# Patient Matters Manual for Public Health Organisations
## Chapter 9 – Health Records and Information

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## Note

Where a number appears at the bottom of an amended page [such as 252 (17/09/15) – amendment number, date] an alteration has been made or new section included. Amendment numbers are sequential, the date represents the date the source document was published on the Policy Distribution System (PDS).

Below is a summary of each policy document. To navigate to the complete policy document, click the hyperlink in the Table of Content or under each policy document title.

# Mental Health Clinical Documentation

Document number PD2021_039 rescinds PD2010_018.

## POLICY STATEMENT

NSW Health organisations must ensure that all mental health services use available electronic medical record (eMR) systems for the documentation of clinical practice and care. This is required in all service settings, for all service types and age groups, and enables integrated health services and clinical information systems across NSW.

Digital documentation facilitates the recording, retrieval and sharing of medical record information in an accessible, standardised and structured format. This is important at all points in the cycle of mental health care from triage through to transfer or discharge.

All NSW Public Health Organisations must ensure that local processes are in place which comply with this Policy.

## SUMMARY OF POLICY REQUIREMENTS

Electronic health systems are to be supported by Local Health Districts (Districts) and Specialty Health Networks (SHNs) by implementing products and functionalities as they become available. Local systems, processes and procedures are to be maintained, including those required for downtime when needed. There must also be training and education provided for clinicians in the areas of mental health clinical documentation, and related eMR systems and processes.

eMR systems must include available electronic mental health (MH) documents, including notes, forms, measures and reports.

Clinical care and information must be documented and are to be recorded within the eMR, with paper records used only where there is no current alternative.

Documentation must occur at appropriate clinical points of care, including triage, assessment, care planning, review, transfer and discharge. It must be made as soon as practically possible in the eMR clinical document(s) relevant to the clinical point of care and needs of the person accessing the service.

Structured documentation is to be used to aid functionalities that auto-populate fields, and transfer information between documents and systems. This is critical to clinical care and support across services and systems within NSW Health. Only relevant fields need to be completed. There are no requirements that all fields or areas of a document are to be completed.

All persons registered to a mental health service must have the following recorded in their documentation: Designated Carer(s) and/or Principal Care Provider information; Diagnosis (issues that are the focus of the current admission or encounter); Legal Status; and Alerts (for care and safety of the person, carer(s) and health workers).

There must be clinical reasons to use non mental health or alternative documentation or free text. In these circumstances, the clinician must be aware that auto-population and transfer functions will not be enabled. The clinician is to ensure that documentation reflects the content of the standardised eMR document, and the format of documentation is legible and locatable by other clinicians involved in care.

For information on Mental Health resources and updates
http://ehnsw.sharepoint.nswhealth.net/apps/ClinP-eMedsHub/Pages/MentalHealth.aspx

# Privacy Management Plan

Document number IB2023_012 rescinds PD2015_036.

## PURPOSE

The NSW Health Privacy Management Plan has been published on the NSW Health website Patient privacy.

All NSW Health organisations are required to adopt and implement the NSW Health Privacy Management Plan within their organisation and promote it to their staff and the public, including through publication of the Plan on their public facing websites.

## KEY INFORMATION

Key actions for NSW Health organisations All NSW Health organisations must ensure the collection, use, management and disclosure of personal and health information complies with the Information Protection Principles and with the Health Privacy Principles, as detailed in the *Privacy and Personal Information Protection Act 1998* (NSW) and *Health Records and Information Privacy Act 2002* (NSW), respectively.

NSW Health organisations are required to have a Privacy Contact Officer (or a designated staff member), whose role includes to facilitate compliance with privacy laws and NSW Health privacy policy in their organisation.

New staff members in NSW Health organisations are to complete mandatory privacy training as part of their induction and orientation process.

Where staff have access to large data sets of personal and health information in their roles, NSW Health organisations must ensure that, in addition to privacy training, appropriate privacy undertakings have been signed, prior to these systems being accessed.

Appropriate collection notices are to be used to satisfy privacy requirements when personal and health information is being collected, particularly when new programs or systems are being developed.

A request for a privacy internal review must be completed as soon as practicable, and within 60 calendar days.

Any wilful act of unauthorised access to, use, or disclosure of, personal or health information by a staff member is to be referred to human resources for advice regarding appropriate disciplinary action. In consultation with the NSW Ministry of Health, the chief executive must give consideration for referring the matter to the police, and/or informing persons affected by a breach, of the option of referral to prosecution.

NSW Health organisations have privacy-related statutory reporting obligations, including obligations under the *Independent Commission Against Corruption Act 1988* (NSW), the *Privacy Act 1988* (Commonwealth), the *My Health Records Act 2012* (Commonwealth), and the *Security of Critical Infrastructure Act 2018* (Commonwealth). Mandatory reporting obligations include privacy breaches involving inappropriate use/ disclosure of Tax File Numbers, My Health Record data breaches, other privacy matters related to corrupt conduct, and for notifying cyber security incidents to the Australian Cyber Security Centre.

Each NSW Health organisation is to provide a submission to the NSW Ministry of Health by 31 July each year, that outlines the actions it has undertaken in relation to privacy management and compliance, and details of privacy statistics, for the financial year immediately prior.

All NSW Health organisations are to publish their own privacy management actions and statistics (as included in the submission to the NSW Ministry of Health) on their own websites after the NSW

Health Annual Report has been published on the NSW Health website, and by no later than 30 November of that same year.

Further information on privacy-related matters is available in the *NSW Health Privacy Manual for Health Information*.

**About the NSW Health Privacy Management Plan**

The NSW Health Privacy Management Plan:

- Demonstrates to members of the public and other third parties how NSW Health meets its obligations under the *Privacy and Personal Information Protection Act 1998* (NSW)
- Provides an overview of how personal information is managed appropriately and in accordance with the law, and provides advice about the management of staff members' personal information
- Demonstrates NSW Health's commitment to respecting the privacy rights of staff, members of the public, and other third parties together with a Privacy Information Sheet for Personal Information
- Sets out how individuals, whether they are staff or members of the public, can access their personal information, seek to amend their personal information, submit a privacy complaint, and request a privacy internal review and how possible breaches of privacy in relation to personal information will be managed by NSW Health
- Outlines limits on access to personal information and legislative exemptions (including Public Registers, Public Interest Directions and Codes of Practice)
- Sets out the remedies available to individuals, if they have a concern that the privacy of their personal information has been breached.

## Photo and Video Imaging in Cases of Suspected Child Sexual Abuse, Physical Abuse and Neglect

Document number PD2015_047.

### PURPOSE

The purpose of this Policy Directive is to:

- Define the NSW Health requirements and minimum standards for the use and management of photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect
- Guide NSW Health staff when capturing, storing and managing images for the purpose of documenting health and clinical features and informing possible future judicial proceedings that require medical opinion.

### MANDATORY REQUIREMENTS

This policy requires that:

- The immediate and longer-term physical and emotional needs of the child and their parent(s) / guardian(s) are identified and taken into account when considering photo and video imaging.
- Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and limited other relevant purposes, and is not excessive or unreasonably intrusive.
- Imaging is only captured where informed consent is sought and obtained for each purpose for which it may be used.
- Capture, recording and storage of images is limited to LHD / SCHN owned memory devices.
- Images are stored securely and are stored separately from the principal health care record, to maintain patient privacy.
- Limited access is provided to images, to maintain patient privacy.
- Capture, use and management of photo and video images in cases of suspected child abuse is conducted in accordance this Policy Directive, in conjunction with:

  Child Wellbeing and Child protection Policies and Procedures for NSW Health (PD_2013_007)

  Current Standards and Practice Guidelines for NSW Health Sexual Assault Services

  Child Wellbeing and Child Protection – NSW Interagency Guidelines,

- Consent, privacy, confidentiality, management and retention is preserved in accordance with the NSW Health Consent to Medical Treatment - Patient Information policy, 2005, NSW Health Privacy Manual for Health Information, 2015, NSW Health Care Records – Documentation and Management Policy (PD2012_069), NSW Health Electronic Information Security Policy (PD2013_033), NSW Government Digital Information Security Policy M2012-15, NSW Health Subpoena policy (PD2010_065) and NSW Government General Retention and Disposal Authority policy (GDA17; 2011).

### IMPLEMENTATION

Chief Executives are responsible and accountable for:

- Establishing mechanisms to ensure the directives and requirements of this policy are applied, achieved and sustained
- Ensuring that NSW Health staff understand and are aware of their obligations in relation to this policy and related policies and procedures
- Ensuring resources are available to deliver and meet the directives and requirements of this policy
- Ensuring that NSW Health staff are trained to operationalise and implement this Policy • Ensuring NSW Health staff are advised that compliance with this policy is part of their patient / client care responsibilities
- Ensuring that procedures for capture, storage, access and security are subject to risk analysis reassessment over time.

Facility managers are responsible for:

- Ensuring the requirements of this policy directive are disseminated and implemented in their service / department / hospital
- Establishing local validated processes for image preparation, capture, processing, storage, transmission, archiving, retention and disposal
- Monitoring implementation and compliance with this policy.

NSW Health workers are responsible for:

- Implementing and complying with the directives and requirements of this policy
- Ensuring that their knowledge of consent, privacy and documentation management processes is maintained, consistent with the requirements of this policy directive.

260 (29/10/15)

## Adoption Act 2000 – Release of Information

Document number PD2016_036 rescinds PD2010_050.

### PURPOSE

This Policy Directive provides:

- Information regarding the rights of adopted persons and their families to access information held by Information Sources under the *Adoption Act 2000*
- NSW Health Information Sources with direction and guidance as to what information should be disclosed to adopted persons and their families and the circumstances in which it should be disclosed.

### MANDATORY REQUIREMENTS

Each NSW Health Information Source must have effective systems and procedures in place to ensure adopted persons and their families can access information in accordance with the *Adoption Act 2000* and this Policy Directive.

### IMPLEMENTATION

#### Roles and Responsibilities

***Chief Executives must ensure:***

- The principles and requirements of this Policy Directive are applied, achieved and sustained
- Their medical record staff are made aware of this Policy Directive.

***Medical record staff have responsibility to:***

- Be aware of this Policy Directive
- Release information to adopted person and their families in accordance with this Policy Directive and the *Adoption Act 2000*.

## Electronic Information Security

Document number PD2020_046 rescinds PD2013_033.

### POLICY STATEMENT

All NSW Health Organisations must have appropriate systems and processes in place to adequately and appropriately protect their information systems and assets. This includes the fundamental responsibility to protect information from inappropriate, illegal or accidental misuse, modification, loss or release.

This policy applies to all users of NSW Health information systems and assets, including, but not limited to, employees, contractors, service providers and third parties, and all NSW Health information systems and assets, regardless of the media or location where information is stored, and the technology used to process the information.

