SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Managing Chart Access Audits in Electronic Health Records
TYPE OF DOCUMENT	Procedure
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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director Clinical Governance and Medical Services
AUTHOR	SESLHD Health Records & Medico-Legal Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Co-Chairs, Health Records & Medico-Legal Committee
FUNCTIONAL GROUP(S)	Records Management – Health
KEY TERMS	Audit, proactive, reactive, Powerchart, chart access, privacy, confidentiality, eMR, Health Records, eMR, Medical Records
SUMMARY	This procedure provides a framework for managing access audits within electronic health records.

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1. POLICY STATEMENT

This procedure has been developed to comply with the NSW Health Privacy Manual for Health Information.

2. BACKGROUND

This procedure outlines the steps required to manage chart access audits within electronic health record systems. Specifically it aims to:

- Maintain a process for auditing all access to electronic health records in accordance with privacy requirements
- Identify irregularities in access to health information and outline actions for management and referral of such matters
- Foster awareness of the auditing process privacy requirements which will assist in preventing the improper access, misuse and/or disclosure of personal health information.

3. DEFINITIONS

Audit by patient: An audit run against an individual *patient* to check all persons who have accessed their electronic record within a specified time range

Audit by staff member: An audit run against an individual *staff member* to check all patient records that have been accessed within a specified time range

Chart: also known as "health record"

Client/patient: any person to whom a health care provider owes a duty of care in respect of provision of health care services

Confidentiality: the restriction of access to information, and the control of the use of release of personal information, in order to protect patient privacy

Electronic Health Record: Includes all electronic health record systems such as eMR Cerner, eMaternity, eRIC, MOSAIQ, ARIA or any other electronic medical record application/system.

Health Information:

(a) personal information that is information or an opinion about:

(i) the physical or mental health or a disability (at any time) of an individual, or

(ii) an individual's express wishes about the future provision of health services to him or her, or

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(iii) a health service provided, or to be provided, to an individual, or

(b) other personal information collected to provide, or in providing, a health service, or

(c) other personal information about an individual collected in connection with the donation, or intended donation, of an individual's body parts, organs or body substances, or

(d) other personal information that is genetic information about an individual arising from a health service provided to the individual in a form that is or could be predictive of the health (at any time) of the individual or of any sibling, relative or descendant of the individual, or

(e) healthcare identifiers, but does not include health information, or a class of health information or health information contained in a class of documents, that is prescribed as exempt health information for the purposes of the HRIP Act generally or for the purposes of specified provisions of the HRIP Act

Health Record: a documented account, whether in hard copy or electronic form, of a client/patient's health, illness, and treatment during each visit or stay at a public health organisation
Note: holds the same meaning as "health care record", "medical record", "clinical record", "clinical notes", "patient record", "patient notes", "patient file", etc.

HIM: Health Information Manager

HRAS: Human Resources Advisory Services

HRIP Act (HRIPA): Health Records and Information Privacy Act 2002 (NSW)

misuse of information: a staff member has knowingly and intentionally accessed, used and/ or disclosed information held by the health service for a purpose outside of, and unrelated to, their work duties. Such breaches of privacy may possibly constitute corrupt conduct.

MRM: Medical Record Manager

PCO: Privacy Contact Officer

Person of interest: A person or group of persons targeted for auditing because of the presence of increased privacy-related risk factors. May include, but not be limited to, the following:

- Celebrity / Famous person
- Politician
- News worthy person / person in the news
- Novelty injuries / "Interesting" conditions ' deceased under concerning circumstances (for example: sentinel events)

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- Staff members
- Staff members' family / partners
- Other patients/clients who have voiced concerns during their stay

In some of the above cases it may be up to staff to use their discretion as to who should be notified as a person of interest.

Proactive audit – random: An audit that is performed monthly by Health Information Managers, Mental Health and Community Clinical Information Coordinators, Drug and Alcohol Health Information Managers, ward/unit or emergency Nurse Unit Managers, and Medical Workforce Managers checking:

- 5 random patient charts (checking all persons who have accessed that electronic record) /and or 5 random staff (checking all electronic patient records that staff member has accessed).

