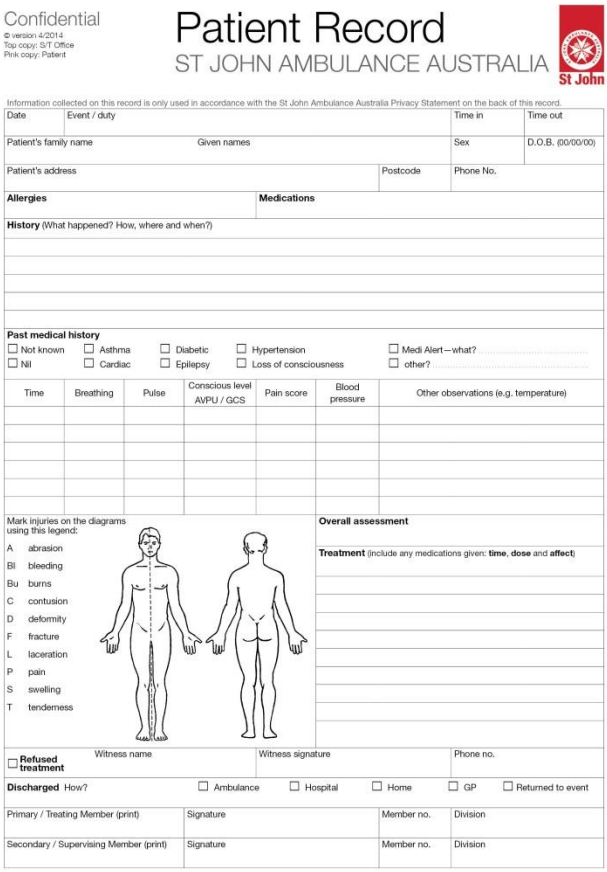
Guidelines for Managing Patient Records



Confidential

© version 4/2014
Top copy: S/T Office
Pink copy: Patient

Patient Record
ST JOHN AMBULANCE AUSTRALIA

Information collected on this record is only used in accordance with the St John Ambulance Australia Privacy Statement on the back of this record.

Date	Event / duty		Time in	Time out
Patient's family name	Given names		Sex	D.O.B. (00/00/00)
Patient's address		Postcode	Phone No.	

Allergies | **Medications**

History (What happened? How, where and when?)

Past medical history

☐ Not known ☐ Asthma ☐ Diabetic ☐ Hypertension ☐ Medi Alert—what? .....
☐ Nil ☐ Cardiac ☐ Epilepsy ☐ Loss of consciousness ☐ other? .....

Time	Breathing	Pulse	Conscious level AVPU / GCS	Pain score	Blood pressure	Other observations (e.g. temperature)

Mark injuries on the diagrams using this legend:

A abrasion
Bl bleeding
Bu burns
C contusion
D deformity
F fracture
L laceration
P pain
S swelling
T tenderness

Overall assessment

Treatment (include any medications given: **time**, **dose** and **affect**)

☐ **Refused treatment** Witness name	Witness signature	Phone no.

Discharged How? ☐ Ambulance ☐ Hospital ☐ Home ☐ GP ☐ Returned to event

Primary / Treating Member (print)	Signature	Member no.	Division
Secondary / Supervising Member (print)	Signature	Member no.	Division

August 2014

Version Control

Date	Changes
August 2010	Original Version.
August 2014	Updated Version. Removal of requirement for Patient Records to be countersigned and reformatting.

Please direct all correspondence in relation to this document to:

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Contents

Purpose

The purpose of these guidelines is to provide key information on the management of St John medical records, viz.:

- A definition for St John medical records
- General handling information
- Completion of a medical record
- Temporary storage of a medical record at an event or emergency site
- Patient copy of the medical record
- Permanent storage of a medical record at a St John facility
- Access
- Minimum period of retention
- Disposal

Authority

The *First Aid Service Standards* contained in the *One St John Policies and Standards Manual* state that:

- *"When providing first aid services, a medical record must be completed for all patients who are treated, advised or refuse treatment or advice. Information recorded on the medical record is confidential and must be managed in accordance with the Guidelines for managing medical records. All non-clinical services (e.g. supply of sunscreen or bandaids without a clinical assessment being conducted) must be recorded on the Non-Clinical Services Record."*

A definition for St John medical records

A St John medical record is:

- a record containing patient details, presenting problems, observations made and treatment/advice given
- a legal document and may be used in a law court

At present there are only two types of St John medical records:

- The standard St John Patient Record
- The St John Extended Practice Patient Record

The Non-Clinical Services Record contains no personal information and therefore is not regarded as a patient record.

General handling information

When handling medical records reasonable steps must be taken to preserve confidentiality and prevent loss, damage or theft. Only people required to handle completed medical records are to do so. The *Privacy Act 1988* (Cth) (http://www.oaic.gov.au/privacy/privacy-act/the-privacy-act) must be upheld.

Handling includes:

- Completion
- Temporary storage at the event or emergency site
- Temporary or permanent storage at other St John facilities
- Access
- Retrieval
- Destruction

Completion of a medical record

Medical records are to be completed in a manner that is:

- accurate
- complete
- objective
- legible
- timely
- contains no abbreviations and symbols
- contains no errors
- signed by the treating member

Temporary storage of medical records at an event or emergency site

The completed medical record is to be stored temporarily at an event or emergency site in a way that preserves confidentiality and prevents loss, damage or theft.

Patient copy of the medical record

The pink (duplicate) copy of a Patient Record or referral notes/letters accompanying an Extended Practice Patient Record must be handed to the patient, their carer or the receiving health professional on handover.

Permanent storage of the medical record at a St John facility

Medical records are to be sent to a permanent storage facility as soon as possible. Preferably, permanent storage should be at the State/Territory Office. If this is not possible, they are to be stored at St John Divisional or Regional Centres in accordance with procedures developed by the State/Territory Office.

Under no circumstances are medical records to be stored at the homes or businesses of individual members.

Medical records may be stored electronically at a secure location. Once scanned, the original medical record may be destroyed after it has been ascertained that the scanned document has captured all information clearly. Data is to be backed up regularly at another location.

Storage sites for hard copy and electronic medical records (including backups) should be protected, as much as is practical, from damage (including but not limited to fire, flood, water damage) and inappropriate access (including theft).

Access

All medical records must be accessible in a timely manner for purposes of:

- provision to the patient if requested
- provision to the police or lawyers in response to an appropriate written request
- review for quality assurance purposes
- St John sanctioned research

Access is restricted to appropriately authorised personnel.

Minimum period of retention

Medical records are to be kept for

- Adult patients – seven (7) full years from the date of completion
- Child patients (i.e. patients below the age of 18 when treated) - until the patient reaches 25 years of age

In addition jurisdictions must ensure they comply with all relevant legislation.

Disposal

Medical records must be disposed of in a manner that preserves confidentiality.