicare Prescriber number for staff authorised to issue PBS prescriptions at patient discharge or in an outpatient setting.
    - iPharmacy User ID for Pharmacist ieMR staff only.
- Authorisers for access to ieMR for Gold Coast Health staff are:
    - Kirsten Hinze, Director Clinical Informatics
    - Jo Broadbent, ADON Clinical Informatics
    - Rachael Sewell, Clinical Applications Manager and
    - Simon Foster, Senior Clinical Applications Specialist.
- Access to the ieMR application is via the desktop icon on all Gold Coast Health PCs.

Agency nurses

The following additional principles apply:

- Following training and once deemed proficient, an ieMR Agency Nurse Access Request form is to be completed and signed by Nursing Support Resource Unit Manager.
- Upon creation of a Novell account, there will be no email account or access to network drives included.
- The ieMR account will be created with an end date equal to three months following start date to ensure timely expiry of access when no longer required.
- A generic Employee ID based on eRoster ID will be used in lieu of an actual Employee ID (Payroll number).

Students

The following additional principles apply:

- Will require a Novell and ieMR account to be created with an end date to ensure timely expiry of access when no longer required.
- A student ID will be used in lieu of an actual Employee ID (Payroll number).

Researchers

- Where access to ieMR is for approved research purposes, initial review and recommendation for the user's access is to be undertaken by the nominated Clinical Trial Co-ordinator / Principal Investigator.
- View-only access can be applied through the GCHHS nominated supervisor. Details of the Human Research Ethics Committee (HREC) approval are to be included.
- A generic Employee ID will be used in lieu of an actual Employee ID (Payroll number).

Requesting and removal of access

- Managers are responsible for removal of ieMR access when an individual leaves the organisation, or transfers to a role that does not require access to ieMR.
- Removal of access is to be requested through IT Support Online Provisioning System.
- Temporary access requests must include the end date to ensure timely expiry of access when no longer required.
- Logins will expire if they have not been active for 90 days.

4. Patient Registration, Demographics and Paper-based Clinical Records

Source of truth

HBCIS will continue to be used to register new patients and will remain the source of truth for the following:

- Patient demographics
- Inpatient encounters
- General Practitioner (GP) information. Patient GP details will not flow from HBCIS to ieMR. Please use HBCIS, printed inpatient front sheet for reference or the Viewer (the latest state-wide HBCIS update will display GP information).
- Next of Kin (NOK) information. Patient NOK information will not flow from HBCIS to ieMR. Please use HBCIS, printed inpatient front sheet for reference or the Viewer (the latest state-wide HBCIS update will display NOK information).
- Interpreter information

FirstNet will be the source of truth for emergency encounter information.

ESM will be the source of truth for outpatient encounter information.

SurgiNet will be the source of truth for operating theatre documentation.

Creation of ieMR patient record

Once a patient is registered on HBCIS or through Emergency Department / FirstNet for the first time, a patient record in ieMR will be created.

Types of paper-based clinical records

End of bed chart
Most traditional end of bed chart forms such as observations and medication charts will be entered directly into the ieMR. Some clinical forms will remain on paper due to reasons such as:

- The ieMR equivalent documentation does not meet local standards.
- There is a patient safety risk.
- The form contains a patient's physical signature (there is no electronic capability to capture this).
- The form is used in urgent situations.

Summary of form types staying on paper

- All local and state-wide Consent forms, or forms that require a patient signature.
- MET Call and Code Blue documentation.
- Acute resuscitation plan, advanced care plan, statement of patient choices.
- Drawings.
- Incoming correspondence.
- Externally provided pathology and radiology results.
- System generated information that is not interfaced with the ieMR.
- Any form that is required under the provision of an Act that requires an original to be submitted to an external agency, e.g. some mental health forms, child protection forms.
- Downtime forms for use in planned or unplanned downtime events.
- Withdrawal Scales (e.g. Alcohol Withdrawal Scale/Protocol)
- All Non-Invasive Ventilation Documentation
- Criteria Led Discharge
- Deceased Adult Body Checklist.

Temporary folders

Temporary folders may be created to ensure current clinical forms for a patient's inpatient admission or during a community program attendance over multiple encounters are kept together.

Temporary folders are to remain with inpatients at all times:

- Patient movements (admissions, discharges, transfers, leave, etc) will be kept up to date on the HBCIS patient movement menu or Patient Flow Manager.
- Following an inpatient or community discharge, the contents of the temporary folder are to be prepared by ward / community staff.
- Clinical Records Service will collect prepared paper from inpatient wards and departments according to collection times.
- The Gold Coast Health driver will collect prepared paper from community sites each business day.

Historical clinical record

- Historical clinical records (paper-based) records created prior to implementation of the EMR in 2011 are used for reference only with subsequent clinical information held in the EMR. A cross reference label is used on the record cover advising staff to check EMR.
- *For elective patient admissions* - historical clinical records will be provided and delivered to admitting areas for elective inpatient admissions upon request to Clinical Records Service.
- *For emergency patients* - If historical record is required for an emergency patient, contact Clinical Records Service as soon as possible. Clinical Records Service will retrieve requested historical records, label, track and deliver to requesting area.
- Contact Clinical Records Service if historical records are no longer to be routinely provided for an Outpatient clinic.

Tracking

- All staff transferring *historical clinical records* between Gold Coast Health locations are responsible for ensuring the correct patient location is recorded on the Hospital Based Corporate Information System (HBCIS) Medical Record Tracking Menu at the time of the movement. This will track the movements of the historical clinical record and reflect the movement of the patient.
- Failure to track historical records on HBCIS is a risk to patient safety as clinical information is unavailable for patient care. In the event that the historical record does not go with the patient, it is the responsibility of ward / department staff to deliver it to the area where the patient is located.
- Tracking of *temporary folders* will not be tracked in HBCIS (historical records only are tracked). The temporary folder should always remain with the patient, therefore, as the location of the patient is updated, the temporary folder can also be located.

Identification

All documentation must be recorded in the correct patient record in ieMR. The following positive patient identification information should be confirmed every time a patient record is accessed and prior to signing clinical notes in accordance with patient identification procedures:

- Unit Record Number
- Patient family name and given name
- Sex
- Date of Birth

5. Encounters

ieMR is an encounter-based system. To ensure orders are placed on the correct encounter, and to ensure easy and consistent viewing of notes and documents, the correct Gold Coast encounter must be accessed when opening the patient record.