### SUMMARY OF POLICY REQUIREMENTS

All users of NSW Health information systems and assets have the responsibility to uphold confidentiality and protect information entrusted to them.

Information security measures and controls must be developed and implemented to ensure privacy of information is preserved, confidentiality of information is protected, integrity of information is maintained, and availability of information is assured.

NSW Health Organisations must identify and implement the appropriate scope of an Information Security Management System (ISMS) or Cyber Security Management System (CSMS) that is compliant with the relevant recognised standards.

A risk-based approach must be adopted to identify and prioritise information systems and assets security risks, ensure proper security measures are implemented and mitigate security risks to an acceptable level. These measures may be preventative, detective, responsive or recovery in nature.

A continual improvement process must be adopted to respond to, monitor, review and improve the effectiveness and efficiency of information security measures and controls in a changing environment.

NSW Health Organisations must ensure a consistent and effective approach to the management and where relevant, the escalation of information security incidents.

333 (09/12/20)

## Subpoenas

Document number PD2019_001 rescinds PD2010_065.

### PURPOSE

This Policy Directive outlines legislative provisions and procedures to be followed when the Ministry of Health and public health organisations are required to produce documents in response to a subpoena.

### MANDATORY REQUIREMENTS

Each NSW Health Agency must have effective systems and procedures in place in order to make sure that subpoenas issued on the agency are complied with appropriately.

### IMPLEMENTATION

Roles and Responsibilities

Chief Executives must ensure that:

- The principles and requirements of this policy and attached procedures are applied, achieved and sustained.
- All staff are made aware of their obligations in relation to this Policy Directive.
- Documented procedures are in place to support the Policy Directive.
- There are documented procedures in place to effectively respond to and investigate alleged breaches of this Policy Directive.

Hospital Managers and Staff have responsibility to

- Understand the legislative requirements of a Subpoena.
- Provide only the documents which are requested under the schedule of the subpoena.
- To be aware of whether any claim for privilege over the documents can be applied and take appropriate action.

### Health Records and Medical/Clinical Reports – Charging Policy

Document number PD2006_050 rescinds PD2005_235.

The contents of this policy directive are to be effective from the date of issue and replaces PD2005_235 (circular 2002/22 dated 14 February 2002).

The following relates to charges for health records and medical/clinical reports that are to apply unless specific legislation specifies a lesser rate or exemption from fees. Health Services should develop local policies, which detail the content of records and reports as they relate to these charges. These policies should take into account the function of the health facility, the type of report produced and the amount of information to be provided.

Rates are advised separately via Information Bulletin.

The decision to charge for requests for health records and medical/clinical reports from researchers is a matter for local determination depending upon the type of request and possible future benefit to the health system. Such charges should be determined on a cost recovery basis.

For the purposes of this policy directive a health record is defined as a documented account, whether in hard or electronic form, of a client/patient's health, Illness and treatment during each visit or stay at a health service (and includes a medical record).

## Health Records and Medical/Clinical Reports – Rates

Document number IB2019_036 rescinds IB2018_035.

### PURPOSE

This Information Bulletin provides an update on charges for Health Records and Medical/Clinical Reports.

The advised charges are to be effective from the date of issue and replace those advised in Information Bulletin IB2018_035 issued on 8 August 2018. This Information Bulletin is to be read in conjunction with Policy Directive PD2006_050.

### KEY INFORMATION

The following are charges for health records and medical/clinical reports and are to apply unless specific legislation specifies a lesser rate or exemption from fees.

### A CHARGES FOR MEDICAL/CLINICAL REPORTS

| | |
|---|---|
| Category 1 | $329 |
| Category 2 | $470 |
| Category 3 | $846 |
| Category 4 | $329 |

The above categories are described in PD2006_050.

### B OTHER CHARGES

1. The charge applicable in relation to categories “1(a) Charges for access to clinical notes requested by a patient/client, or by a person acting on behalf of the patient” and “1(b) Charges for information requested by an insurer”, which include search fees, photocopying charges, labour costs, administrative charges and postage is as follows:

| | |
|---|---|
| Provision of a copy of the medical record, or part thereof e.g. continuation notes, pathology reports and charts (maximum eighty pages). | $30 |
| Pages in excess of eighty (per page) | $0.41 |
| Cost recovery for the provision of other material (e.g. reproduction of X-rays, audio-visual tapes, copies of photographs and operation footage contained on DVD’s). | Cost recovery |

2. Search fees

| | |
|---|---|
| Other than requests made by a party concerned with a patient’s continued treatment | $30 |

| | |
|---|---|
| or future management. | |

Other than requests made by a party concerned with a patient's continued treatment or future management.

| | |
|---|---|
| C SUMMARY OF INJURIES | $30 |

These are generally requested by Compulsory Third Party (CTP) insurers for patients whose fees are covered by the Bulk Billing Arrangements.

**GST in relation to categories A, B and C (above)**

These are taxable supplies (i.e. subject to GST) unless deemed GST-free under the provisions of the 'A New Tax System (Goods and Services Tax) Act 1999' (GST Act). The criteria to be followed by Local Health Districts/Hospitals in assessing the GST status are advised in PD2006_050. Further details are contained in the "NSW HealthFinance and Business Management-Tax Reform-GST Manual (Chapter 2, Section 2.1.3, pages 5 & 6)", which is available on NSW Health's Intranet. Please note that where the service is determined as being 'GST-free' the rates specified above apply. Where the GST free test is not satisfied the service is therefore a taxable supply (subject to GST) and the rates specified above are to be grossed-up by 10%.

**D HEALTH RECORDS REQUIRED TO BE PRODUCED BY SUBPOENA**

This refers to the retrieval of all the information required by the schedule noted on the subpoena and forwarding it to Court.

| | |
|---|---|
| Where at least 5 working days' notice is given | **$75*** |
| Where less than 5 working days' notice is given | **$113*** |

* plus a photocopying charge of $0.41 per page

Please note that SafeWork NSW is not to be charged in complying with notices to produce documents issued by its inspectors in accordance with the Work Health and Safety Act 2011.

Charges under Category D are not subject to GST as they are 'out of scope' under a Division 81 Determination.

349 (04/09/19)

### Consent to gender affirming medical treatment - update to Consent to Medical and Healthcare Manual

Document number IB2023_052 rescinds IB2020_010.

## PURPOSE

To advise the NSW Health system of an update to the Consent to Medical and Healthcare Treatment Manual (**Consent Manual**), which includes a new section (**8.12**) in Section 8 – Minors entitled '**Consent requirements for gender affirming medical treatments**'.

The new section provides specific guidance on the consent requirements for young people under the age of 18 (**minors**) to access gender affirming medical treatment (**GAMT**) in the NSW Statewide Specialist Trans and Gender Diverse Health Service (the 'TGD Health Service').

These consent requirements are distinct from and additional to the general consent requirements for minors as set out in section 8 of the current edition of the Consent Manual.

Other minor editorial changes have been made to the Consent Manual to reflect updated policy and legislative references.

## KEY INFORMATION

### Updated Consent Manual

An electronic version of the updated Consent Manual can be found on the NSW Health website - Consent to Medical and Healthcare Treatment Manual - Policy and procedure manuals (nsw.gov.au)

The Consent Manual was first published on 26 March 2020. It provides operational guidance and procedures to support compliance with the NSW law on obtaining consent to medical and healthcare treatment. Its intention is to cover all legal requirements for consent across the NSW Health system.

The NSW Ministry of Health has recently published an update to the Consent Manual which includes a new section (8.12) providing specific guidance on the consent requirements for young people under the age of 18 to access GAMT in the Statewide TGD Health Services, entitled '**Consent requirements for gender affirming medical treatments**'. This is distinct from and additional to the usual consent requirements for a minor.

Other updates include:

- Minor associated amendments to section **8.3** (**What is a Mature Minor and when can they consent to non-emergency treatment?**), referring to the specific requirements for GAMT.
- Insertion of gender affirming medical treatment into section **11.3** (**Consent table – quick finder for Minors**)

Several minor amendments to reflect updated policy references, legislation and resources.

349 (14/12/23)

## Adult-to-Adult Living Donor Liver Transplantation Guidelines

Document number GL2008_019.

### Purpose of the Guideline

The LDLT National Policy Framework has been endorsed by the Australian Health Ministers' Advisory Council (AHMAC). Recognising the clinical need, complexity and risks of the procedure, AHMAC undertook a national development and consultation process in preparing this National Policy Framework. It sets appropriate ethical principles and clinical standards for the practice of adult-to-adult living donor liver transplantation.

### Recommended standards

NSW Health has adopted as a guideline for provision of LDLT in the NSW public health system the 'Adult-to-Adult Living Donor Liver Transplantation (LDLT) National Policy Framework'.

This guideline seeks to promote ethical, lawful and consistent application of quality processes in provision of this complex procedure to donors, recipients and their families; to provide guidance to health professionals; and additional protection for prospective adult Living Donor Liver Transplantation (LDLT) donors. It includes reference to donor selection criteria, necessary consent processes including use of an independent donor advocate, institutional requirements for provision of LDLT, and permissibility of LDLT in the emergency setting.

This guideline should be read in conjunction with: PD2005_406 Consent to Medical Treatment-Patient Information. It should also be read in conjunction with local policy developed by the participating liver transplant unit.

### Implementation

Advice is intended for use by clinical and medical staff involved in transplants at institutions that will provide LDLT.

(22/12/08)

## Notification of Infectious Diseases under the NSW Public Health Act 2010

Document number IB2013_010 rescinds IB2012_011.

### PURPOSE

Under the provisions of the Public Health Act 2010 and the Public Health Regulation 2012, doctors, hospital chief executive officers (or general managers), pathology laboratories, directors of child care centres and school principals are required to notify certain medical conditions listed on the Ministry of Health website.