Proactive audit – persons of interest: An audit that is initiated based on notification of person of interest presentation to a health service. The audit will be run to check all eMR account holders who have accessed the patient chart

Reactive audit: An audit that is initiated following a complaint/potential breach of confidentiality from a patient, authorised representative or staff member.

Settings: Health care or business settings which should be in scope of this audit procedure:

- Inpatient units/wards
- Emergency departments
- Mental health community
- Community health services
- Outpatient Clinics.

4. RESPONSIBILITIES

4.1. Health Information Managers/Medical Record Managers will:

- Perform reactive audits based on a complaint or notification
- Perform proactive audits based on presentation notification of a person of interest
- Perform proactive random audits on a monthly basis, the suggested volume is 5 patient charts and/ or 5 staff member audits for their department
- Submit the results of all audits to the SESLHD Health Records and Medicolegal Committee.
- Retain a copy of the audits and provide as requested for Accreditation purposes.
- Secure the paper health record if necessary
- Fill in details for persons of interest and complaint/notification audits within the Chart Access Audits Log on the SESLHD share drive
- Liaise with data managers for non-Cerner EHRs for system reports
- Escalate confirmed breaches to Human Resources and SESLHD PCO

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4.2. Data Managers for electronic health record (non-Cerner) systems will:

- Liaise with site HIMs/MRMs regarding person of interest or complaint audits. This includes:
  - Providing HIMs/MRMs reports/audits when required/requested
  - Escalating any complaints, persons of interest, or issues to site HIMs/MRMs for investigation
- Perform proactive random audits on monthly basis, the suggested volume is 5 patient charts and/ or 5 staff member audits
- Retain a copy of the audits and provide as requested for Accreditation purposes.

4.3. Mental Health Information Manager or delegate will:

- Notification of attendances by Persons of Interest or complaints/notifications to site HIMs/MRMs for audit initiation.
- Perform proactive random audits on monthly basis, the suggested volume is 5 patient charts and/ or 5 staff member audits across the District.
- Submit the results to SESLHD MHS Governance Committee's and SESLHD Health Records & Medico-Legal Committee.
- Retain a copy of the audits and provide as requested for Accreditation purposes.
- Securing the paper health record if necessary.

4.4. Drug and Alcohol Health Information Manager will:

- Perform reactive audits based on a complaint or notification
- Perform proactive audits based on presentation notification of a person of interest
- Perform proactive random audits on a monthly basis, the suggested volume is 5 patient charts and/ or 5 staff member audits for their department
- Submit results to Drug and Alcohol Governance Group and Community Health Outpatient Care (CHOC) Working Groups and the SESLHD Health Records and Medicolegal Committee
- Retain a copy of the audits and provide as requested for Accreditation purposes.
- Secure the paper health record if necessary
- Fill in details for persons of interest and complaint/notification audits within the Chart Access Audits Log on the SESLHD share drive
- Escalate any potential breaches to Human Resources and SESLHD PCO via the relevant line manager

4.5. Community Health Service Team Leaders will:

- Perform proactive random audits on monthly basis, the suggested volume is 5 patient charts and/or 5 staff member audits
- Feed results to Community Health Managers and Community Health Outpatient Care (CHOC) Working Groups and the SESLHD Health Records and Medicolegal Committee
- Where community health sits in a 3rd scheduled hospital refer results to the medical records department.
- Retain a copy of the audits and provide as requested for Accreditation purposes.
- Securing the paper health record if necessary

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- Notification of attendances by Persons of Interest or complaints/notifications to site HIMs/MRMs for audit initiation.

4.6. Nurse, Midwifery, Medical Workforce, Outpatient Clinic, and Allied Health Managers should:

- Perform proactive random audits on monthly basis, the suggested volume is 5 patient charts and/or 5 staff member audits
- Retain a copy of the audits and provide as requested for Accreditation purposes.
- Notification of attendances by Persons of Interest or complaints/notifications to site HIMs/MRMs for audit initiation

4.7. Health ICT

- Provide first level support and escalation to vendor.
- Refer any requests for privacy breaches / investigations to the SESLHD PCO or relevant site-based HIM/MRM.