An encounter can represent the following activity:

- An occasion of service (Inpatient, Outpatient, Emergency)
- Multiple occasions of service (Chronic, Community)
- A planned occasion of service (Pre-Arrival)
- Other non-activity requirements (No visit, Results only)

Principles

ieMR includes the following encounter types and their functions:

Encounter type	Creation method	Purpose
Community	Manually created for each community service	Used for community documentation
Emergency	Automatically created following FirstNet quick registration.	Used for documentation and ordering while the patient is being treated in the Emergency Department. The Emergency encounter is flipped to an Inpatient encounter if the patient is admitted in HBCIS as a result of the emergency presentation.
Inpatient	Automatically created when a patient is admitted as an inpatient on HBCIS.	Used for documentation and ordering related to the inpatient admission. This includes outpatient services provided to a patient who is currently admitted.
No Visit	Generated upon registration of the patient at an ieMR facility.	Used for documentation when the patient has not presented or does not have a pre-arrival encounter. Orders cannot be placed against a No Visit encounter.
Outpatient	Created upon ESM appointment arrival or fail to attend.	Used for documentation and ordering related to the outpatient service.
Pre-Arrival	Created upon ESM referral entry.	Used for documentation and ordering related to an upcoming outpatient service. The Pre-Arrival encounter will flip to an Outpatient encounter when the patient presents for the outpatient service. Also used by other services, e.g. Multi-Disciplinary Team meetings, which do not generate an encounter in ESM but require the ability to order.
Chronic	Manually created every 367 days.	For use by approved services only - Renal Dialysis.
Results Only	Generated by laboratory and radiology systems where the order for the result has not been created in ieMR.	Placeholder for unsolicited results. Not to be used for documentation, scanning or ordering.

6. Clinical Documentation

Please access Gold Coast EMR (Legacy) for historical clinical documentation prior to implementation of ieMR.

Principles

The following general principles for progress notes should be followed:

- Information must be recorded contemporaneously and in chronological order unless in circumstances such as an emergency or downtime situation. All clinical notes relevant to a patient interaction / consultation or treatment provided must be completed and signed by the end of the shift.
- To ensure progress notes are easily located in a consistent manner, clinicians must:
  - Select the correct patient. Always confirm the patient family name, given names, date of birth and Gold Coast Health UR number on the banner bar upon opening a patient record.
  - Select the correct encounter.
  - Select the correct document type according to the Order of Filing principles.
  - Use a meaningful subject line to describe the purpose of the note using a standardised naming convention: Team / Role / Reason.
- All progress notes must include the name, designation and contact phone number at the end of each note. This can be entered efficiently via personal auto text functionality.
- The recommended font type and style are:
  - Arial
  - Size 11
  - Black colour
- Bold may be used for headings.
- All progress notes must be 'signed' (not saved).
- Use the appropriate format / content as recommended by your professional and clinical area.

Order of Filing

The Order of Filing is a state-wide series of folders used to locate information available in ieMR.

The following principles apply to the order of filing:

- Reflect a consistent state-wide approach focusing on the patient; not hospital, disease or service requirements.
- Staff within each treating team, ward, outpatient department and community service should determine the most appropriate note type for their documentation and ensure consistent use.

The following table reflects the Order of Filing including folders and note types available in ieMR:

First level folder	Second level folder	Note type
Administrative	Administrative	Administrative
Alerts and Adverse Reactions	Alerts and Adverse Reactions	Alerts and Adverse Reactions
Assessments	Allied Health	Assessments Allied Health
	Medical	Assessments Medical
	Multidisciplinary	Assessments Multidisciplinary
	Nursing-Midwifery	Assessments Nursing-Midwifery
	Self-Assessment Questionnaires	Assessments Self-Assessment Questionnaires
Consents	Procedural	Consents Procedural
	Non-procedural	Consents Non-procedural
Correspondence and Referrals	Inward-Internal	Corro and Referrals Inward-Internal
	Outward	Corro and Referrals Outward
	Referrals In	Referrals In
	Referrals Out	Referrals Out
Discharges-Transfers-Deceased Information	Transfer Information	Transfer Information
	Discharge Information	Discharge Information
	Deceased Information	Deceased Information
Clinical Document	Admission Note	Admission Note
	Clinic Note	Clinic Note
Procedures and Operations	Anaesthetic	Anaesthetic
	Peri-operative - Procedure	Peri-operative - Procedure
	Care plans	Care Plans
	Pathways	Pathways

Pathways – Care Plans - Protocols	Protocols	Protocols
Investigations-Reports-Measurement	Clinical Measurements	Clinical Measurements
	Clinical Reports	Clinical Reports
	Medical Imaging	Medical Imaging
	Pathology	Pathology
	Photos	Photos
Medications and Infusions	Infusions	Infusions
	Medication Approval Forms	Medication Approval Forms
	Medications Charts and Plans	Medications Charts and Plans
	Transfusions	Transfusions
Observations-Inputs-Outputs	Inputs-Outputs	Inputs-Outputs
	Observations	Observations
Legal	Legal	Legal
Progress Notes	Outpatient Addiction Medicine	Outpatient Addiction Medicine
	Outpatient Anaesthesia	Outpatient Anaesthesia
	Outpatient Audiology	Outpatient Audiology
	Outpatient Burns	Outpatient Burns
	Outpatient Cardio-Thoracic Surgery	Outpatient Cardio-Thoracic Surgery
	Outpatient Cardiology	Outpatient Cardiology
	Outpatient Child Development / Protection	Outpatient Child Development/Protection
	Outpatient Clinical Genetics	Outpatient Clinical Genetics
	Outpatient Clinical Pharmacology	Outpatient Clinical Pharmacology
	Outpatient Dental	Outpatient Dental
	Outpatient Dermatology	Outpatient Dermatology
	Outpatient Dietetics / Nutrition	Outpatient Dietetics / Nutrition
	Outpatient Endocrinology / Diabetes	Outpatient Endocrinology / Diabetes

	Outpatient Gastroenterology / Hepatology	Outpatient Gastroenterology / Hepatology
	Outpatient General Practice	Outpatient General Practice
	Outpatient Geriatric Medicine	Outpatient Geriatric Medicine
	Outpatient GynaeOncology	Outpatient GynaeOncology
	Outpatient Haematology	Outpatient Haematology
	Outpatient Hyperbaric Medicine	Outpatient Hyperbaric Medicine
	Outpatient Hypertension	Outpatient Hypertension
	Outpatient Immunisation Services	Outpatient Immunisation Services
	Outpatient Immunology / Allergy	Outpatient Immunology / Allergy
	Outpatient Infectious Diseases	Outpatient Infectious Diseases
	Outpatient Internal Medicine - General	Outpatient Internal Medicine - General
	Outpatient Metabolic Medicine	Outpatient Metabolic Medicine
	Outpatient Neonatal / Perinatal Medicine	Outpatient Neonatal / Perinatal Medicine
	Outpatient Nephrology	Outpatient Nephrology
	Outpatient Neurology	Outpatient Neurology
	Outpatient Neurosurgery	Outpatient Neurosurgery
	Outpatient Obstetrics / Gynaecology	Outpatient Obstetrics / Gynaecology
	Outpatient Occupational Therapy	Outpatient Occupational Therapy
	Outpatient Other Allied Health	Outpatient Other Allied Health
	Outpatient Oncology - Medical	Outpatient Oncology - Medical
	Outpatient Oncology - Radiology	Outpatient Oncology - Radiology
	Outpatient Ophthalmology	Outpatient Ophthalmology
	Outpatient Oral/Maxillofacial Surgery	Outpatient Oral/Maxillofacial Surgery