### NOTIFICATION MECHANISMS

- Infectious disease notifications should be directed to the local Public Health Unit, and should be initiated as soon as possible within 24 hours of diagnosis.
- In order to protect patient confidentiality, notifications must not be made by facsimile machine except in exceptional circumstances and when confidentiality is ensured.
- Disease notification guidelines for notifiers are available at: www.health.nsw.gov.au/Infectious/Pages/notification.aspx

### NOTIFICATION FORMS

Doctors and Hospitals

- Doctors and hospital chief executive officers (or general managers) must notify scheduled medical conditions and provide information specified in the **Doctor/Hospital Notification Form**, either by telephone or in writing. The notification can be found at: http://www.health.nsw.gov.au/Infectious/Documents/doctor-hospital-notificatonform.pdf
- Notifications for AIDS must only include the first 2 letters of the patient's first and last names, and date of birth. Full name and addresses are not to be included.
    - The **AIDS Notification Form** can be found at: www.health.nsw.gov.au/Infectious/Documents/aids-notification-form.pdf

Laboratories

- Laboratories must notify scheduled medical conditions and provide information specified in the **Laboratory Notification Form**, either by telephone or in writing.
    - The laboratory notification form can be found at: www.health.nsw.gov.au/Infectious/Documents/lab-notification-form.pdf
- Notifications for HIV infection should only include the first 2 letters of the patient's first and last names, and date of birth. Full name and addresses are not to be included.
    - Laboratories carrying out confirmatory testing for HIV must notify infections directly to Communicable Diseases Branch. The **HIV notification form** can be found at: www.health.nsw.gov.au/Infectious/Forms/hiv-notification-form.pdf

## NSW Perinatal Data Collection (PDC) Reporting and Submission Requirements from 1 January 2016

Document number PD2015_025 rescinds PD2010_072.

### PURPOSE

This Policy Directive is effective from 1 January 2016. It covers reporting and submission requirements for the Perinatal Data Collection (PDC), which is used for state wide surveillance to monitor patterns of pregnancy care, and maternal and newborn outcomes and to support national and state reporting obligations.

### MANDATORY REQUIREMENTS

This policy applies to all midwives and doctors working in public and/or private facilities where a birth occurs. Reporting of all births in NSW to the PDC is a statutory requirement under the *NSW Public Health Act 2010*.

A PDC record must be completed for all births in NSW, including live born babies regardless of gestational age or birth weight, and stillborn babies of at least twenty (20) weeks gestation OR four hundred (400) grams birth weight. In the case of multiple births, a separate record must be completed in full for each baby.

From 1 January 2016 all records must be submitted in accordance with the timeframes described in section 1.3 of the attached *Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures*.

Section 3 of the attached *Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures* details the data items to be reported. Section 5 details the mandatory security requirements for data management.

### IMPLEMENTATION

Chief Executives of LHDs and General Managers of Private Hospitals are to ensure:

- This policy directive is distributed to all staff involved in collecting and supplying data for the PDC. This includes staff of obstetric and neonatal units, medical record and information services staff.
- Staff have access to electronic systems able to collect the data items in accordance with Section 3 of the attached *Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures* by 1 January 2016.
- Data collected in accordance with the statutory requirement and this policy directive is submitted in compliance to the schedule provided and in the form required for submission.

### NSW Register of Congenital Conditions – Reporting Requirements

Document number PD2018_006 rescinds PD2012_055.

**PURPOSE**

This Policy Directive provides guidance to NSW Health staff on the procedure to be followed for the reporting of congenital conditions to the NSW Register of Congenital Conditions.

**MANDATORY REQUIREMENTS**

All hospitals must notify the Register of Congenital Conditions (the Register) of scheduled congenital conditions detected in a fetus during pregnancy or in a child up to one year of age. This includes staff of obstetrics, neonatal and paediatric units, prenatal genetic services for chromosomal and DNA testing, feto-maternal units and anatomical pathology departments.

This Policy Directive outlines the process for submitting paper and electronic notifications to the Ministry of Health, and presents information on data quality, security, access and dissemination. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

**IMPLEMENTATION**

This Policy Directive should be distributed to all LHD staff. Staff involved in the identification of scheduled congenital conditions during pregnancy or the post-natal period must follow the procedure set out in this policy directive.

300 (07/02/18)

## Notifying Cancer-Related Data to the NSW Cancer Registry

Document number PD2022_008 rescinds PD2009_012.

### POLICY STATEMENT

NSW Health is committed to reducing the burden of cancer in the NSW population and will do this by continuing to capture cancer-related data into the NSW Cancer Registry. The data captured will be used to report on incidence and mortality from cancer and support programs that utilise the data to reduce incidence and improve outcomes for people diagnosed and treated for cancer.

### SUMMARY OF POLICY REQUIREMENTS

This Policy Directive outlines the requirements for submitting notifications to the NSW cancer registry and presents information on data quality, security, access, and dissemination.

Under the provisions of the Public Health Act 2010 and the Public Health Regulation 2012, public and private sector admitted and non-admitted patient facilities, and pathology laboratories are required to notify the NSW cancer registry of all cancer cases.

Under these same provisions, the registrar of births, deaths, and marriages is required to notify the NSW cancer registry of deaths due to cancer.

The provisions of the Cancer Institute (NSW) Act 2003 also allow for the NSW Cancer Registry to request and collect clinical data relating to cancer treatment from any facility providing care to cancer patients in NSW.

All data submitted to the NSW cancer registry undergo a series of quality checks and validations. If data quality issues are detected that require resolution at the source, an error report is generated and sent to the notifier.

The procedures outlined in the NSW Health privacy manual for health information and the Cancer Institute NSW Data Governance Policy are adhered to by NSW cancer registry staff in order to ensure that appropriate data security and governance safeguards are in place.

Data held within the NSW cancer registry can be used to support the functions of the Cancer Institute NSW:

- Monitor and record the number of new cases of notifiable cancers and deaths due to notifiable cancers in NSW;
- Produce regular and ad hoc reports on cancer incidence, treatment patterns, mortality, and survival;
- Evaluate the effectiveness of cancer screening programs;
- Assist in planning and monitoring services for cancer control and the care of cancer patients;
- Contribute cancer data to national and international agencies to assist in cancer control.
- Review adherence to best practice guidelines and optimal care pathways
- Assist in development and implementation of culturally safe cancer care for Aboriginal people across the optimal care pathways
- Review treatment outcomes of standards of care and also review clinical trial outcomes when transitioned into best practice care for a wider cohort.
- Inform reporting which supports quality improvements in cancer care.

### Child Wellbeing and Child Protection Policies and Procedures for NSW Health

Document number PD2013_007 rescinds IB2010_005, PD2005_299, PD2006_104, PD2007_023, PD2011_057.

**PURPOSE**

This policy articulates the professional and legal responsibilities of all health workers to promote the health, safety, welfare and well-being of children and young people, working collaboratively with interagency partners in the shared system of child protection in NSW. These responsibilities apply whether workers are providing health care directly to children and young people or to adult clients who are parents / carers or are pregnant.

This policy informs Local Health Districts, Specialty Health Networks, other health services and health workers about the tools and resources available and the interagency arrangements in place to assist them to meet their responsibilities and provide a consistent NSW Health response to child protection and wellbeing.

**MANDATORY REQUIREMENTS**

Every health worker has a responsibility to protect the health, safety, welfare and wellbeing of children or young people with whom they have contact.

The legal responsibilities of health services and health workers are identified in the following legislation:

*Children and Young Persons (Care and Protection) Act 1998*

- Collaborate with interagency partners and comply with information exchange provisions to promote the safety, welfare and wellbeing of children and young people, including taking reasonable steps to coordinate the provision of services with other agencies;
- Meet requirements for mandatory reporting of children and reporting of young people (or classes/groups of children or young people) at suspected risk of significant harm (ROSH);
- Report unborn children where it is suspected they may be at ROSH after their birth;
- Respond to the needs of children and young people after making a report to Community Services or to the NSW Health Child Wellbeing Unit;
- Respond to Community Services' and Children's Court requests to provide health services and or Community Services and Police Force requests to provide medical examinations and treatment;
- Assist with Children's Court proceedings when required.

*Commission for Children and Young People Act 1998* / *Child Protection (Working with Children) Act 2012*

- Meet requirements to ensure that only people with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years).

Ombudsman Act 1974

- Maintain systems to prevent 'reportable conduct' by health workers and for reporting and responding to alleged reportable conduct involving NSW Health employees.

The policy responsibilities of health workers are to:

- Recognise and respond appropriately to the vulnerabilities, risks and needs of families, children and young people when providing any health service;
- Collaborate across NSW Health services and with interagency partners to support and strengthen families and promote child health, safety, welfare and wellbeing;
- Use the Mandatory Reporter Guide and seek assistance from the NSW Health Child Wellbeing Unit to help identify children or young people at suspected risk of significant harm (ROSH);
- Seek assistance from the NSW Health Child Wellbeing Unit and the Family Referral Services to help respond to vulnerable families, children and young people below the ROSH threshold;
- Actively seek feedback from Community Services after making a child protection report and continue to support the child, young person or family consistent with the health worker's roles and responsibilities;
- Follow the Child Wellbeing and Child Protection - NSW Interagency Guidelines and other agreed interagency procedures when working with children, young people and families, including in relation to information exchange, High Risk Birth Alerts, Prenatal Reporting, escalation of child protection concerns, assumption of care by Community Services and out of home care health assessments;
- Collaborate in joint investigation and response to matters involving alleged child sexual assault or serious child abuse or neglect leading to criminal proceedings; and
- Participate in mandatory and / or other child protection training for NSW Health workers.

**IMPLEMENTATION**

Chief Executives across the NSW public health system are responsible and accountable for:

1. Ensuring that this policy and the associated *Child Wellbeing and Child Protection Fact Sheet for NSW Health Workers* are understood and implemented by all health workers; and
2. Enabling frontline staff to operationalise this Policy Statement in accordance with the attached *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

231 (18/12/14)

## General Retention and Disposal Authority: Patient Records (GDA17) and Administrative Records (GDA21)

Document number IB2019_015 rescinds IB2005_027.

### PURPOSE

The Board of the State Archives and Records Authority NSW has approved a revised General retention and disposal authority: Public health services - patient records (GDA17), and made a minor change to General retention and disposal authority: Public health services - administrative records (GDA 21) in line with the approval of the Functional retention and disposal authority: *Provision and regulation of childcare services* (FA404).

### KEY INFORMATION

1. **General retention and disposal authority: Public health services - patient records (GDA17)**

GDA17 applies to the records of patient care provided by the NSW Health system. The authority underwent a review and was revised on 30 May 2019.

The disposal action for certain patient records has been changed as a result of the review. NSW State Archives and Records website has available the current version of GDA17 and a schedule of amendments and justifications to show where the retention periods have changed. Where they have changed the old entries in GDA17 can no longer be used as the source of legal authority for the disposal of records under the State Records Act 1998.

2. **General retention and disposal authority: Public health services - administrative records (GDA 21)**

GDA21 applies to records created and maintained to support the management and delivery of public health care services and programs. It was amended on 30 May 2019 to remove classes covered by FA404, Provision and regulation of childcare services. Those sections of GDA21 relating to childcare can no longer be used as the source of legal authority for the disposal of records under the State Records Act 1998.

FA404 applies to the provision of childcare services by NSW public offices including the local health districts.

Refer to the NSW State Archives and Records website for the latest version of both GDA21 and FA404.

318 (19/06/19)

## General Retention and Disposal Authority - Original or source records that have been copied (GA45)

Document number IB2015_052 rescinds IB2009_064.