4.8. Privacy Contact Officer

- Support the auditing process
- Advise on, refer or investigate matters as required
- Notification of attendances by Persons of Interest or complaints/notifications to site HIMs/MRMs for audit initiation
- Responsible for NSW Health or other external notifications, for example as per requirements of NSWHealth Information Sheet H17/50926-2 – Reporting Misuse of Information as Suspected Corrupt Conduct
- Decide whether full disclosure is appropriate/required for confirmed breaches of patient confidentiality and carry out as appropriate

4.9. Human Resources Advisory Services

- Provide site HIMs/MRMs information regarding employee employment information when required/requested
- Support site HIMs/MRMs, SESLHD PCO, and line managers in HRAS processes where required
- Manage confirmed breaches escalated by HIMs/MRMs in accordance with Managing Misconduct PD2018_031
- Report the outcomes of confirmed breaches to the site HIM/MRM and SESLHD privacy contact officer

5. PROCEDURE

This procedure is initiated:

- Upon patient complaint or identified potential breach of confidentiality
- For random patient chart audits or staff member audits
- When a breach of confidentiality has been identified
- Upon notification of attendance of a person of interest to a facility/service.

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5.1 Reactive Audits

- Notification of potential breach of privacy (e.g. complaint or concern) is received
- Health Information Manager (HIM) or Medical Record Manager (MRM) for relevant site is contacted
- HIM/MRM record details of the notification in local Chart Access Audits Log (Example in Appendix B)
- HIM/MRD runs the eMR Chart Access Audit against staff member or particular patient record (dependent upon nature of complaint)
- If a patient has been identified as presenting to departments/facilities/wards that utilize a non-Cerner electronic health record system, the relevant data manager/s should be contacted to run the same reactive audit report and provide the results.
- Audit report/s are analysed against particulars of complaint (see Appendix A for more information on analysing reports)
- If analysis identifies irregularities or possible breaches in access to health information the HIM/MRM:
    - updates details within the local Chart Access Audits Log
    - escalates the matter to the staff member's direct line manager (See Appendix C for sample notification)
- Staff member's direct line manager investigate potential breach in accordance with Managing Misconduct PD2018_031, ensuring appropriate documentation of investigation.
- Staff member's direct line manager informs HIM/MRM of outcome of investigation
- If breach is not confirmed:
    - HIM/MRM documents outcome in local register
- If breach is confirmed:
    - HIM/MRM logs an IMS+ and records reference number
    - Site HIM/MRM forwards investigation information, outcome, and IMS+ reference to site Human Resources Advisory Services (HRAS) and SESLHD PCO
    - HRAS will review investigation and outcome details and proceed with appropriate disciplinary action under Managing Misconduct PD2018_031
      Note: HRAS will liaise with other facilities/sites/District HRAS where required
      Note: Includes HRAS reviewing staff HR record for any previous/current related issues/breaches that should be considered
    - SESLHD PCO will review investigation and outcome with and make decisions as to whether:
        - Breach requires notification to NSW Health or other external body
        - Full disclosure of breach to patient is required/appropriate
    - HRAS and SESLHD PCO will inform HIM/MRM of general results/actions for documentation in local Chart Access Audit Log
      Note: Specifics not required – just general actions for reporting and training purposes
- Summary of de-identified audit results is provided as outlined in section 4 to the SESLHD Health Records and Medico-legal Working Group
- HIM/MRM provides feedback of investigation to the complainant/notifier where required/appropriate.

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Note: If the complainant/notifier is unhappy with the response, the opportunity to submit an internal review request for the SESLHD PCO must be offered

- HIM/MRM will re-run audit in 3 months and 6 months by following the above process

5.2 Proactive Audits (random)

Managers, HIMs, Data Managers, team leaders, and other disciplines outlined above should run random eMR Chart Access Audits on monthly basis for their relevant business unit:

  - Based on random patient charts and/or
  - Based on random staff members

- Audit report/s are analysed against particulars of audit (see Appendix A for more information on analysing reports)
- If analysis identifies irregularities or possible breaches in access to health information the staff member should escalate to the site HIM/MRM for further investigation
- Site HIM/MRM:
  - updates details within the local Chart Access Audits Log
  - escalates the matter to the staff member's direct line manager (See Appendix C for sample notification)
- Staff member's direct line manager investigate potential breach in accordance with Managing Misconduct PD2018_031, ensuring appropriate documentation of investigation.
- Staff member's direct line manager informs HIM/MRM of outcome of investigation
- If breach is not confirmed:
  - HIM/MRM documents outcome in local register
- If breach is confirmed:
  - HIM/MRM logs an IMS+ and records reference number
  - Site HIM/MRM forwards investigation information, outcome, and IMS+ reference to site Human Resources Advisory Services (HRAS) and SESLHD PCO
  - HRAS will review investigation and outcome details and proceed with appropriate disciplinary action under Managing Misconduct PD2018_031
    Note: HRAS will liaise with other facilities/sites/District HRAS where required
    Note: Includes HRAS reviewing staff HR record for any previous/current related issues/breaches that should be considered
  - SESLHD PCO will review investigation and outcome with and make decisions as to whether:
    - Breach requires notification to NSW Health or other external body
    - Full disclosure of breach to patient is required/appropriate
  - HRAS and SESLHD PCO will inform HIM/MRM of general results/actions for documentation in local Chart Access Audit Log
    Note: Specifics not required – just general actions for reporting and training purposes
- Summary of de-identified audit results is provided as outlined in section 4 to the SESLHD Health Records and Medico-legal Working Group
- HIM/MRM provides feedback of investigation to the complainant/notifier where required/appropriate.

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Note: If the complainant/notifier is unhappy with the response, the opportunity to submit an internal review request for the SESLHD PCO must be offered

- If breach is confirmed, HIM/MRM will re-run audit in 3 months and 6 months by following the above process

5.3 Proactive Audits (*Persons of Interest*)

- Notification of person of interest presentation may be made to site HIM/MRD manager by any member of staff. Notifications must include:
    - Name
    - MRN
    - Reason for Request
    - Time frame for audit if outside of current/most recent attendance
- HIM/MRD manager runs the eMR Chart Access Audit against staff member or particular patient record (dependent on nature of complaint)
- If patient has been identified as presenting to departments/facilities/wards that utilize their own electronic health record systems, the relevant data manager/s should be contacted to run the same reactive audit report and provide the results.
- Audit report/s are analysed against particulars of notification (see Appendix A for more information on analysing reports)
- If analysis identifies irregularities or possible breaches in access to health information the HIM/MRM:
    - updates details within the local Chart Access Audits Log
    - escalates the matter to the staff member's direct line manager (See Appendix C for sample notification)
- Staff member's direct line manager investigate potential breach in accordance with Managing Misconduct PD2018_031, ensuring appropriate documentation of investigation.
- Staff member's direct line manager informs HIM/MRM of outcome of investigation
- If breach is not confirmed:
    - HIM/MRM documents outcome in local register
- If breach is confirmed:
    - HIM/MRM logs an IMS+ and records reference number
    - Site HIM/MRM forwards investigation information, outcome, and IMS+ reference to site Human Resources Advisory Services (HRAS) and SESLHD PCO
    - HRAS will review investigation and outcome details and proceed with appropriate disciplinary action under Managing Misconduct PD2018_031
      Note: HRAS will liaise with other facilities/sites/District HRAS where required
      Note: Includes HRAS reviewing staff HR record for any previous/current related issues/breaches that should be considered
    - SESLHD PCO will review investigation and outcome with and make decisions as to whether:
        - Breach requires notification to NSW Health or other external body
        - Full disclosure of breach to patient is required/appropriate
    - HRAS and SESLHD PCO will inform HIM/MRM of general results/actions for documentation in local Chart Access Audit Log

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Note: Specifics not required – just general actions for reporting and training purposes

- Summary of de-identified audit results is provided as outlined in section 4 to the SESLHD Health Records and Medico-legal Working Group
- HIM/MRM provides feedback of investigation to the complainant/notifier where required/appropriate.
  Note: If the complainant/notifier is unhappy with the response, the opportunity to submit an internal review request for the SESLHD PCO must be offered
- HIM/MRM will re-run audit in 3 months and 6 months by following the above process

5.4 Miscellaneous electronic health records audits

Each electronic health record system may allow for varying levels of audit functionality. Possible further audits may include, but not be limited to audits of:

- Access by staff member to patient information with the same name
- Access to by staff member to an excessive number of patients' information
- Access to particular patient's information by an unusually large number of staff members

The general process for these audits should follow the most relevant of the above processes as closely as appropriate.