	Outpatient Orthopaedic Surgery	Outpatient Orthopaedic Surgery
	Outpatient Orthotics / Prosthetics	Outpatient Orthotics / Prosthetics
	Outpatient Otolaryngology/ Head / Neck Surgery	Outpatient Otolaryngology/ Head / Neck Surgery
	Outpatient Paediatric Medicine	Outpatient Paediatric Medicine
	Outpatient Paediatric Surgery	Outpatient Paediatric Surgery
	Outpatient Pain Medicine	Outpatient Pain Medicine
	Outpatient Palliative Care	Outpatient Palliative Care
	Outpatient Physiotherapy	Outpatient Physiotherapy
	Outpatient Plastic / Reconstructive Surgery	Outpatient Plastic / Reconstructive Surgery
	Outpatient Podiatry	Outpatient Podiatry
	Outpatient Psychiatry	Outpatient Psychiatry
	Outpatient Psychology	Outpatient Psychology
	Outpatient Rehabilitation	Outpatient Rehabilitation
	Outpatient Rehabilitation Engineering	Outpatient Rehabilitation Engineering
	Outpatient Respiratory / Sleep	Outpatient Respiratory / Sleep
	Outpatient Rheumatology	Outpatient Rheumatology
	Outpatient Sexual Health Medicine	Outpatient Sexual Health Medicine
	Outpatient Social Work / Welfare	Outpatient Social Work / Welfare
	Outpatient Speech / Language Pathology	Outpatient Speech / Language Pathology
	Outpatient Spinal Injuries	Outpatient Spinal Injuries
	Outpatient Surgery - General	Outpatient Surgery - General
	Outpatient Transplant	Outpatient Transplant
	Outpatient Urology	Outpatient Urology
	Outpatient Vascular Medicine	Outpatient Vascular Medicine

	Outpatient Vascular Surgery	Outpatient Vascular Surgery
	Outpatient Wound Care / Stomal Therapy	Outpatient Wound Care / Stomal Therapy
	Medical Imaging	Medical Imaging
	Community	Progress Note Community
	Emergency	Progress Notes Emergency
	Inpatient	Progress Notes Inpatient
	Outpatient	Progress Notes Outpatient
Research	Research	Research

Subject Line

The naming convention for clinical notes within ieMR are important because they influence the efficiency and completeness of the review of a patient's clinical record.

Naming clinical notes consistently, logically and in a predictable way will:

- Distinguish similar records from one another at a glance.
- Enable users to browse documents more effectively and efficiently.
- Make naming easier for staff because they will not have to "re-think' the process each time.

The approach for subject line naming conventions is 'Team – Role – Reason'.
For example:

- 'Cardiology Consultant Ward Round'.
- 'Transition Care Program Physio Initial Assessment'

Copy and Paste

Copy and paste is defined as reproducing text or other data from one source to another.

- If not managed appropriately, use of copy and paste functionality can result in redundant, erroneous clinical documentation in ieMR and other clinical systems.
- This can impact upon communication amongst staff, result in unnecessarily lengthy and inconsistent notes and compromise quality of patient care.
- No images are to be copied and pasted into clinical notes as this may impact upon the ability to print the note.
- Images such as clinical photos may be imported by Clinical Records Service.
- Ensure that email signature blocks that include images are not copied and pasted into personal auto text to produce a signature block within a clinical note.

Documentation for unplanned encounters

Telephone Calls

- Staff will ensure that relevant details of telephone conversations with patients and carers are documented in ieMR.
- If the patient is physically located in the health service at the time, then the telephone conversation will need to be documented against the current Gold Coast encounter in ieMR.
- If the patient is not physically located in the health service at the time, the choice of encounter will depend on the situation:
    - If the call relates to a recent inpatient or outpatient encounter, then that encounter should be used.
    - If the call relates to an upcoming outpatient appointment, then the relevant pre-arrival encounter should be used.
    - If the telephone call is replacing a face to face appointment and meets the counting rules / requirements for Activity Based Funding (ABF), however there is no upcoming appointment, a pre-arrival encounter should be created in ieMR and an ESM appointment entered/actioned retrospectively.
    - If the telephone conversation does not meet the requirements for ABF and there is no suitable encounter already in existence, then:
        - documentation should be entered against the most recent, relevant Gold Coast encounter, or
        - if there is no recent, relevant Gold Coast encounter, documentation should be entered against the Gold Coast No visit encounter'.

Unplanned care / arrivals

- All staff are required to complete the relevant documentation for any unplanned care or patients that arrival without a planned encounter.
- Select an encounter to document for unplanned care / patient arrivals as follows;
    - If the unplanned care / arrival relates to a recent inpatient or outpatient encounter, then that encounter should be used.
    - If the unplanned care / arrival relates to an upcoming outpatient appointment, then the relevant pre-arrival encounter should be used.
    - If the unplanned care / arrival meets the counting rules / requirements for ABF related, however there is no upcoming appointment, a pre-arrival encounter should be created in ieMR and an ESM appointment entered/actioned retrospectively.
    - If the unplanned care / arrival does not meet the requirements for ABF and there is no suitable encounter already in existence, then:
        - documentation should be entered against the most recent, relevant Gold Coast encounter, or
        - if there is no recent, relevant Gold Coast encounter, documentation should be entered against the Gold Coast No visit encounter'.

7. Allergies

Please access Gold Coast EMR (Legacy) for historical patient Allergies documented prior to implementation of ieMR.

Principles

The following general principles for allergies should be followed:

- ieMR is considered as the 'source of truth' for allergy information across the health service.
- All adverse reactions, encompassing the clinical terms of allergy, intolerance and sensitivity are to be documented in the Allergies module of the ieMR.
- All patients must be assessed by the treating team on presentation and reviewed throughout the patient's course of care to identify any history of allergies or adverse reactions to any substances.
- It should be noted that patients may already have an allergy record in the ieMR, Gold Coast EMR (Legacy) or scanned record of allergies. If the allergies in these notes or scanned forms are still current at the time of patient review, the information should be added, reviewed and / or updated in the ieMR Allergies module.
- ieMR will send allergy information to the state-wide Viewer and Enterprise Discharge Summary.