### PURPOSE

To notify the Health system that State Records Authority General Retention and Disposal Authority: *Original or source records that have been copied (GA 45)* has been issued to replace General Retention and Disposal Authority: *Imaged records (GA36)*.

GA 45 provides for the authorised destruction of original or source records that have been copied, provided that certain conditions are met.

### KEY INFORMATION

GA 45 provides for the authorised disposal of certain State records which have been successfully copied using microfilming or digital imaging processes. In particular, it describes the circumstances and conditions under which the destruction of certain original or source records is permitted under the provisions of the *State Records Act 1998* after they have been copied.

Whereas GA36 established the conditions under which original records that had been microfilmed or imaged could be destroyed, it primarily applied to paper and excluded records identified as State archives or those required to be retained where created prior to 2000.

The main changes from GA36 to GA45 are:

- Records that are required as State archives or required to be retained in agency may now be destroyed after copying (if the conditions have been met and they do not fall within the exclusions categories) if they were created after 1980, rather than 2000.
- The scope of the authority was widened from original records copied using microfilming or digital imaging processes, to original or source records that have been copied.
- The requirement to assess all requirements for retaining originals was removed, as this condition has become less relevant due to digital copies of paper records being widely accepted.
- Additional exclusions have been included in GA 45 to cover State archives on loan from State Records and records that have high personal value to individuals who were subject to Government control.

Further information on GA45 can be accessed on the State Records website:
http://www.records.nsw.gov.au/recordkeeping/rules/retention-and-disposalauthorities/general-retention-and-disposal-authorities/original-or-source-records-thathave-been-copied-1/frequently-asked-questions-re-original-or-source-records-thathave-been-copied

## Child Death Review Team – Access to Records

Document number IB2014_028 rescinds PD2005_286.

### PURPOSE

The NSW Child Death Review Team (CDRT) reviews the deaths of children in NSW. The purpose of the CDRT is to prevent and reduce child deaths. The purpose of this information bulletin is to provide advice to the NSW Health system regarding the requirements of current legislation in relation to the CDRT's access to medical/health records.

### KEY INFORMATION

Amendments to the *Community Services (Complaints, Reviews and Monitoring) Act 1993 No 2* were made in 2011[1] in response to the Special Commission of Inquiry into Child Protection Services in NSW which was led by the Hon James Wood AO QC in 2008.

These changes had no ostensible impact on the existing requirements for NSW Health agencies in relation to providing full and unrestricted access to records reasonably required for the CDRT to perform its functions. One notable change however, was the transfer of responsibility for support and assistance of the CDRT from the then Commission for Children and Young People to the office of the NSW Ombudsman, and made the Ombudsman the Convenor of the CDRT.

Legislation providing for the Ombudsman to be the Convenor of the CDRT came into effect on 16 November 2011. Under the *Children and Young Persons (Care and Protection) Act 1998* and Section 38 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, there are provisions for the exchange of information about children and young people who have died. The Ombudsman can request full and unrestricted access to NSW Health records when investigating a reviewable death or a death reviewable by the CDRT.

Under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the CDRT's functions include:

- Maintaining the register of child deaths occurring in NSW
- Classifying those deaths according to cause, demographic criteria and other relevant factors
- Data analysis to identify relevant patterns and trends
- Undertake research to prevent or reduce the likelihood of child deaths
- Make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths
- Identify further research required by the CDRT or other agencies or persons.

The following persons are required under Section 34K to provide the CDRT with full and unrestricted access to records reasonably required for the purpose of the CDRT exercising its functions:

- The Director-General, the Department Head, Chief Executive Officer or senior member of any department of the government, statutory body or local authority
- The Commissioner of Police

1 Children Legislation Amendment (Child Death Review Team) Act 2011 No 60
http://www.austlii.edu.au/au/legis/nsw/num_act/cladrta2011n60480.pdf

- The State Coroner
- A medical practitioner or health care professional who, or the head of a body which, delivers health services to children
- A person who, or the head of a body which, delivers welfare services to children (including family support services, children's services, foster care or residential out-of-home care, and disability services)
- The principal of a non-government school (within the meaning of the Education Act 1990).

This includes the right to inspect and, on request, to be provided with copies of, any record referred to in that subsection and to inspect any non-documentary evidence associated with any such record. In the legislation, 'record' means *any document or other source of information compiled, recorded or stored in written form or on film, or by electronic process, or in any other manner or by any other means*.

The legislation also details the requirements of the CDRT related persons in relation to maintaining confidentiality of any information acquired for the purposes of the CDRT.

Each Local Health District must ensure requests for information by the CDRT are met as required, and should implement protocols to facilitate this.

It is noted that:

- Any request from the CDRT should be in writing and reference the legislative provisions relied upon by the CDRT for the release of patient information, namely section 34K of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* ("the Act"). The release must be required for the purpose of the CDRT exercising its functions pursuant to section 34D of the Act.
- Any request from the Ombudsman should be in writing and reference the legislative provisions relied upon for the release of patient information, namely section 38 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* ("the Act"). The release must be required for the purpose of the Ombudsman's functions pursuant to section 36 of the Act."

NSW privacy legislation allows the release of personal and/or health information in circumstances where the organisation (a Local Health District for example) is lawfully authorised to disclose the information; as outlined above.

Where information requested by the Ombudsman or the CDRT contains any reference to reports of Risk of Significant Harm (ROSH), the Health service or health worker handling the request should confirm whether details of the reporter's identity and/or the ROSH report itself are required. If not, de-identified information should be provided. Refer to section 29 of the *Children and Young Persons (Care and Protection) Act 1998* or further information regarding the protection of reporter identity and legal exceptions. Also see PD2013 007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health Section 9.1.2 for legal and policy advice on the protection of a reporter's identity.

212 (15/05/14)

### Notifiable Conditions Data Security and Confidentiality

Document number PD2012_047 rescinds PD2005_181.

## PURPOSE

The purpose of this policy is to provide guidance for NSW Health staff to manage the security and confidentiality of Notifiable Conditions data in any form, either unit records or aggregated form. This includes:

- paper notification records
- electronic notification records,
- the Notifiable Conditions Information Management System (NCIMS),
- the Secure Analytics for Population Health Research and Intelligence (SAPHaRI), and/or
- any other form of data that has not been approved for release in the public domain.

## MANDATORY REQUIREMENTS

All NSW Health and Local Health District staff must comply with this policy when accessing, managing or analysing notifiable conditions data.

Prior to accessing notifiable conditions data, NSW Health staff must sign each page of the Notifiable Conditions Data Security and Confidentiality Policy Directive, to confirm that they have read, understood and agreed to comply with the policies, procedures and conditions set out in it.

Release of notifiable conditions data must be managed according to section 4 – Data and information release.

## IMPLEMENTATION

This policy directive should be distributed to all NSW Health staff. Staff with access to notifiable conditions data must follow the procedure set out in this policy directive.

All staff with access to notifiable conditions data in any form must sign the Notifiable Conditions Data - Confidentiality and Security Agreement at Appendix 1.

161 (16/08/12)

### Intellectual Property arising from Health Research

Document number PD2023_007 rescinds PD2005_370.

## POLICY STATEMENT

NSW Health recognises that the acquisition and dissemination of knowledge and skills in the area of research and clinical practice is of major public benefit and a primary role of Public Health Organisations.

Public Health Organisations must establish a centralised system of managing their Intellectual Property, utilising an Intellectual Property Committee or other Committees which adhere to the requirements of this Policy Directive. They must also ensure that relevant agreements are in place with Clinical Academics, Visiting Practitioners, Visitors, Students, Independent Research Institutes and other third parties which appropriately deal with Intellectual Property.

## SUMMARY OF POLICY REQUIREMENTS

Occasionally, the outcome of Health Research may have a significant commercial value. The objectives of this Policy are to:

- provide a framework for the use, generation, acquisition and management of Intellectual Property in NSW Health
- ensure that Intellectual Property owned by NSW Health is used to generate public value, knowledge transfer and innovation to the fullest extent possible
- encourage health research relating to the public health system and the acquisition and dissemination of knowledge and skills
- foster an environment within which the role of Intellectual Property in enabling clinical application of health research and realising commercial value is understood and recognised
- manage Intellectual Property with a potential commercial value in a manner which benefits the public health system as a whole
- foster an environment within which Intellectual Property issues can be identified and developed, and
- recognise and reward innovation by staff of NSW Health Organisations.

NSW Health provides an environment in which NSW Public Health Organisations are rewarded for the commercial exploitation of Intellectual Property.

The Office for Health and Medical Research will establish a Central Support Service offering assistance in commercialising intellectual property, which Public Health Organisations can delegate matters of that nature to if they are unable to establish or utilise a Committee.

Employees of Public Health Organisations will be required to notify the Committee or Central Support Service (whichever is applicable within their Organisation) of Intellectual Property they develop or will imminently develop.

The Committee/ Central Support Service must examine and consider all notifications provided to it by Employees. Further, they will offer legal and commercialisation advice, and make recommendations to the Chief Executive of the relevant Public Health Organisation. They will also act as a resource for staff on Intellectual Property matters, particularly in relation to the provision of advice on prior disclosure.

## State Health Forms

Document number PD2009_072.

### PURPOSE

This policy and attached procedures define the processes for the creation and management of State Health Record Forms incorporated in Health Care Records.

The scope of the policy is to have clinical statewide forms filed in the Health Care Record and the standardisation of the physical Health Care/Medical Record Cover as well as other health record documents such as labels and dividers. This policy includes but is not limited to Inpatient facilities, Community Health Centres and outpatient clinics/areas.

### MANDATORY REQUIREMENTS

Health services are required to use standardised forms developed by the NSW Health State Forms Management Committee.

All State Health Record Forms for inclusion (or potential for inclusion) in the Health Care Record must be approved by the NSW Health State Forms Management Committee (SFMC) or Health Service forms for use only within the Health Service must be endorsed by the local forms committee.

Health Services must establish:

- A functional health service Health Records Forms Committee
- Processes to ensure all line managers are accountable for the effective implementation of standard health record forms across the health service, including Directors of Clinical Operations, Clinical Governance and Nursing and Midwifery Services, Health Information Management units and facility based Health Information services.

All NSW Health **State** Record forms can **only be obtained** from the State Print and Print Management contracted supplier.

### IMPLEMENTATION

**The Health Service Chief Executive is responsible for:**

- Establishing a functional health service Health Records Forms Committee, a member of which must act as representative to the NSW Health State Forms Management Committee (SFMC).
- Establishing processes to ensure all line managers are accountable for the effective implementation of standard health record forms across the health service, including Directors of Clinical Operations, Clinical Governance and Nursing and Midwifery Services, Health Information Management units and facility based Health Information services.

