**Sample Policy for Open Notes and Electronic Health Record Systems**

Policy for documentation principles at **(Practice Name)** for open notes and electronic health record systems

From **(date)** the practice will allow patients’ access to their clinical notes via the patient portal/ electronic record. We encourage patients to access their health records to be better able to engage in their medical care and interact with their care team.

Documentation in the medical notes reflects the quality of care and services delivered. It acts as a communication tool between the patient and the patient’s primary care team and allows for improved continuity of care.

Documentation is also essential to accurately reflect the patient’s healthcare acuity and severity; it supports the capture of diagnoses and procedural codes.

Documentation should be completed on the day of consultation or as soon as is physically possible afterwards. All contacts with all patients should be recorded.

The practice should have a general guideline for writing notes. The PMS should include information on: past history, medications, allergies, READ codes, date of consultation and by whom.

Daily record notes should include:

* History of presenting complaint
* Examination findings
* Diagnosis/ differential diagnoses
* Diagnosis supported by History and Exam
* Investigations ordered
* Treatment
* Consent if applicable
* Follow up plan and advice given
* Referrals documented

The plan and follow-up details should be clear and are likely to be the most important sections within the “open notes” form.

**Documentation Principles:**

Notes must reflect respect for the patient and provide an objective description of the consultation and management plan.

* Use specific language and avoid vague words and generalisations
* Be complete with all significant information related to the patient condition and your care plan
* Be objective and respectful while avoiding terms that may be perceived as judgmental or critical
* Be timely in recording every patient contact
1. Be Specific

Use specific language and avoid vague words and generalisations. Do not speculate. The consultation notes should reflect factual information and be written using that factual information.

If speculating, for example if unsure of diagnosis, make that clear.

Avoid generalisations such as “patient doing well” or “patient uncooperative” when a more specific “patient declines to eat” would be more accurate

1. Be Complete

Make sure documentation is complete and contains all significant information related to an event, course of treatment, patient condition, response to care and deviation from standard treatment (including the reason(s) for it).

Make certain that everything specific to the consultation and course of treatment (physical, psychological and emotional status) is recorded.

Enter factual information about any unusual occurrence or adverse event.

When adverse events occur, it is important to objectively document disclosure to the patient.

Write the plan clearly, with actions for the doctor and for the patient clearly marked.

1. Be Objective

Describe signs and symptoms. By entering what can be seen, heard, touched and smelled, entries can be specific and objective. Use quotation marks when quoting the patient.

* Avoid terms that may be considered judgemental:

Use “declined” instead of “refused”

Use “adherence” instead of “compliance”

Use “BMI of 35” instead of fat/ overweight or obese

Use “untucked shirt” instead of “dishevelled”

* Avoid Extraneous remarks

Don’t criticise, argue, complain about another health professional’s care.

Don’t enter any significant event evidence or litigious information or confidential reports

1. Other

Remember all communications should be recorded but consider areas that shouldn’t be included as “open” notes (see Guidelines on restricting open notes).

Write notes on the day a patient is seen or as soon as possible

Take special care documenting patient plan especially self-care for necessary satisfactory outcomes. Record patient’s understanding of the plan. Document if other whanau or friends are informed about care and supervision of a patient

**Guidelines for restricting a note in “open notes”**

Under rule 6 of the Code, people in New Zealand have a right to access health information about themselves no matter where it is held. The individual’s right of access is subject only to some withholding grounds contained in the Privacy Act.

Exceptions may include:

* Psychotherapy notes
* Information complied in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding
* Research information that may compromise the research and for the duration of the research, provided the patient has agreed to the denial of access when consenting to take part in the research.
* If protected health information was obtained from someone other than a health care provider and the access requested would be likely to reveal the source of the information and the information would be deemed harmful to the patient or the source of the information.

**Reasons to withhold information**

 **The only reasons available to refuse a request from the patient for access to health information about herself or himself are contained in sections 27 to 29 of the Privacy Act**.

Some of the more common reasons are explained below:

**Information may be withheld if its release would be likely to prejudice the maintenance of the law – section 27(1)(c) “Would be likely” means there must be a distinct or significant possibility of the risk eventuating**.

 This withholding ground can be used to protect the identity of an informant who has contacted a health agency. For instance, a patient is concerned that his neighbour abuses her children. He does not wish to go to Child, Youth and Family but thinks something should be done. He tells his doctor and asks her to look into the matter and contact CYF if it seems appropriate. His identity could probably be withheld from the neighbour because if informant identities were routinely disclosed, people would be less likely to report suspected child abuse.

 **Information may be withheld if its disclosure would be likely to endanger the physical safety of any individual – section 27(1)(d) There must be a link between disclosure and endangering safety.**

Consider providing a summary which does not refer to that information or use the words likely to endanger a person’s safety.

 **Information may be withheld if disclosing it would be an unwarranted disclosure of someone else’s affairs – section** 29(1)(a) This requires a balance to be struck between the privacy interests of the requester and the other person. Consider whether the information about the other person can be separated. If it cannot, consider whether disclosure would be seriously intrusive. For instance, would its cause harm or embarrass the other person? Is the information sensitive? Was it given in confidence? Can you give a summary of the information without intruding on the other person’s privacy? For example, allegations could be released but information about the other person’s thoughts and feelings may be withheld.

**Appendix A**

**People have a right to ask for their health information to be corrected.**

The clinical record should be contemporaneous. Any attempt to retrospectively alter it will render it largely useless in terms of defending your actions in the event of a complication or adverse event. It is acceptable to add a retrospective note clarifying or correcting something that may be relevant, but it must be clear that this observation has been added after the event by signing and dating it. Indeed, if there is an adverse incident, it is a good idea to write a narrative account of the incident, again, signed and dated, while memories are fresh.

The practice does not have to make the correction, but must, if requested, take reasonable steps to attach a statement of the correction that the requester wants. The statement must be attached so that it will always be read with the disputed information. For example, where a patient disagrees with a diagnosis and wants it removed from the file, removing the disputed diagnosis could render the notes incomplete. The notes would not reflect the decision made at a particular time or the treatment which followed. Instead, agencies should offer to attach a statement of the correction the patient wants, to the disputed record. Even if the agency acknowledges that the original diagnosis was wrong it may need to be retained as an accurate record of the diagnosis made at the time with the later, correct, diagnosis noted at that place in the record. A reference to it could also be left on the file but with the details removed or sealed in an envelope so they are not as readily accessible. The requester must provide the statement of correction in his or her own words. However, agencies must provide reasonable assistance and it might be helpful if the agency prepares a draft statement, setting out the requester’s objections, for his or her approval. Agencies should take steps on their own initiative to correct information where necessary. If information has not been directly obtained from the individual concerned, it may be best to verify it with that person. If an agency suspects the information is not accurate, it must be checked before being used. When steps are taken to correct information or attach a statement, the agency must then take reasonable steps to inform everyone who has previously received the information. This could be by way of an email, a telephone call or a letter. The more significant the potential consequences of the information going uncorrected, the more important it is for the agency to let relevant people know about the correction.