Allergy status

It is the responsibility of the first clinician (medical officer, nurse, pharmacist or other health practitioner) who initially identifies an adverse reaction to ensure that the details are documented in all required areas within the ieMR.
All clinicians are responsible for reviewing and updating the documentation of allergies and ensuring they remain accurate and current.

Allergies will be displayed in the ieMR Banner Bar and Summary Page as one of the following status:

- 'Allergies not recorded' – allergies have not been recorded for the patient.
- 'No known allergies' – a clinician has indicated that no allergies have been identified for this patient.
- List of allergies recorded for the patient.
- If a patient or significant other is not able to inform the clinician of their allergy status, 'unable to obtain' should be recorded from the 'other' folder.

Adding an allergy

- It is the responsibility of the first clinician who initially identifies an adverse reaction to ensure that the details are documented in all required areas within the patient record.
- The adverse reaction should be entered into the ieMR using the codified terms where possible
- All clinicians are responsible for reviewing and updating the documentation of adverse reactions and ensuring they remain accurate and current.
- Roles that currently require supervision of documentation (e.g. medical students and nurse students) will require supervision if entering allergy information in the ieMR. Students are not to enter a status of No Known Allergies (NKA).
- The status of 'proposed' is to be used by clinicians who wish the allergy to be confirmed by the medical team or pharmacist. This is based on the premise that patient safety is enhanced by the inclusion, rather than the omission, of suspected allergies for consideration.
- The reaction type: allergy, intolerance or sensitivity should be selected based on the reported symptoms and the clinical judgement of the clinician.
- Generic drug names should be used wherever possible for recording drug allergies.
- Reaction symptoms should be added where reported, using codified terms where possible.

Reviewing allergies

- Allergies should be marked as reviewed at the point of presentation to the health service.
- Allergies should be marked as reviewed by all clinicians when clinically indicated, for example; Medication ordering and administration and at clinical handover.
- Clinicians are expected to work within their scope of practice with regards to reviewing allergies. It is possible to review each allergy separately if required, for example pharmacists may review only drug allergies and dietitians review only food allergies.

Modifying an allergy

- It is important that allergies information is updated as required. For example, the allergy may have been written in error, a side effect or intolerance may have been documented incorrectly as an allergy and some allergies resolve with age, particularly food allergies, such as egg.
- Clinicians who can add allergies as part of their scope of practice are able to modify allergies.
- If the modification is to reduce the severity and/or to change the reaction type of the allergy, then it is to be discussed with a medical officer or pharmacist first. Such modifications require a comment to be added in the comments field of the allergy, including the name of the medical officer or pharmacist who was consulted.

Resolving an allergy

- Only medical officers and pharmacists should resolve an allergy.
- Clinicians other than a medical officer or pharmacist, who suspect that an allergy should be resolved, are to notify a medical officer or pharmacist who will take the responsibility to resolve the allergy.
- Paediatric allergies can be resolved by any clinician who can add allergies as part of their scope of practice– discussion with a medical officer is recommended.
- A comment as to why the allergy has been resolved should be added to the record.

Cancelling an allergy

- The cancelled status should only be used for allergies entered in error. The reason for cancellation is a mandatory field.
- If a brand name drug has been recorded, such as Panadol this may be cancelled and the generic drug added in its place. The reason for the cancellation should be given as other, with an explanation added using the comment note.

Documentation of allergy severity

- Documentation of allergy reaction severity is mandatory, and may be documented as mild, moderate, severe or unknown.
- The categorisation of an allergy reaction as severe will influence the display of the allergy within the ieMR. Allergies marked as severe will be marked in red on the Summary Page, and listed first (after unknown reaction severities) on the Banner Bar.
- An anaphylaxis reaction should always be documented as a 'severe' reaction.
- Selection of an allergy reaction severity for other reaction types should be based on clinical discretion. The following definitions may be used as a guide to determine severity:
    - **Mild**: The adverse reaction has no sequelae.
    - **Moderate**: The adverse reaction has sequelae; however, it does not cause loss or restriction of functional ability or activity.
    - **Severe**: The adverse reaction has sequelae of temporary or permanent loss or restriction of functional ability or activity, or may lead to a life-threatening reaction or death.
    - **Unknown**: The seriousness of the reaction is unknown or is unable to be determined.

8. Alerts

Please access Gold Coast EMR (Legacy) for historical patient Alerts documented prior to implementation of ieMR.

Definition

Alerts are information pertaining to a patient which may affect subsequent clinical decisions or notify clinicians of special circumstances which may be relevant in delivering care to the patient on any current or future encounter with the patient. Alerts may also refer to an actual or potential patient or staff safety risk.

Alerts are grouped into the following subgroups:

- Administrative
- Clinical
- Home environment
- Infection control
- Safety and security
- Special needs
- Other

Principles

- ieMR is considered as the 'source of truth' for alert information across the health service.
- It should be noted that patients may already have an alert information in the ieMR, Gold Coast EMR (Legacy), HBCIS or other clinical systems. If the alert information is still current at the time of patient review, the information should be added, reviewed and / or updated in the ieMR Alerts module.
- Clinicians should review, update, take actions and make decisions according to Alert information at every patient presentation.
- Alerts appear within the Diagnosis/Problems/Alerts module, on the Summary Page and can be accessed through the Diagnosis/Problems/Alerts tab on the menu. When a patient has one or more Alerts added, the word 'Alert(s)' will populate the Banner Bar.
- The ieMR process does not replace the need to maintain Alerts in other agreed systems or on other clinical documentation. In particular, Alerts used for reporting purposes will need to continue to be updated in HBCIS.
- ieMR will send alert information to the state-wide Viewer and Enterprise Discharge Summary.

Alert considerations

The following key points will assist when adding or modifying Alerts:

- For an Alert to appear on the Banner Bar and Summary Page, it is essential that the Alert has been chosen from one of the seven Alert folders (subgroups) in the Diagnosis/Problems/Alerts module.
- It is essential that the Alert status is kept up to date: active, cancelled, resolved or inactive throughout the patient journey to ensure that the medical record is reflective of the patient's current clinical situation.
- Some medical conditions will be associated with, or result in one or more patient management Alerts.
- Certain clinical conditions should be added as an Alert/s with additional information added to the comments section to clarify the Alert further (e.g. bleeding risk). Additional clinical information may also need to be added to the clinical notes.
- The ieMR will auto populate certain alerts based on clinical information documented within the ieMR. For example, Falls risk alert will populate based on clinical documentation within falls risk assessment.