**The Health Service Records Forms Committee is responsible for:**

- Reviewing clinical forms intended for statewide use.
- Approving all clinical forms to be used by its Health Service.
- Ensuring all clinical forms meet the requirements of relevant Australian Standards (e.g. AS2828), NSW Health Policy Directives, a Health Service and State Health Records Forms templates.

- Working with the NSW Health, appointed Print and Print Management Services contracted provider, to facilitate Statewide implementation of the Policy.
- To standardise clinical forms across their health service where possible.
- To provide a formalised communication network between Health Service forms users, Executive, the contracted Print Management Services provider and the SFMC.
- To make recommendations for ongoing introduction/amendment/deletion of forms.
- Ensuring that the terms of reference includes a requirement that direct clinical contribution is obtained as required.

**The custodians and authors of Health Records Forms (including the NSW Department of Health) are responsible for:**

- Ensuring all steps in the health record forms development processes adhere to policy.
- Submitting relevant forms through their health service representative to the SFMC for review and endorsement.
- If NSW Health Policy Directive or Guideline requires a Health Record form to be used or created in order to comply with that policy or guideline the form must be submitted directly to and processed through the NSW Health SFMC and form a part of that Policy Directive or Guideline before it is distributed for implementation.

**Health Support is responsible for:**

- Monitoring and Reporting:
    - Supplier (Print and Print Management Services) performance
    - Quality issues (product, artwork and supply)
    - Health Service usage and expenditure
    - Health Records Forms gallery
- Management and support of the SFMC.
- Implementation of a Communication Plan.
- Collaboration with Health Item Master File program.
- Maintenance of the State Health Record Forms and bar-code number allocation register.
- Management of print supplier contract and meeting costs associated with contract, (e.g. destruction of obsolete forms etc).

**Persons undertaking the evaluation of forms are responsible for:**

- Confirming that the form is compliant with the current Australian Standards on Hospital Medical Records (AS2828).
- Ensuring the form has a consistent format and template.
- Ensuring that the form meets the criteria as per stated throughout the Appendices to this policy.
- There is clear evaluation criteria against which the form is to be evaluated.
- A diverse group is selected to evaluate where applicable and possible and that consultation with any Health Service which is taking part in the evaluation has been consulted with at the highest level.

- Evaluation report is clearly documented and that any changes made to a form are within the boundaries of any policy directive which the form maybe written from.
- That any change which is outside a policy within which the form has been written from is referred back to the content owners for approval.
- That the form is in and remains in State Forms Management Committee State forms template.

73 (12/09)

## Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients

Document number PD2012_042 rescinds PD2005_547.

### PURPOSE

The policy directive and the associated procedures document outlines the requirements for collecting and recording accurate information on whether clients of NSW Health services are Aboriginal and/or Torres Strait Islander. Aboriginal and Torres Strait Islander people are under-reported in many health related data collections in NSW. Self-report in response to the standard Australian Bureau of Statistics question about a person's Aboriginality is the most accurate means of ascertaining whether a client is Aboriginal and/or Torres Strait islander. The standard question must be asked of all clients of NSW Health services, and the information needs to be recorded accurately according to national standards.

### MANDATORY REQUIREMENTS

1. All NSW Health services are required to collect consistent and comprehensive data on Aboriginal and Torres Strait Islander health.
2. The *Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients: Procedures* document describes the standards required for the accurate collection and recording of data.
3. The standard question seeking information about a person's Aboriginality should be asked of all clients of NSW Health services to establish whether they are Aboriginal and / or Torres Strait Islander: '*Are you (is the person) of Aboriginal or Torres Strait Islander origin?*"
4. These standard response options should be provided to the clients to answer the questions (either verbally or on a written form):
   - ☐ No
   - ☐ Yes, Aboriginal
   - ☐ Yes, Torres Strait Islander
   - ☐ Yes, both Aboriginal and Torres Strait Islander
5. Asking the question:
   - Staff responsible for registering a client should ask the standard question when the client is first registered with the service.
   - The question should be asked of all clients irrespective of appearance, country of birth, or whether or not the staff know the client or their family background
   - Clients may be asked the question directly, or asked to complete a form with the question included, and the client should answer this question themselves.
   - Specific situations related to asking the question are described in Section 2 and Section 4 of the Procedures document.
6. Recording the Information:
   - Information systems should record whether a client is Aboriginal or Torres Strait Islander using the standard categories, which are outlined in Section 3 in the Procedures document.

- Responses to the standard questions should be coded as described in Section 3 in the Procedures document.
- A response to the standard question should be a mandatory requirement when registering or entering client details in electronic recording systems.
- Local data management systems must be able to identify those records that are coded as not stated / inadequately described which require follow-up.

7. Training in the correct and consistent recording of whether a client is Aboriginal and/or Torres Strait Islander must be delivered to all staff. See Section 5 in the Procedures document.
8. Data quality assurance and validation activities must be undertaken at the local level (Section 6 Procedures document) and by NSW Ministry of Health (Section 7 Procedures document).

**IMPLEMENTATION**

1. Roles and Responsibilities of NSW Health agencies:
   - Chief Executives, Health Service Executives, and Managers are responsible for the implementation of this policy and procedures at the local level.
   - All NSW Health employees are responsible for the accurate recording of Aboriginality when ever this is part of their role.
2. Roles and Responsibilities of NSW Ministry of Health:
   - NSW Ministry of Health is responsible for providing the mandatory requirements and procedures, and to support the implementation and evaluation of this policy.
3. Activity Based Funding With the implementation of activity based funding in July 2012, accurate and consistent recording of Aboriginality is essential for the effective application of associated weighting and will enable LHDs/SHNs to:
   - Monitor expenditure on health care against funding for Aboriginal clients
   - Enable clinicians and managers to understand the factors contributing to cost variations including the extent to which these relate to patient complexity or differences in the way services are delivered to Aboriginal clients
   - Make decisions about where to invest additional resources to meet increasing demand in the most cost effective way for Aboriginal clients.
   - Contribute information about costs to the national “price setter”, the Independent Hospital Pricing Authority.
   - Be appropriately funded according to the efficient pricing for treating Aboriginal patients.

## Health Care Records – Documentation and Management

Document number PD2012_069 rescinds PD2005_015, PD2005_127, PD2005_004.

### PURPOSE

The purpose of this policy is to:

- Define the requirements for the documentation and management of health care records across public health organisations (PHOs) in the NSW public health system.
- Ensure that high standards for documentation and management of health care records are maintained consistent with common law, legislative, ethical and current best practice requirements.

### MANDATORY REQUIREMENTS

Documentation in health care records must provide an accurate description of each patient / client's episodes of care or contact with health care personnel. The policy requires that a health care record is available for every patient / client to assist with assessment and treatment, continuity of care, clinical handover, patient safety and clinical quality improvement, education, research, evaluation, medico-legal, funding and statutory requirements.

Health care record management practices must comply with this policy.

### IMPLEMENTATION

**Chief Executives are responsible for:**

- Establishing mechanisms to ensure compliance with the requirements of this policy.
- Ensuring health care personnel are advised that compliance with this policy is part of their patient / client care responsibilities.
- Ensuring line managers are advised that they are accountable for implementation of this policy.
- Ensuring implementation of a framework for auditing of health care records and reporting of results.
- Ensuring health care records are audited and results reported within the PHO.

**Facility / service managers are responsible for:**

- Ensuring the requirements of this policy are disseminated and implemented in their hospital / department / service.
- Ensuring health care personnel within their facility / service have timely access to paper based and electronic health care records.
- Monitoring compliance with this policy, including health care record audit programs, and acting on the audit results.

**Health care personnel are responsible for:**

- Maintaining their knowledge, documentation and management of health care records consistent with the requirements of this policy.
- Ensuring they are aware of current information about the patient / client under their care including where appropriate reviewing entries in the health record.

## Notification of Acute Rheumatic Fever and Rheumatic Heart Disease - the NSW Public Health Act 2010

Document number IB2015_057.

### PURPOSE

This Information Bulletin provides guidance on the addition of Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) to the list of medical conditions in Schedule 1 of the *NSW Public Health Act*, and to the list of notifiable diseases in Schedule 2 of the Act.

Under the provisions of the *Public Health Act 2010* and the *Public Health Regulation 2012*, doctors, hospital chief executive officers (or general managers), pathology laboratories, directors of child care centres and school principals are required to notify certain medical conditions listed on the NSW Ministry of Health website.

### KEY INFORMATION

On 2 October 2015 the *NSW Public Health Act 2010* was amended to add ARF and RHD in a person under the age of 35 to:

a) The list of medical conditions in Schedule 1 to that Act:
    i. That must be notified by medical practitioners to the Secretary of the NSW Ministry of Health, and
b) The list of notifiable diseases in Schedule 2 to that Act:
    i. That must be notified by health practitioners providing care in hospitals to the chief executive officer of the hospital concerned, and
    ii. That must be notified by the chief executive officer of a hospital to the Secretary of the NSW Ministry of Health.

### NOTIFICATION MECHANISMS

Information on the notification of infectious diseases under the *Public Health Act 2010* is detailed in the Information Bulletin IB2013_010.

Infectious disease notifications should be directed to the local Public Health Unit, and should be initiated as soon as possible within 24 hours of diagnosis.

In order to protect patient confidentiality, notifications must not be made by facsimile machine except in exceptional circumstances and when confidentiality is ensured.

Disease notification guidelines and notification forms for notifiers are available at: www.health.nsw.gov.au/Infectious/Pages/notification.aspx.

254 (01/10/15)

## Non-Admitted Patient Data Collection: Changes for Reporting via WebNAP effective 1 July 2016

Document number IB2016_039 rescinds IB2016_038.

### PURPOSE

The purpose of this Information Bulletin is to inform NSW Health service providers and source system administrators of changes to the classification and code set standard for reporting non-admitted patient service provided from 1 July 2016.

### KEY INFORMATION

#### Due Dates for Reporting

Non-admitted patient activity data must be submitted and of acceptable quality by the 10th calendar day of the month after the month the service was delivered.

#### Patient or summary level non-admitted patient activity reporting

Patient level non-admitted patient activity is to be reported for in scope activity.

Where the requirement to report patient level activity data cannot be met summary level data must be reported.

The following services are only required to report non-admitted patient activity at the summary level.

1. Group immunisation services (Service Type 023 Immunisation – On Mass (no patient level data)
2. Group diagnostic screening services
3. Needle exchange services and supervised injecting room services (including service units classified to Service Unit Establishment Type 11.04 Needle Exchange Allied Health / CNS Unit).
4. Crisis line counselling telephone services.

This data is to be reported by WebNAP, or by mLoad when that capability is provided.

Summary level must not be reported for any service unit reporting activity at the patient level.