6 DOCUMENTATION

Audit documentation and Chart Access Audit Log should be kept at a site/unit level.

7 AUDIT

Not required as the procedure itself is an audit.

8 REFERENCES

- Health Records and Information Privacy Act 2002
- NSW Health Privacy Manual for Health Information (2015)
- eMR Chart Access Audit Quick Reference Guide (QRG)
- MoH Information Sheet – Reporting Misuse of Information as Suspected Corrupt Conduct H17/50926-2
- MoH PD2015_049 Code of Conduct
- The Independent Commission Against Corruption Act 1988 (NSW)
- MoH PD2016_029 Corrupt Conduct – Reporting to the Independent Commission Against Corruption (ICAC)
- MoH PD2018_031 Managing Misconduct

9 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
17/06/2015	0.1	Author: Lee Speir (initial draft)
07/10/2015	0.2	Author: Hayley Ryan (conversion to standard SESLHD procedure

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		format).
25/11/15	0.3	Reviewed and Approved: SESLHD Health Records and Medicolegal Working Group
September 2016	0.4	Draft for Comment
October 2016	0.5	Changes following Draft for Comment
November 2016	0.6	Tony Sara: Draft for Comment circulated to Directors of Clinical Services and Directors of Nursing
February 2017	0.7	Changes following Draft for Comment in November 2016 Reviewed and Approved: SESLHD Health Records and Medicolegal Working Group
July- August 2017	0.8	Changes following Draft for Comment in April and May 2017 Reviewed and Approved: SESLHD Health Records and Medicolegal Working Group
November 2017	0.9	Changes following initial DET review and further input by Internal Audit, PCO and Human Resources Advisory Services Reviewed and Accepted: SESLHD Health Records and Medicolegal Working Group
June 2020		Margaret Suda: Review as per recommendation from Executive.
September 2020	DRAFT	Major review - reviewed and endorsed by the Health Records & Medico Legal Committee
December 2020	1	Draft for comment period – changes incorporated and endorsed by Health Records & Medico-Legal Committee. Endorsed by Executive Sponsor. Processed by Executive Services prior to progression to Clinical and Quality Council.
February 2021	1	Approved by Clinical and Quality Council. Published by Executive Services.

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Appendix A: Tips for reviewing an access report

1) Manipulate the report in Excel so that every column can clearly be seen.
2) Add one columns for “Auditor Comments”
3) Review the report to confirm staff members’ involvement in care. This can be done by:
    a. Checking the “eMR Comment” column on the report (this displays the comments put in by staff members when accessing the eMR)
    b. Using XR Charting to produce a PDF for each relevant episode of care. Then using the “Find” tool, search for each staff members name
    c. Checking other electronic health record systems for docuemtnation
    d. Checking staff members area of employment against the Employee Information List provided by Human Resources Advisory Services
    e. Review JMO rosters
    f. Staff duty rosters
4) Highlight all staff members/patients that have been unable to be identified as being accessed as part of employment related duties

Appendix B:

Example of Received Audit Log for local sites.

Audit Number	Patient/Staff Member LAST NAME	Patient/Staff Member FIRST NAME	Facility	MRN	Source of Notification / Request	Date of Notification	Date of Audit	Audited dates	Audit Comments	Audit Submission Date	Submission/ Feedback Comments	Manager Completing Request	3 Month Follow up Audit	6 Month Follow up Audit
1														
2														
3														
4														
5														
6														

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Appendix C: Sample of email from HIM/MRM to line manager requesting investigation of potential privacy breach

Private and Confidential

Dear *<insert name of line manager>*

I am writing to you in relation to a potential privacy breach by one of your staff members. An audit conducted on <*date*> identified that staff member <name of *staff member*> accessed the patient information via electronic health record for <*patient name – MRN: MRN*> on the following dates/times:

<Insert list of dates/times of access by staff member>

As the staff members direct line manager, it is your responsibility to review and/or investigate whether this staff member had a legitimate work related reason for accessing this health record. All reviews and/or investigations must be managed in a confidential manner accordance with NSW Health Policy Directive *Managing Misconduct (PD2018_031).*

The results of your review/investigation must be reported back to me in a timely manner, after which:

- If the investigation confirms legitimate access to the health record, no further action will be taken or required
- If the investigation confirms a breach in access to patient information, the matter will be referred to the Human Resources Advisory Service for potential disciplinary action and the SESLHD Privacy Contact Officer for any required mandatory notifications.