Adding an Alert

- It is the responsibility of the first clinician (medical officer, nurse, pharmacist or other health practitioner) or some administrative staff members who initially identifies an Alert to ensure that the details are documented in all required areas within the patient's medical record. Subsequent clinicians and administrative staff are responsible for reviewing and taking appropriate action based on the Alert, and to ensure it remains accurate and current.
- Those roles that currently require supervision of documentation into a patient's medical record (e.g. nursing and medical students) will require supervision if entering Alert information in the ieMR.
- Infection control alerts are recorded and managed in both ieMR and HBCIS by Infection Control Services.
- Child Protection Unit (Jungara) will be responsible for the entering and management of Child Protection related alerts, including Unborn Child at High Risk Alerts (UCHRA)

Alert status

- Alerts that have been documented may need to be changed during an inpatient stay or outpatient visit. For example, depending on the circumstances, an Alert may be inactivated, resolved, or cancelled.
- There are four Alert status types that can be selected when adding and maintaining a patient's medical record. It is important that the Alert information be changed appropriately in these situations.

a. Active Alert

- The Alert is active in the patient's ieMR.
- If there is one or more Alert with a status of active, the word Alert(s) will appear in the Banner Bar.
- Individual Alerts will be listed on the Summary Page and the Alerts list.

b. Inactive Alert

- The Alert is no longer current however, needs to stay on the Alerts list as it may have an impact on future encounters. Alerts may need to be made inactive during a patient's stay. The Alert should be re-activated as per the principles above when appropriate.
- Inactive Alerts will not be visible on the patient's Banner Bar or the Summary Page.

c. Resolving an Alert

- The Alert has been resolved and is not reasonably expected to recur. Alerts which are no longer relevant to the patient should be resolved, not cancelled from the patient record.
- Resolved Alerts will not be visible on the patient's Banner Bar or the Summary Page.
- Resolved Alerts appear on the Alerts list and are visible across all encounters.
- 'Resolved at: Age' and 'Resolved at: Date' can be documented when resolving an Alert. A comment on the reason for the resolution is also recommended.

d. Cancelling an Alert

- The cancelled status should only be used for Alerts entered in error, for example; if entered against an incorrect patient.
- The reason for cancellation is a mandatory field in ieMR.

Confirmation of Alerts

Alerts are confirmed under the following status:

- Confirmed.
- Patient Stated: this level of confirmation allows an Alert asserted by the patient or family but not yet confirmed to be recorded. A clinician reading the record may infer a lower level of confidence in an Alert with this level of confirmation.

- Provisional: used where an Alert is probable but requires further investigation. It is expected that when further information is available, that the Alert is updated.

Reviewing an Alert

Alerts should be marked as reviewed in the ieMR in the following scenarios:

- At each presentation to the health service.
- At each discharge.
- At regular intervals during the inpatient journey.

9. Diagnoses

Please access Gold Coast EMR (Legacy) for historical patient diagnosis information documented prior to implementation of ieMR.

Definition

ieMR is considered the 'source of truth' for patient diagnosis information across the health service. Diagnoses are those medical conditions, presenting complaints or working diagnoses being addressed in the current encounter. SNOMED CT is the standard terminology used to code diagnoses in the ieMR. Diagnoses appear within the Diagnosis/Problems/Alerts module, Summary Page and can be accessed through the Diagnosis/Problems/Alerts tab on the menu.

All patients must be assessed by the treating team on presentation and throughout the patient's course of care to identify any changes to diagnosis information. This ensures that the information is up to date and available for all staff caring for the patient at all times.

The ieMR process does not replace the need to document the patient's diagnosis in other systems such as Patient Flow Manager.

Diagnosis Status

- Diagnoses will default to and be displayed in the Diagnosis/Problems/Alerts module as a 'Working' status.
- Diagnoses status that has been previously documented may require change. For example, the diagnosis may have been documented as an admitting diagnosis prior to receiving the results from further diagnostic tests such as radiology or pathology. It is important that the diagnosis status be changed and updated appropriately in these situations (e.g. from admitting to working diagnosis).

Adding a Diagnosis

- It is the responsibility of the first medical officer, nurse practitioner or allied health practitioner (within scope of practice), who initially identifies a diagnosis to ensure that the details relating to the diagnosis are documented in all required areas within the patient's medical record.
- Subsequent medical officers, nurse practitioners and allied health practitioners (within scope of practice) are responsible for checking that diagnosis information remains accurate and current.

Confirmation of a Diagnosis

Diagnoses are confirmed under the following classification levels:

- **Confirmed**: Tests/procedures/results confirm the diagnosis.
- **Patient Stated**: This level of confirmation allows a diagnosis asserted by the patient or family but not yet confirmed to be recorded. A clinician reading the record may infer a lower level of confidence in a diagnosis with this level of confirmation.
- **Provisional**: Used where a diagnosis is probable but requires further investigation. It is expected that when further information is available, that the diagnosis is updated.

Modifying/Removing a Diagnosis

- A diagnosis should only be modified or removed by a medical officer, nurse practitioner or allied health practitioner (within scope of practice).

Reviewing a Diagnosis

- A diagnosis recorded for inpatients should be marked as reviewed daily and prior to discharge by the treating clinical team.

10. Problems

Please access Gold Coast EMR (Legacy) for historical patient problems documented prior to implementation of ieMR.

Principles

Problem information entered in the ieMR will be considered as the 'source of truth' across the health service.

Problems are continuing or chronic medical conditions that will affect subsequent medical decision making on any future encounter with the patient. Problems persist across all encounters. Problems can be accessed, added and reviewed within the Diagnosis/Problems/Alerts module and are visible on the Summary Page.

The ieMR process does not replace the need to document problems in other agreed systems or on other clinical documentation for example, CIMHA.

The following clinicians have the ability to add and update a patient's problem status, including being able to inactivate, resolve and cancel a problem:

- Medical officers.
- Registered nurses, enrolled nurses and midwives.
- Allied health practitioner (including assistants).

*Please note – other positions (e.g. non-clinical staff and students) will have the capacity to add and modify problem information in the ieMR; however, this task is not within their scope of practice and therefore should not be undertaken. Only those roles identified above should add or modify problem information.

What constitutes a Problem?

Problems are information pertaining to a patient which may affect subsequent clinical decisions or notify clinicians of special circumstances which may be relevant in delivering care to the patient on any current or future encounter with the patient. Problems are also referred to as co-morbidities. Unlike diagnoses, problems are not encounter specific.