There is no longer a requirement to advise the Executive Director, Health System Information and Performance Reporting Branch of the Local Health Districts (LHDs) and Specialist Health Networks (SHNs) intention to decommission summary level reporting for those service units reporting at the patient level.

#### Reporting of Services with Multiple Providers

When reporting non-admitted patient services in a WebNAP extract via mLoad each individual service provider should be reported, even if two or more providers have the same provider type code.

#### Occasion of Service Record Identifier

Each occasion of service must be reported with a unique record identifier in the ‘Service Event Record ID’ field. When resubmitting an occasion of service record the same record identifier must be reported so that the original record is identified and updated.

Where a record identifier is not unique within a single submission to EDWARD, mLoad will prevent the entire file from loading.

**Data element classifications subject to change**

The requirements for reporting non-admitted patient activity to the Non-Admitted Patient Data Collection will change for the following data elements:

1. Provider Type
2. Setting Type
3. Financial group.

The changes are of the following type:

1. Some new categories will become effective from 1 July 2016
2. Some existing categories will expire on 30 June 2016
3. Some continuing categories have descriptive label changes.

**Implementation**

The classification changes must be implemented for the reporting of non-admitted patient services provided on or after 1 July 2016 where they are reported via a WebNAP extract format.

These changes will require LHDs / SHNs to:

- Modify local source system classifications
- Map the local source system categories to the appropriate WebNAP alias code values
- Modify WebNAP Service Options for the service units reporting summary level data and impacted by the changed classifications

  This involves:

  - End dating existing service options containing expired reference codes effective 30 June 2016
  - Establishment of new service options containing the new reference codes effective from 1 July 2016.

LHD / SHNs must advise and instruct their source system vendors of the changed requirements and any subsequent need to modify systems. Where a source system is shared between multiple LHDs / SHNs; are compliant with a State Based Build; and / or are subject to application support services provided by eHealth NSW, it is the responsibility of each LHD / SHN to ensure the technical implementation of the modified reporting requirements are raised through the appropriate application support mechanisms. This includes:

- The LHD / SHN Application Advisory Group (AAG) representative ensuring that the change requirements are on the AAG meeting agenda, discussed at the AAG meetings and are approved within a time frame that will enable the implementation due date to be met.
- Directing and authorising eHealth NSW to make the application build change by raising the request for change on the State-wide Service Desk and tracking the change through to its delivery.

**Clarification Advice**

The NSW Ministry of Health will provide clarification advice regarding the changed reporting requirements outlined in the attachments. Requests for advice should be directed to the Health System Information and Performance Reporting Branch, NSW Ministry of Health.

**Primary Contact:**

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261 (8/10/15)

**Non-Admitted Patient Data Collection Transition from WebNAP to EDWARD Reporting**

Document number GL2015_012.

## PURPOSE

The purpose of this Guideline is to advise NSW Health non-admitted patient service providers and non-admitted patient activity source system support staff of the changes in requirements involved in the transition from reporting via WebNAP to reporting via the EDWARD.

An understanding of these differences, and the three phases of implementation, is required to reconfigure source system builds and patient level activity extracts, and redesign non-admitted patient activity reporting business processes.

## KEY PRINCIPLES

In line with NSW Health's strategic direction and the significantly increased volumes of non-admitted patient services being reported at the patient level by NSW Health services the Non-Admitted Patient Data Collection will transition to be reported via EDWARD rather than the interim system WebNAP.

The migration of the data collection to EDWARD will have significant benefits for Local Health Districts (LHDs) / Specialist Health Networks (SHNs) and other NSW Health agencies. LHDs / SHNs should expect higher data availability, more efficient data loading and resubmission processes, significantly improved data error reporting functionality and appropriately secured access to activity data.

When reported via EDWARD the non-admitted patient, admitted patient and emergency department activity data will be automatically allocated the appropriate National Weighed Activity Unit (NWAU) and integrated into a single data mart that supports full patient journey analysis utilising the Enterprise Patient Registry unique identifier.

## USE OF THE GUIDELINE

In order to minimise the transition burden, requirements have been prioritised across three phases:

- **Phase 1**: Report current scope via EDWARD and decommission WebNAP
- **Phase 2**: Convert source system extracts and classifications to the EDWARD format
- **Phase 3**: Integrate additional reporting requirements for specific clinical streams

The EDWARD Business Implementation (EBI) Program collaborating with the NSW Ministry of Health's Health Systems Information and Performance Reporting (HSIPR) Branch will establish a small project team to support transition, testing and address queries as they arise during the migration period.

### Phase 1

Implementation of phase 1 requires LHDs/SHNs to load WebNAP patient level and summary level extracts into EDWARD and to cease reporting to WebNAP.

To support the transition to EDWARD reporting during Phases 1 and 2, a file upload, conversion and transfer tool, the EDWARD mLoad Tool, will be available for LHDs/SHNs to upload patient level and summary level data extracts from source systems in either the WebNAP extract format, or the EDWARD extract format.

The tool will apply the necessary file format conversions to WebNAP extracts compliant with the 2015/16 WebNAP reporting requirements and file format. It will also produce a container header file (based on user inputs) for both WebNAP and EDWARD flat file formats, and transfer files to the EDWARD drop zone where they will be automatically loaded into EDWARD.

During this phase LHDs / SHNs:

1. Must build EDWARD extracts for non-admitted patient source systems that are not yet reporting at the patient level
2. Must commence the reconfiguration of WebNAP extracts such that the source system can report activity directly in the EDWARD extract format
3. May cease reporting summary level data for services reporting at the patient level once reporting through the EDWARD mLoad Tool
4. May commence (or fully implement any) transition steps outlined in later phases.

Phase 1 must be completed by **30 June 2016**, to enable the decommissioning of WebNAP.

**Phase 2**

Implementation of Phase 2 requires LHDs / SHNs to complete the reconfiguration of WebNAP source system extracts into the EDWARD extract format and source systems to be fully aligned with the EDWARD classification standards.

During this phase any changes effective from 1 July 2016 will also need to be incorporated into the EDWARD extracts.

During this phase LHDs/SHNs may implement Phase 3 implementation steps.

Phase 2 must be completed by **30 June 2017**, to enable the decommissioning of the WebNAP patient level file conversion functionality, compliance with 2016/17 reporting requirements and to establish the foundations required for implementation of Phase 3.

**Phase 3**

Phase 3 involves reporting the additional data elements set aside in the EDWARD extract file format for the integration of other non-admitted patient data collections for specific clinical streams. It will involve decommissioning the legacy extracts and legacy data repositories (such as HIE and other disparate databases).

This phase may only impact selected source systems. For example, radiotherapy sources system would add data elements required for the integration of radiotherapy waiting times and non-admitted patient cancer notifications, while source systems used by Hepatitis, HIV/AIDS and sexually transmissible diseases services would add data elements pertaining to communicable diseases.

Phase 3 is expected to be completed by **30 June 2018**, to enable the decommissioning of the HIE and other legacy data repositories and to establish a single comprehensive non-admitted patient data collection.

**FURTHER INFORMATION**

The NSW Ministry of Health will provide advice and clarifications regarding the requirements for reporting non-admitted patient activity via EDWARD. Requests for advice should be directed to the Health System Information & Performance Reporting Branch, NSW Ministry of Health.

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262 (18/8/16)

### Right to access medical records by legal representatives - Mental Health Review Tribunal hearings

Document number IB2018_019 rescinds IB2017_027.

## PURPOSE

The purpose of this information bulletin is to inform Local Health Districts/Specialty Networks of the right of a patient's legal representative to inspect and access the patient's medical records when the patient has a matter before the Mental Health Review Tribunal and the need to facilitate a legal representative's access to such records.

## KEY INFORMATION

Under the Mental Health Act 2007, where the Mental Health Review Tribunal (Tribunal) holds a hearing or review in respect of a mental health patient, the patient has a right to be represented by a legal representative. In certain hearings, such as a mental health inquiry, the patient must be represented by a legal representative (or other person approved by the Tribunal). In most cases, a patient's legal representative will be a legal practitioner from LegalAid or a LegalAid panel firm.

In order to ensure that a patient's legal representative can appropriately represent the patient, the Mental Health Act gives a patient's legal representative the right to inspect or have access to any medical records in the possession of the mental health facility at the Local Health District/Specialty Network relating to a patient who has a hearing before the Tribunal.

A legal representative's right to access a patient's records is important in order to ensure that that the legal representative can understand the basis on which the patient has been detained and can properly and fully make submissions to the Tribunal in relation to the patient's detention.

A Local Health District/Specialty Network must facilitate a patient's legal representative's right to inspect or access information about a patient's detention, including admission documents, progress notes and relevant reports.

In advance of a hearing before the Tribunal, the relevant unit in a Local Health District/Specialty Network (such as a mental health facility or medical record unit) must provide the patient's legal representative with access to the medical records of patients who have a hearing before the Tribunal and who are represented by the legal representative. This should generally be done as follows:

- A list of all patients who will be seen by the Tribunal should be prepared by the relevant unit in the Local Health District/Specialty Network in advance of the Tribunal hearing.
- Two copies of the each patient's "relevant medical records" should be printed in advance of the Tribunal hearing - one copy for the Tribunal and one for the patients' legal representative.
- Where a legal practitioner from LegalAid, or a LegalAid panel firm, attends to represent patients, they should be asked to confirm they have been appointed by LegalAid to act as the patients' legal representative. Once they have confirmed they are acting for the patient/s that will be seen by the Tribunal and the practitioner's identification documents have been sighted, a copy of the relevant records should be provided to the legal representative. A form of Confirmation as Legal Representative is at Appendix 1.
- The relevant unit in a Local Health District/Specialty Network (such as a mental health facility or medical record unit) must keep a copy of the Confirmation as Legal Representative form. This could be kept in a separate file or register in the relevant unit and where reasonable a note should be included in each patient's file noting that the patient's legal representative has been given access to the records.

- In a small number of cases, a legal representative other than from LegalAid, or a LegalAid panel firm, will represent a patient. In such cases, written confirmation they act for the patient, and identification documents sighted, must be provided for inclusion in the patient's medical record before a copy of the relevant records is provided to the legal representative. A copy of the written confirmation should be placed in the patient's medical record.
- If a medical practitioner considers that there is information in the medical records that will be harmful for the patient's legal representative to share with the patient, the medical practitioner should warn the legal representative that it would be harmful to share the information with the patient. A legal representative is obliged to have due regard to the warning and not obliged to disclose the information to the patient. If the medical practitioner remains concerned, the practitioner can seek an order prohibiting the disclosure of information to the patient from the Tribunal.