If you require assistance or guidance in completing this process, please contact your Human Resources Advisory Service officer. If you have any further questions or issues, please contact me directly.

Yours sincerely

<insert signature block>

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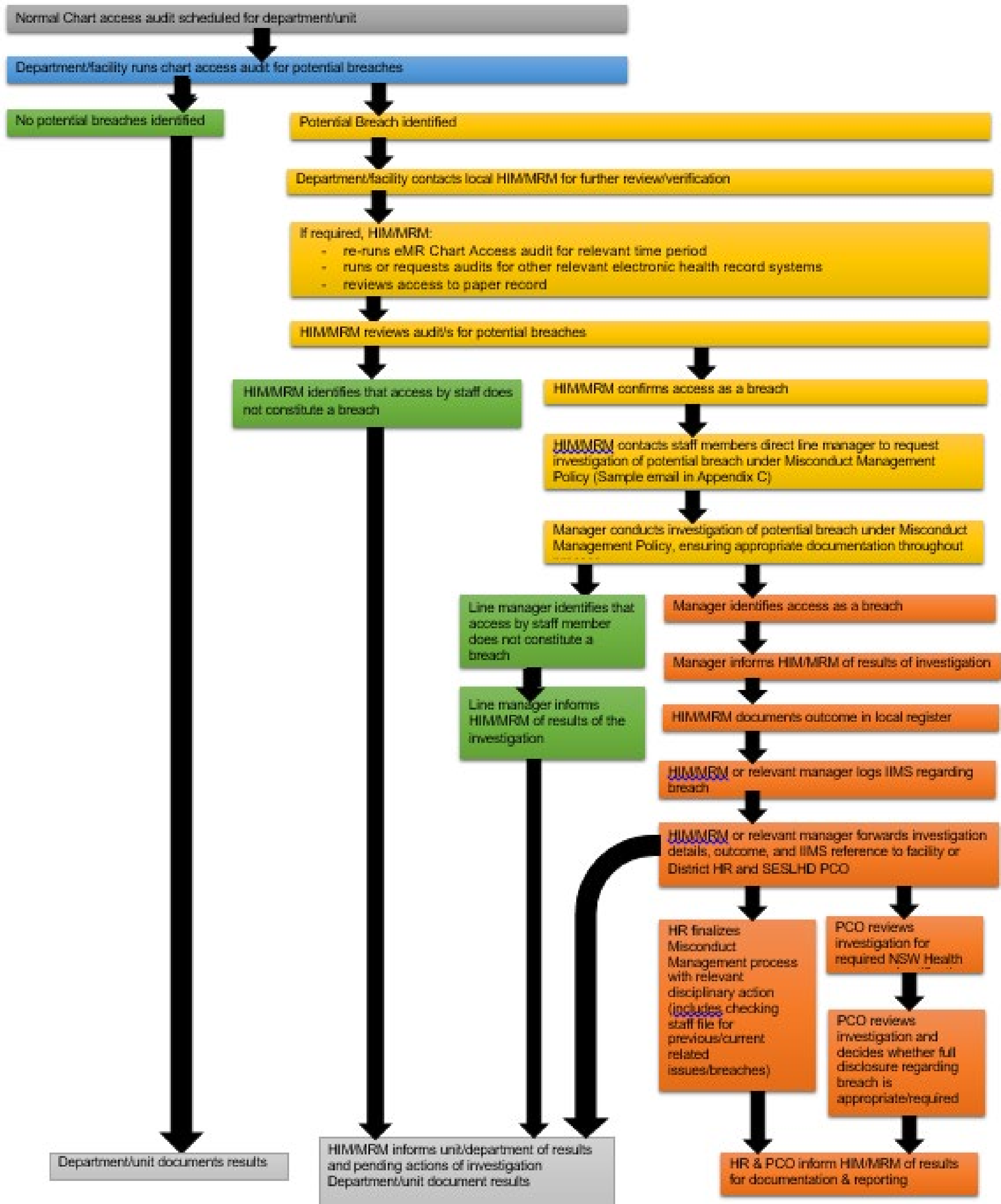
Appendix D: Flowchart



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