Problems are grouped into the following folders in the ieMR:

- Brain and Nervous System
- Cancer
- Cardiovascular and Circulatory
- Child Development
- Child Protection
- Chronic Conditions
- Dementia
- Ear, Nose, Throat, head and Neck

- Endocrine, Nutritional and Metabolic
- Eye and Vision
- Gastrointestinal and Liver
- Genetic and Chromosomal
- Haematology
- Immunology and Allergy
- Infectious Diseases
- Kidney and Genitourinary
- Mental Health and Behavioural
- Musculoskeletal and Connective Tissue
- Neonatal
- Pregnancy, Childbirth and Puerperium
- Respiratory, Sleep and Chest
- Skin
- Trauma Injury and Poisoning
- Undifferentiated Symptoms, Signs and Findings

Each of these folders contain common 'codified' SNOMED conditions that when added to the patient's medical record form a part of the overall clinical picture.

Considerations

- It is essential that the problem status is kept up to date: active, cancelled, resolved or inactive throughout the patient journey to ensure that the medical record is reflective of the patient's current clinical situation.
- Certain clinical conditions should be added as a problem with additional information added to the comments section to clarify the problem further (e.g. Infectious Disease). Additional clinical information should also be reflected in the patient's progress notes.

Adding a Problem

- It is the responsibility of the first clinician (medical officer, nurse or allied health practitioner) who initially identifies a problem to ensure that the details relating to the problem are documented in all required areas within the patient record. Subsequent clinicians are responsible for checking that documentation of problems remains accurate and current.

- All staff are to work within their professional scope of practice for documentation into a patient health record.

Problem Status

Problems that have been documented may need to be changed. There are four status types that can be selected when adding and maintaining a patient's problems. It is important that the problem information be reviewed and changed appropriately in these situations.

a. Active Problem

- The problem is active and is documented in the patient's medical record.
- Active problems will visible on the patient's Summary Page.

b. Inactive Problem

- The problem is no longer current but needs to stay on the problems list as it may have an impact on future encounters. Problems may need to be made inactive during a patient's inpatient stay. The problem should be re-activated if or when appropriate.
- Inactive problems will not be visible on the patient's Summary Page.

c. Resolved Problem

- The problem has been resolved and is not reasonably expected to recur. Problems which are no longer relevant to the patient should be resolved, not cancelled from the patient record.
- Resolved problems will be visible in the historical section of the Diagnosis/Problems/Alerts widget on the Summary Page.
- Resolved problems appear on the problems list and are visible across all encounters.
- 'Resolved at: Age' and 'Resolved at: Date' can be documented when resolving a problem. A comment on the reason for the resolution is also recommended.

d. Cancelled Problem

- The cancelled status should only be used for problems entered in error, for example; entered against an incorrect patient.
- The reason for cancellation is a mandatory field in ieMR.

Confirmation of Problems

Problems are acknowledged under the following classifications:

- **Confirmed**: Tests/procedures/results confirm the problem.
- **Patient Stated**: This level of confirmation allows a problem asserted by the patient or family but not yet confirmed to be recorded. A clinician reading the record may infer a lower level of confidence in a problem with this level of confirmation.
- **Provisional:** Used where a problem is probable but requires further investigation. It is expected that when further information is available, that the problem is updated.

Reviewing a Problem

Problems should be marked as reviewed in the ieMR. A patient's problem status should be reviewed:

- At each presentation to the health service.
- At each inpatient discharge.
- At regular intervals during the inpatient journey.

11. Histories

Please access Gold Coast EMR (Legacy) for historical patient procedure information documented prior to implementation of ieMR.

History information entered in the ieMR will be considered as the 'source of truth' across the health service.

The Histories module provides a single area to document and review:

- past medical history
- surgical procedures
- social history
- family history and
- pregnancy history, if applicable.

History information may be viewed on the Summary Page. As patients are assessed throughout the course of care and report their past history, any new information or changes should be documented. This ensures that the information is up to date and available for all staff caring for the patient at all times.

Procedure history is a record of past medical and surgical procedures that the patient has had over their lifetime including the type of procedure, the date or approximate date the procedure

was performed and where it was performed. Procedure information can be captured historically in the procedure history tab and procedures captured in SurgiNet.

12. Growth Charts

Please access Gold Coast EMR (Legacy) for historical patient growth chart measurements prior to implementation of ieMR.

Principles

Children's growth is an important marker of their health and development. Growth assessment is one of the easiest ways to confirm the health and nutrition of children. This is because changes in health and nutrition almost always affect growth.

Growth charts show the growth of a reference population and are used to assess individuals and groups of children. Serial measurements of the child's growth are plotted on a growth chart to assess patterns of growth over time.

Growth charts are not a diagnostic tool, but rather contribute to forming an overall clinical impression for the child being measured. Growth assessment involves measuring of weight, length or height (and the head circumference of infants) followed by accurate plotting on a growth chart.

Adding a measurement

Universal serial growth assessment should be undertaken at key critical developmental stages with the aim of confirming healthy growth, and for the early detection and prompt attention to any deviation from normal expectations.

Targeted growth assessment should be undertaken more regularly where there is parental or professional concern regarding growth or development, or any identified risk. Staff may add a measurement to be plotted on a growth chart in the following circumstances:

- At each outpatient or community appointment for all infants up to twelve months of age.
- For children with specific conditions, such as cystic fibrosis or eating disorders, at each outpatient appointment irrespective of age.
- On discharge from the Paediatric Inpatient Unit for all children.
- On discharge from Newborn Care Services for all babies.
- For children seen in the Emergency Department for whom ongoing growth assessment is important, for example, a suspected undernourished child.

Documentation of measurements can be entered with interactive view in ieMR or advanced growth chart, with both documentation approaches plotting on the growth chart

Retrospective entries may be added if deemed clinically relevant.

Modifying a measurement

Staff who are able to add measurements are able to modify measurements. For example, an incorrect weight may have been recorded. The staff member who identifies the error can overwrite the incorrect weight with the correct weight.

Deleting a measurement

Staff who are able to add measurements are able to delete measurements. A measurement may be deleted in the ieMR if recorded in error, for example, if a measurement was entered against the wrong patient.

Printing growth charts

Growth charts should only be printed in the following circumstances:

- Ongoing growth monitoring by a primary health care provider e.g. General Practitioner or Child Health Nurse.
- Referral information for review or transfer of care to an external service e.g. interstate service/hospital.
- Information sharing for HHS care providers who don't have ieMR access at the point of care e.g. home visiting.

If a growth chart is printed:

- It should be stamped with the word 'Copy' to ensure that it is not scanned into the ieMR.
- It cannot be written on. For example, it cannot have new measurements added to it. All new measurements need to be added using the ieMR Advanced Growth Chart.

13. Discharge / transfers

To other hospitals (non-Gold Coast Health facilities)

- Do not send the original temporary folder documentation or historical patient record with the patient.