**This procedure can be adapted locally when giving access to electronic records.**

Relevant medical records will include, at a minimum:

- For a mental health inquiry, all admission and detention documents relating to the current detention of the patient. This will include Assessment Form/s completed at the time of admission. If a person is transferred from another facility there may be more than one such form.
- For a mental health inquiry, a copy of the Statement of Rights, signed and dated by the patient where possible or, if refused, annotated copies recording the same and notations documenting later service.
- Nomination of Designated Carer form/s (including any exclusions) and, if nomination is refused, documentation of any determination by an authorised medical officer or Director of Community Treatment in relation to their appointment of a Principal Care Provider; evidence of further attempts to have the person nominate a Designated Carer.
- Documentation of any recent reviews carried out by a Consultant and/or Registrar or other member of the treating team.
- Documentation by the Consultant/Registrar of their final review prior to the Tribunal hearing, including any plan that specifies the order to be sought at the hearing.
- Recent progress notes.
- Any recent medical practitioner's report.
- Any recent social work or allied health report.
- Any other documents specifically requested by the Tribunal in relation to the matter.

If the patient's medical record contains details about a risk of significant harm under the Children and Young Persons (Care and Protection) Act, details about the mandatory reporter or the report must not be disclosed to the patient's legal representative.

In some circumstances, a patient's legal representative may request access to additional information about the patient. Where the request relates to the patient's mental health or detention, the information should be provided to the patient's legal representative.

Once the legal practitioner is given a copy of the records, the copy of the records is the responsibility of the legal practitioner and can be removed from the hospital. A patient's legal representative will have their own professional and privacy obligations to maintain the confidentiality of the patient's medical records.

### The Guardianship Application Process for Adult Inpatients of NSW Health Facilities

Document number GL2017_013 rescinds GL2016_026.

**PURPOSE**

This Guideline will assist relevant professionals, including medical, allied health, nursing and midwifery staff in NSW Health facilities to understand their roles and responsibilities when making an application to the Guardianship Division of NCAT.

**KEY PRINCIPLES**

The Guideline aims to standardise practice across NSW Health facilities to improve the process for adult inpatients waiting for a guardianship hearing by ensuring that NSW Health facilities are aware of:

1. When an application to the Guardianship Division of NCAT is necessary and appropriate.
2. Who is responsible for coordinating the application.
3. Who to consult for advice when considering making a guardianship/financial management application.
4. Making applications and providing reports to the Guardianship Division of NCAT within seven days.
5. What assessments and evidence is required when submitting an application to the Guardianship Division of NCAT.
6. How to record data for patients waiting for guardianship on the patient flow portal.

**USE OF THE GUIDELINE**

This document provides guidance to NSW Health inpatient facilities and their relevant staff when considering whether an application to the Guardianship division of NCAT is necessary. This document should be used as a practice guideline rather than a mandatory directive.

318 (09/01/17)

### The Guardianship Application Process for Adult Inpatients of NSW Health Facilities

Document number IB2017_001.

**PURPOSE**

The purpose of this Information Bulletin is to inform NSW Health staff:

1. How to obtain assistance in making submissions to NCAT arguing that Local Health Districts (LHDs) and Specialty Networks have legal standing to lodge applications for guardianship orders on behalf of inpatients, and
2. Of changes to NCAT's practice and procedures.

**KEY INFORMATION**

*GL2016_026: The Guardianship Application Process for Adult inpatients of NSW Health Facilities*, has been developed in collaboration with clinicians from across Local Health Districts and Pillar organisations.

**1. Applications should now be made in the name of the LHD or Specialty Network and legal assistance is available to support this change**

The Guideline recommends that applications to NCAT for guardianship orders be made in the name of the LHD or Specialty Network, rather than in the name of an individual health professional. This represents a change to the previous practice of health professionals, typically social workers, lodging applicants in their own name. The primary purpose of this change is to protect individual health professionals from any adverse consequences of being named as a party to Tribunal proceedings.

Where applications are made in the name of the LHD, NCAT may hold a directions hearing, and request submissions on whether the organisation has standing to be an applicant.

Should this occur in respect of an application, please contact Legal and Regulatory Services at the NSW Ministry of Health (legalmail@doh.health.nsw.gov.au / telephone 9391 9606) so that assistance with preparing and lodging submissions can be provided.

**2. Changes to practices and procedures in the Guardianship Division of NCAT**

NCAT has advised that from 1 January 2017:

- The guardianship and financial management application forms will be separated into two forms
- The applicant will be directed to give (serve) a copy of the application and any attachments to the parties and the subject person
- The parties will be directed to give (serve) each other any material instead of the registry distributing it • All parties will receive a notice of hearing, and
- Prior to the hearing the registry will send a list of the materials provided to the Tribunal to the parties and send the material to the subject person.

Service of a copy of the application and any attachments to the parties and the subject person may be done by providing it to the party, or by posting it to them. Service should be documented by the LHD (for example by making a file note stating that the document was handed to the party or keeping a copy of the covering letter, if service is by post).

318 (09/01/17)

### NSW Health Admission Policy

Document number PD2017_015.

**PURPOSE**

The purpose of this policy is to provide guidance to health service staff in regard to the decision to admit, the admission of patients to hospital and associated business processes. This policy aims to ensure consistency in the way that admissions occur and applies to all NSW public hospitals and publically contracted care in other facilities in NSW.

**MANDATORY REQUIREMENTS**

This Policy Directive applies to all NSW public hospitals (and publically contracted care facilities), which are required to have local policies, protocols and procedures in place consistent with the attached Admission Policy for NSW Health procedures document.

This policy does not describe the data or reporting requirements for the Admitted (and Non-Admitted) Patient Data Collections, which are outlined in separate policies.

**IMPLEMENTATION**

Chief Executives are responsible for ensuring that this Policy Directive is brought to the attention of Clinical, Finance and Administrative staff who are involved in the admissions process.

Health System Information and Performance Reporting (HSIPR) branch will provide information to existing data governance groups and key established reference groups to assist with local implementation. HSIPR will arrange individual Local Health District/Speciality Health Network information sessions in 2017 to facilitate the introduction of the Admission Policy.

318 (15/06/17)

## NSW Health Privacy Internal Review Guidelines

Document number GL2019_015 rescinds GL2006_007.

### PURPOSE

NSW privacy law establishes a process of internal review for handling a privacy complaint, in certain circumstances.

These Guidelines help staff navigate and comply with all legislative requirements in conducting a privacy internal review.

Guidance is provided on undertaking an appropriate investigation into the privacy complaint, including conducting interviews and consultation requirements.

The Appendices include template letters and reports to provide practical assistance to staff, and a consistent approach to privacy complaint handling for NSW Health agencies.

### KEY PRINCIPLES

#### 60-day time limit

A privacy internal review must be completed as soon as practicable, and a time limit of 60 calendar days applies. The 60-day time limit starts from the receipt of the first written privacy complaint or request for privacy internal review. In exceptional circumstances, the agency may ask the applicant for an extension of time. *(Sections 5.3 and 5.4)*

#### NSW Privacy Commissioner

The NSW Privacy Commissioner must be notified of all applications for privacy internal review, provided with a draft investigation report for comment, and provided with the final report and covering letter to the applicant. *(Sections 5.7 and 7.3)*

#### NSW Civil and Administrative Tribunal

An individual who is dissatisfied with the outcome of the agency's privacy internal review, can lodge an application for administrative review with the NSW Civil and Administrative Tribunal (NCAT). This must be lodged within 28 calendar days of receipt of the privacy internal review report from the NSW Health agency. *(Section 7.1)*

### USE OF THE GUIDELINE

#### Chief Executive

The Chief Executive, or their Senior Executive delegate, is ultimately responsible for the privacy internal review process and outcome. The Chief Executive, or their Senior Executive delegate, should approve the final internal review report and letter to the applicant. *(Section 3.4)*

#### Privacy Contact Officer, NSW Health agency

Privacy internal review is normally undertaken by the Privacy Contact Officer for the NSW Health agency. Privacy internal review must be undertaken without bias, and by an officer who is neutral to the circumstances relating to the complaint. If an officer was substantially involved in the matter relating to the complaint, including attempts to informally resolve the complaint, they are unable to

undertake the privacy internal review. In such case, an alternative review officer must be appointed. *(Section 3.4 and 5.1)*

**Ministry of Health**

The Privacy Contact Officer, Ministry of Health and legal officers within the Legal and Regulatory Services Branch, may assist agency staff with matters of privacy internal review.

NSW Health agencies should:

- notify relevant privacy internal review matters to the Ministry, *(Section 5.5)*
- seek advice and clarification from the Ministry as necessary, *(throughout)*
- provide the draft internal review report to the Ministry for comment, *(Section 6.2)*
- provide final letter and internal review report to the Ministry, *(Section 6.4)*
- report statistical data on privacy internal reviews in the agency's privacy annual report *(Section 7.2)*

### Use of Exchange of Information Part 13A Crimes (Domestic and Family Violence) Act 2007 Form

Document number IB2016_056.

**PURPOSE**

The purpose of this Information Bulletin is to inform NSW Health service providers and Health Information Management staff of the publication of the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act 2007* Form. This Information Bulletin also provides guidelines for the use of the form.

The Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act 2007* Form is a paper form **ONLY** and is **NOT** to be scanned into any electronic medical records systems.

**KEY INFORMATION**

Reducing domestic violence is a NSW Premier's Priority. Safer Pathway is a whole-ofgovernment response designed to provide accessible and effective domestic violence support services to victims, with a focus on victims at serious threat. Under Safer Pathway, police, justice, health, education, child protection and victim service agencies work in an integrated manner to reduce threat to adult and children victims of domestic violence. This is to ensure that a seamless response can meet the individual needs of victims and children, and service providers jointly manage threats of further violence.

NSW Health has a key role as an interagency partner in fortnightly Safety Action Meetings, which are a component of Safer Pathway. Participation in Safety Action Meetings includes file searches for relevant health information, participation in fortnightly meetings and follow up actions resulting from Safety Action Plans. NSW Health is represented by up to three clinicians / healthcare professionals at a Safety Action Meeting, including Mental Health and Drug and Alcohol services wherever possible.

Please note that the information contained in this document is to be read in conjunction with the NSW Government guidelines listed below, and attached to this Information Bulletin. Information and records relating to Safety Action Meetings must be managed and stored in accordance with these documents:

- Safer Pathway Domestic Violence Information Sharing Protocol
- Safety Action Meeting Manual
- Domestic Violence and Child Protection Guidelines

**Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form**

The NSW Health Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act 2007* Form is a state form that assists NSW Health workers to comply with requirements under the NSW *Crimes (Domestic and Family Violence) Act 2007*. This legislation governs information sharing related to Safety Action Meetings, and other victims of domestic and family violence at Serious Threat.