- The Gold Coast Health clinical area transferring the patient is responsible for photocopying the documentation (or part thereof) and printing from the ieMR.
- Required printing from the ieMR includes:
    - Medication Transport Report
    - Medical Record Request
- Sufficient photocopied sections of the temporary folder documentation and printed ieMR clinical notes should be supplied to the receiving facility to ensure safe practice and continuity of care. This paperwork may be faxed or sent with the ambulance, escort, or in a secure satchel with the patient.
- Refer to ieMR Medication Management Business Rule for further transfer information.
- Ward staff are to create an ieMR clinical note including medical and nursing summary of the patient's history and treatment to date, the facility to which the patient is being transferred and the time of transfer.
- Discharge patient on HBCIS as a hospital transfer.
- Ensure discharge preparation process is followed and completed forms are placed in designated tray for collection by Clinical Records Service for scanning within agreed timeframes.
- Clinical Records Service will routinely collect and scan discharged patient information into the ieMR within 24 hours.

Discharge home

- Refer to ieMR Care Delivery Inpatient wards for Clinician Business Rules.
- Ensure that Enterprise Discharge Summary (EDS) is updated throughout inpatient stay and completed / provided to patient on discharge.
- HBCIS discharge to be completed.
- Ensure discharge preparation process is followed and completed forms are placed in designated tray for collection by Clinical Records Service for scanning within agreed timeframes.
- Clinical Records Service will routinely collect and scan discharged patient information into the ieMR within 24 hours of receipt.

Died in Hospital - Within Gold Coast Health Facility

- Deceased patient PowerForm may be documented in the ieMR, however is not mandatory
- Original clinical forms must stay on the ward when the patient is transferred to the mortuary. Only death pack forms should go with the patient when being transferred to the mortuary.

- Original forms are to stay in possession of Clinical Records Service. Only copies are to be provided to Queensland Police Service (QPS).
- QPS must provide a Coroner Representative Form to obtain copies of the clinical records of the deceased patient.

This request is handled as follows:

- Coroners request form received during business hours (Monday to Friday, 08:00 - 17:00) will be handled by Information Access Service (IAS).
- Contact Clinical Record Service to perform urgent scanning of current patient's encounter documents.
- IAS will provide copies of requested documents.

Coroners request form received after hours (public holidays, outside business hours) will be managed by CRS.

- Contact Clinical Record Service to perform urgent scanning of current patient's encounter documents.
- CRS process and scan paper documents for current admission into ieMR as urgent scanning.
- ROI after hours officer / CRS Administrative staff will print out from ieMR / EMR clinical notes and scanned documents for the current admission.
- ROI after hours officer / CRS Administrative staff will provide QPS with the copy of current documents only when QPS present CRS with the required Coroner Representative Form. Note if QPS require more than the current encounter documents the extra documents will be provided by IAS in Business Hours.

  Coroner Representative Form to be forwarded to IAS with comments of what has been released and number of documents. IAS can then release any additional documents if required.

14. Episode of Care Changes

When a patient requires an episode of care change in HBCIS, there is no change to their ieMR encounter, as the inpatient encounter will remain as 'one hospital stay'.

Current / pending orders for patients having an episode of care change will not be impacted, and new patient labels are not required to be printed.

For further information, refer to PRO51001 Sub and Non-Acute Patient (SNAP) Management and Episode of Care Type Changes for Clinicians and Administration Staff.

15. Scanning

Clinical Records Service is responsible for all collections of prepared paper clinical forms, scanning and importing and quality processes for Gold Coast Health.

Accurate and timely scanning is reliant on key information provided by clinical areas. To assist an efficient collection, sorting and scanning process, Gold Coast Health staff must ensure the following scanning preparation process is completed upon inpatient discharge, ward transfer, transfer to another Gold Coast Health facility, outpatient and community attendance.

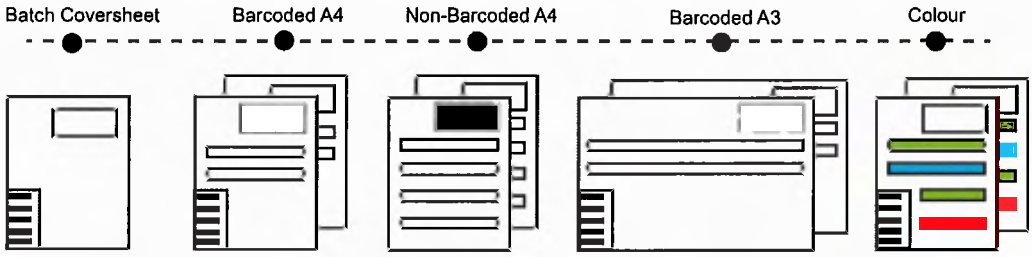
When documents are provided to Clinical Records Service that do not meet the requirements in this business rule, the documents will be returned with an 'Insufficient Pre-Preparation Attention Slip. Please note due to this the scanning process may be delayed. Regular monitoring of collected documents by clinical area is conducted to ensure compliance with the scanning preparation process.

Pre-Preparation Requirements

Discharged inpatients

- Historical clinical records (pre-EMR) are to be checked to ensure that no new forms have been included.
- Gather all completed forms from end of bed, temporary folder, nurses' station, etc.
- If temporary folder dividers are in use, these are to remain within temporary folders.
- Refer to 'do not scan list' and remove forms that are not to be scanned. Return to clinician.
- Ensure there is no duplicates or copies.
- Ensure all forms contain a correct ieMR patient label (specific to the current encounter) on all pages, including double sided. Include remaining patient labels in batch (excluding labels from Emergency Department encounter when patient is transferred to inpatient ward).
- Ensure that patient labels are affixed in the designated position, usually the top right corner of the form. For forms without a designated position, affix the label on the back of the page or in a position that does not cover information on the form.
- Ensure all forms within temporary folder are for the same patient.
- Ensure all staples, tape and post-it notes are removed.

- Cardiac Rhythm Strips are to be mounted onto Cardiac Rhythm Strip form. Rhythm strips cannot overlap each other or extend off the barcoded form.
- Inpatient documentation should be available for collection as soon as possible following discharge.
- For long-stay patients, forms from the beginning of the admission that are no longer referred to, may be batched for collection and an interim scan by Clinical Records Service (generally after one month).
- Sort multiple forms of the same type into date/time sequence.
- For Inpatient batches collate the batch in the following order per patient:



- Complete the Scanning Batch Cover Sheet for each patient batch, ensure remaining labels are sent to Clinical Records and fasten documents together with a bulldog clip.
- For loose documents, such as correspondence or prescriptions not with the inpatient batch, group by same form and attach a Scanning Batch Coversheet and write 'Mixed' on top right-hand corner.

Outpatients

- Gather all completed forms from outpatient consultation rooms, nursing stations etc.
- Ensure all forms contain a correct ieMR patient label (specific to the current encounter) on all pages, including double sided. Include remaining patient labels in batch
- Ensure all staples, tape and post-it notes are removed.
- Documents may include referrals, private pathology, correspondence, hospital prescriptions, results and other non-admitted forms.
- Unique Scanning Location Sheets are available for specific outpatient services to assist with scanning instructions. Contact GCRecordsSupervisor@health.qld.gov.au for the most recent Scanning Location Sheets for each specific service.
- Collate documentation by form type using a Scanning Location Sheet and Scanning Batch Cover Sheet fastened together with a bulldog clip.

- Outpatient documentation should be available for collection as soon as possible following discharge.

Incoming correspondence / loose documents

Loose documents may include private pathology / radiology results, correspondence received that are not related to a current inpatient / outpatient or emergency encounter. The following principles apply to loose documents:

- An encounter label is to be attached to the first and last page of incoming correspondence such as inter-hospital notes and large referrals.
- Please note: No other changes to labelling practices can occur. All other documentation collected for scanning requires an encounter label attached to every page.
- Insert the labelled forms into an internal envelope, address to Clinical Records Service and include in your collection tray / send to Clinical Records Service closest to your facility.

Receiving facility / ward

The facility or ward who are receiving a transferred patient must:

- Refer to original clinical forms provided for clinical handover.
- Generate new ED encounter and / or admit patient on HBCIS if required.
- Create temporary folder and file transferred original clinical forms in temporary folder.
- Print new patient labels.
- Update clinical notes including: the facility / ward from which the patient has been transferred, the time of transfer, new ward, unit and bed number, patient condition and treating doctor.
- At patient discharge, ensure discharge preparation process is followed and completed forms are placed in designated tray for collection by Clinical Records Service for scanning within agreed timeframes (following discharge or when no longer referred to). If a patient is discharged and transferred to another Hospital/Health Service (outside of GCHHS) the original documents must be kept on site with the originals collected by Clinical Records Service for scanning to ieMR.
- Photocopies are to go with patient to an external facility.

Collection

Hospitals

- For emergency, inpatient and outpatient areas and departments, completed prepared batches are to be placed in green designated trays for collection and scanning by Clinical Records Service according to the following times:
    - Inpatient wards, Emergency Department and Adult Outpatients

- 7am and 12 midday Monday to Friday

- Laminated signs are on each tray with Clinical Records Service contact details, specific collection times and Pre-Preparation requirements.

Community

- Attach Scanning Coversheet to documents with clip and place in secure blue satchel.
- Ensure satchel window is displaying: Robina Hospital Clinical Records Service.
- Place satchel in collection area.
- Complete Collections Log for each satchel.
- Driver will collect satchels on next business day and complete remaining Collections Log.
- Driver will return satchels following business day.

Timeframes

The categories for scanning / importing into the ieMR:

Priority	Timeframes	Principles
Routine	Within 24 hours from collection	Applies to: - Discharged inpatients information - Community information - Outpatient information
Request Priority 1 Scan	Within 30 minutes from collection	Applies to: - Patient representations. - Patient en-route to another ieMR site. - Urgent Coronial and Child Safety matters
Request Priority 2 Scan	Within 8 Hours from collection	Applies to: - Information relating to next day patient appointments.

Priority

Documentation has not been collected

- If priority scanning is required for documents being prepped, clinical areas must alert Clinical Records Service by completing the Green Scanning Batch Cover sheet, selecting Priority 1 or Priority 2 and notifying the Clinical Records Service.

- The clinical rationale is required to be completed eg. 'Representation', 'Urgent Coronial Request' etc.
- If there is no routine collection scheduled within the hour, contact Clinical Records Service to request priority scanning.
- The patient batch with Green Scanning Cover sheet is to be left in the designated green tray for collection.
- For after-hours patient representations contact the Clinical Records Service to collect the documentation from the available green tray on the ward.

Documentation has been collected
If a patient represents to a Gold Coast Health facility, priority scanning will generally be required if the last discharge has not been scanned into the ieMR.
Contact the Clinical Records Service and provide the patient's UR number and confirmation of patient representation.

- Gold Coast University Hospital priority scanning, please call [redacted]
- Robina Hospital priority scanning, please call [redacted]

Back-scanning

Back-scanning of historical documents is out of scope for the Clinical Records Service and requires Clinical Records Committee approval via Director, Health Informatics and Business Analytics.

Do Not Scan List

The following forms are not within scope of the clinical record, and are therefore not scanned into ieMR:

- Printed information from Gold Coast EMR (Legacy) or the ieMR
- Forms without patient labels or three points of identification and encounter (patient name, URN, DOB)
- Enterprise Discharge Summaries
- AUSLAB pathology results
- Education brochures
- Database entry forms
- Interpreter requests
- Feeding calculations and ARDS Net Calculations
- Outpatient appointment card
- Request for Electronic Image Transfer

- Any non-clinical forms, including fax cover sheets, financial records, administrative forms, attendance records, etc.

Clinical forms received for scanning that do not meet the criteria for inclusion in the ieMR, or do not have an easily identified document type will be returned to the clinical area for clarification. Those forms to be included in the ieMR will be referred to Clinical Documentation Officer for approval through Clinical Forms Subgroup.

16. Importing

Clinical Records Service is responsible for all importing of clinical image files for Gold Coast Health.

- Clinical images for importing must be in pdf or jpeg format.
- Clinical images must be created electronically such as:
  - Reports generated from clinical systems
  - Clinical photographs
- Clinical images for importing must not scanned from a paper-based source.
- The clinical image file must named according to the following standard:
  - ieMR Document Type_Patient Surname_UR Number
  - *For example; Assessment Allied Health_Fraser_UR 2123457*
- One single patient or single document type must be created. Multiple patient's clinical images cannot be saved in the one file.
- The ieMR document type is according to ieMR Order of Filing principles (refer to Clinical Documentation Business Rule).

Central Storage Location

Central Storage Location is a secure network drive owned and managed by Clinical Records Service.

Each clinical area meeting the requirements and approved for importing will be provided a secure / individual folder to store their clinical image files.

Request for network access is to be submitted to the Clinical Records Manager.

A request will be approved following review of:

- Type of clinical images requiring importing
- Volume of clinical images submitted per day / week / month
- Proposed document types to be submitted.

Timeframes

The categories for importing into the ieMR:

Priority	Timeframes
Routine	Within 24 hours
Request Priority 1 Import	Within 30 minutes Phone call to Clinical Records Service on [redacted] stating UR Number an urgency rationale.

CCC EXHIBIT