The form is available for download as an interactive PDF or to print on demand via Stream Solutions.

A number of key principles underlie information exchange at Safety Action Meetings. These include:

- The threshold of serious threat under which information exchange at Safety Action Meetings takes place, means that there is a reasonable belief that there is serious threat to

a victim's life, health or safety, or other person's life, health or safety, due to domestic violence, and action is necessary to prevent or lessen this threat. A threat does not have to be imminent to be serious.

- Information sharing at Safety Action Meetings is limited to that which is necessary to prevent or lessen a serious threat to the life, health or safety of victims, their children or other persons. Each member is responsible for decisions about what information it considers reasonably necessary to share.
- Consent to share information is preferable, but in instances of Serious Threat, not necessary. The Local Coordination Point which is staffed by the Women's Domestic Violence Court Advocacy Support Service, or Victim's Services, are usually responsible for seeking consent from a victim for information sharing at a Safety Action Meeting.
- Consent to share information is NEVER requested from a person listed on a Safety Action Meeting agenda as a perpetrator of violence. Information about Safety Action Meetings and Safety Action Plans must likewise NOT be shared with alleged perpetrators of violence. This could be vital to ensuring the safety of a victim.

**The Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form is to be used with the following guidelines:**

- Use in preparation for Safety Action Meetings, and other information exchange that takes place under Part 13A of the NSW *Crimes (Domestic and Family Violence) Act 2007*
- A new form is to be used per client and per client file system reviewed:
    - Information from other service areas are NOT to be compiled on a single form
    - Information from other clients' files are NOT to be compiled on a single form
- Store in the client file reviewed. This must be in paper form ONLY and is NOT to be scanned into electronic systems.
- Actions from a Safety Action Meeting are to form part of the contemporaneous client notes in the appropriate client file.

The Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form intersects with other healthcare privacy considerations and information exchange processes including:

1. Sexual Assault Communications Privilege

   It is vital that staff are aware that information sharing at Safety Action Meetings is limited to that which is necessary. In the case of information which may be subject to the Sexual Assault Communications Privilege, it is recommended that advice from Local Health District legal services, or the Domestic and Family Violence team at the Ministry of Health be sought prior to information exchange under 13A.

   Sexual assault communications are made in the course of a confidential relationship between a victim of sexual assault and a counsellor. The sexual assault communications privilege provides an absolute prohibition, in NSW courts, against requiring the production of documents recording counselling communications in preliminary criminal proceedings. Once the main criminal proceedings have started, the privilege will also apply unless the court specifically grants leave and requires the documents be provided. Documents that are the subject of this privilege in any criminal proceedings continue to be privileged in subsequent civil proceedings. A sexual assault privilege also applies in ADVO proceedings.

   The purpose of this privilege is to give victims a confidential and safe place to talk about, or disclose, information about their traumatic experience, personal or sensitive issues and

concerns. It includes counselling communications made by, to or about a victim. In NSW, an objection may be made to produce a protected confidence on the ground that it is privileged; but the victim of the sexual assault can consent to disclosure.

2. Child Protection

   In cases of domestic violence where children are victims, or are affected by domestic violence in the home (including when listed on a SAM agenda as a perpetrator of violence), prescribed bodies should exchange information under Chapter 16A in the first instance. Both Part 13A and Chapter 16A prioritises the safety, welfare, and wellbeing of a child or young person over an individual's right to privacy.

   Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998 (CYPCP Act)* overrides other laws that prohibit or restrict the disclosure of personal information such as the *Privacy and Personal Information Protection Act 1998 (PIPP Act)* and the *Health Records and Information Privacy Act 2002 (HRIP Act)*. The focus of the exchange of information is on the safety, welfare and wellbeing of children, and facilitating the provision of services to these children and their families.

   Service providers who are prescribed bodies under the *CYPCP Act* may exchange information that relates to a child or young person's safety, welfare or wellbeing, whether or not the child or young person is known to the Department of Family and Community Services (FACS).

   Where Chapter 16A does not apply, information may be shared under Part 13A and the Safer Pathway Domestic Violence Information Sharing Protocol.

   NSW Health staff should also be aware that information sharing under 13A does not replace mandatory reporting obligations for children and young people at risk of significant harm. Where information exchange processes identify risk of harm to a child or young person, NSW Health staff are required to apply usual clinical practice, including application of the Mandatory Reporter's Guide, and reports to FACs where indicated. This occurs within the normal timeframe for any risk of harm identification and is not dependent on Safety Action Meeting dates or processes.

3. Health Information Access

   The *Health Records and Information Privacy Act 2002*; the *Government Information (Public Access) Act 2009* and the *Privacy and Personal Information Protection Act 1998* govern access to information held in health records. As a general rule, a victim's personal and health information must never be disclosed to an alleged perpetrator or any other person acting on behalf of the alleged perpetrator, such as the alleged perpetrator's legal representative. Part 13A and the Protocol seek to ensure that the victim's safety is not compromised by individuals' right to access their information under NSW privacy laws. For this reason, Part 13A and the Protocol override the *PPIP Act* and the *HRIP Act* in when the applicant is the alleged perpetrator.

   In domestic violence situations it can be important for the victim's safety that the alleged perpetrator remains unaware of impending interventions. If the alleged perpetrator is aware, this may result in an escalation of violence. Service providers must also consider the potential for placing the victim at increased risk of violence where the attempt to reduce or prevent the serious threat was not successful and the alleged perpetrator becomes aware that the victim has reached out for support.

   Requests for any file containing the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form and other related file notes, where the applicant is the alleged perpetrator, **could reasonably be expected to expose a person to a risk of harm**. For information relating to this see the NSW Health *Privacy Manual for Health*

*Information*, section 12. Where any doubt exists about the release of information relating to Safety Action Meetings, consult Local Health District legal advice.

4. Subpoenas

   A service provider that has used or disclosed information may be subpoenaed to produce the information held, including the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form. If a Local Health District or Specialty Health Network receives a subpoena to produce information about a victim or an alleged perpetrator, that service provider must seek legal advice before producing any information. A subpoena may be challenged on a number of different grounds, including abuse of process, oppression and/or on the basis of a privilege at law over the information.

   All subpoenaed files containing the Exchange of Information Part 13A *Crimes (Domestic and Personal Violence) Act* 2007 Form, where privilege at law does not exist, should be subject to a Sensitive Information Claim. See NSW Health Subpoenas Policy (PD2010_065) for how to make these claims.

## Electronic Medical Records of Information Exchange to reduce Domestic and Family Violence Threat

Document number IB2020_022.

### PURPOSE

This Information Bulletin clarifies the requirements around notations made within electronic medical records of information exchange under Part 13A Crimes (Domestic and Personal Violence) Act 2007.

It contains information for health services which supplements the NSW Health Information Bulletin *Use of Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form* (IB2016_056).

### KEY INFORMATION

The *NSW Health Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form* is a state form that assists NSW Health workers to comply with requirements under the NSW *Crimes (Domestic and Personal Violence) Act 2007*.

This legislation governs information sharing related to Safety Action Meetings, and other victims of domestic and family violence at Serious Threat.

Health workers are to continue to follow the NSW Health Information Bulletin *Use of Exchange of Information Part 13A Crimes (Domestic and Personal Violence) Act 2007 Form* (IB2016_056), including the guidance around use of the State Form.

Health services may include minimal information in the progress notes of the electronic medical record indicating that information exchange has occurred to reduce a serious domestic violence threat to a person. Standard statements are included below for use in the progress notes. The statements include a prompt on how to respond where clinicians have ongoing concerns regarding a domestic violence threat.

#### Information shared under Part 13A about a client who is the alleged perpetrator

Staff may include a brief statement in the progress notes of the electronic medical record when information is shared under Part 13A about a client who is the alleged perpetrator and a Safety Action Meeting is held that identifies actions for Health pertaining to the perpetrator.

- Any such statement should be labelled *'VAN Progress Note: Strictly Confidential - **not** to be shared with client'* and indicate that:

  > *"This client's file has been reviewed and relevant information shared for the express purpose of reducing a serious domestic violence threat to another person/s including children.*
  >
  > ***The client must not be informed that this has occurred.***
  >
  > *Any inappropriate disclosure of the information to [insert client's name] has potential harmful consequences for the safety of a victim/s.*
  >
  > *To discuss concerns about an ongoing or escalating domestic violence threat, contact [LHD service/contact]. Where a clinician has reasonable grounds to suspect that there is a serious and imminent risk to the victim/s or others' safety, Police should be contacted."*

**Information shared under Part 13A about a client who is a victim**

Staff may include a brief statement in the progress notes of the electronic medical record when information is shared under Part 13A about a client who is a victim, and a Safety Action Meeting is held which identifies actions for Health.

- Any such statement should be labelled *'VAN Progress Note: Strictly Confidential – not to be shared before contacting the nominated clinician/service below'* and indicate that:

  > *"This client's file has been reviewed and relevant information about the client shared for the express purpose of reducing a serious domestic violence threat to the client or another person, including a child.*
  >
  > *Any inappropriate disclosure of the information has potential harmful consequences for the victims' safety.*
  >
  > *To discuss the above information and/or concerns about an ongoing or escalating domestic violence threat, contact [LHD service/contact]. Where a clinician has reasonable grounds to suspect that there is a serious and imminent risk to the victim/s or others' safety, Police should be contacted."*

The suggested statements for progress notes above can also be applied where information is shared at Safety Action Meetings using Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*.

For further relevant information on information sharing and documentation please refer to the *NSW Government* *Domestic Violence Information Sharing Protocol* and, where sharing information under Chapter 16A, the NSW Health Policy Directive Child Wellbeing and Child Protection Policies and Procedures for NSW Health (PD2013_007).

331 (18/06/20)

## Lookback

Document number PD2023_003 rescinds PD2007_075.

### POLICY STATEMENT

NSW Health Services are to implement lookback processes consistent with the requirements of this Policy Directive to ensure the timely notification and coordinated tracking of affected or potentially affected groups of patients.

### SUMMARY OF POLICY REQUIREMENTS

Health Services are to initiate a lookback process when a clinical incident or concern has affected or may affect a group of patients.

Health Services are to undertake the four-step lookback process to identify, track, communicate and provide ongoing advice to these patients. The scope and scale of a lookback process can vary, so Health Services are to use an initial risk assessment to determine whether each element within a step is required.

The lookback process is to align to incident management, open disclosure, critical response and privacy processes.

Health Services are to notify appropriate internal and external bodies and regulators.

In keeping with a risk management approach, Health Services are to escalate as required to the NSW Ministry of Health and/ or the Clinical Excellence Commission.

The lookback process may involve a system wide communication strategy and/ or notifying the wider community. In such circumstances, the Clinical Excellence Commission and/ or NSW Ministry of Health will provide guidance.

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