

INTERNAL ONLY
ISLHD PROCEDURE
COVER SHEET



Health
Illawarra Shoalhaven
Local Health District

NAME OF DOCUMENT	Procedure for Single Document Capture in eMR: Scanning and Importing (Non-Admitted)
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AUTHOR	Medical Records Manager
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SUMMARY	<p>To outline the approval process and procedure to follow when a ISLHD non-admitted unit/department intends to commence single document capture in eMR for the first time or when approved units/departments require additional single page documents to be captured.</p> <p>The scope of this procedure is limited to the capturing of single page documents that are:</p> <ul style="list-style-type: none">• to form part of the patient health care record• created by a non-admitted department/unit/facility within ISLHD

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to ISLHD-Policies@health.nsw.gov.au

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1. POLICY STATEMENT

ISLHD has identified the need to develop a consistent and clear approval process and procedure in order to ensure that single document capture into the eMR via scanning and importing is conducted in accordance with statutory requirements. The procedure supports local, district and state legislation and policy, whilst ensuring efficient and effective health record management.

Single document capture should not be used to scan/import:

- entire medical records or bulk documentation
- clinical forms not approved by either the State Management Forms Committee (SFMC) or the ISLHD Clinical Forms Committee

2. BACKGROUND

The aim of the procedure is to provide a framework to support the control of scanned/imported documents into the eMR, during the transition to a complete electronic health record. The procedure provides the Local Health District and governance with assurance that there are processes in place to protect information assets in line with policy. Single document capture provides clinicians with additional patient information available centrally, to support a complete patient record. It reduces the requirement to create and store paper records when small numbers of documents can be included as part of the electronic record.

The initial requirement for single document capture into the Cerner eMR resulted from the transition of Community Health migrating from CHIME to CHOC. The procedure applies to certain departments/units/facilities with a defined use for single document capture. These include:

- Community services including A&PHC, C&F, Aged Care, Palliative Care, Mental Health and Drug and Alcohol
- Health Information Unit
- Non-admitted departments/units

3. DEFINITIONS AND ABBREVIATIONS

eMR	Electronic Medical Record
SDC	Single Document Capture: the scanning or importing of singular documents into the electronic medical record against a predefined record type
CHOC	Community Health Outpatient Clinic
CHIME	Community Health Information Management Enterprise
SFMC	State Forms Management Committee

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4. RESPONSIBILITIES

4.1 Employees will:

- Adhere to this procedure by scanning/importing documents against the correct client, correct encounter and correct document type
- Complete/approve the electronic application form for Request for Single Document Capture in eMR
- Liaise with the nominated Data Custodian for all required data fixes
- Ensure quality assurance processes are undertaken prior to destruction of paper documents, once documents have been scanned/imported into the eMR Ref to 5.9
- Ensure destruction of scanned/imported paper documents by placing documents for destruction in confidential bins or shred and dispose.
- Adhere to the eMR quick reference guides: Single Document Capture (SDC): Scanning/Importing
- Adhere to the eMR quick reference guide: Single Document Capture (SDC): Troubleshooting and Data Fixes for Errors

4.2 Data Custodians will:

- Responsible for quality assurance and destruction processes for the department/service.
- Data fixes for errors

4.3 Service / Line Managers will:

- Oversee compliance to this procedure
- Approve the electronic application form for Request for Single Document Capture in eMR and attach copies of the proposed document required to be scanned/imported.

4.4 Area Advisor – Medical Records

- Receive, and process applications for single document capture
- Review forms included with the application and determine
 - Are they approved forms?
 - If not, are there approved forms available for use?
 - If not, advise the applicant of the process to submit forms to the ISLHD Forms Committee
- Approve application form for Request for Single Document Capture in eMR
- Notify Service Manager and Line Manager if approved/not approved.

4.5 ISLHD Forms Committee

- Review and approve/reject forms submitted for inclusion in eMR CHOC via single document capture

4.6 eMR Application Support Representative:

- Develop, update and maintain the relevant eMR quick reference guides

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4.7 CHOC/Super user Representative:

- Support all end users utilising single document capture via scanning/importing into the eMR

5. PROCEDURE

5.1 Approval Process

- Non-admitted departments or units required or intending to implement single document capture in eMR are required to seek approval from the Area Advisor – Medical Records
- Managers of the above departments or units are to complete the referenced application form and submit to the Area Advisor Medical Records in order to demonstrate that the required record management processes meet the statutory requirements as outlined in the NSW General Retention and Disposal Authority 45 (GA45).

5.2 Approved clinical forms

- Only internal clinical forms approved by the State Forms Management Committee (SFMC) or the ISLHD Clinical Forms Committee are eligible to be scanned/imported into the eMR (external documents are exempt)

5.3 Mapping against the event set hierarchy

- To ensure that scanned/imported documents are readily accessible, all scanned/imported documents must be assigned to a document type within the eMR event set hierarchy. Refer to intranet for listing of approved documents. Following roll-out all forms will be approved by the ISLHD Forms Committee and will be allocated a document type as part of this process.

5.4 Training

- Staff required to undertake the scanning/importing of documents must receive training from the eMR Training and Support Team prior to commencing.

5.5 Reporting of Errors and Data Fixes

- Notify Data Custodian upon identification of an error where an uploaded document was either scanned/imported against the incorrect patient, encounter or document type.
- Documents are to be located, printed (only need to be printed if the original document is not available) and flagged as an “in error document”. An in error comment is to be entered. Documents are to be re-scanned/imported where required against the correct patient, encounter or document type.

5.6 Approved Hardware/technical specifications

- Ensure compatible hardware is procured and use recommended settings to support network and performance stability whilst maintaining visual quality of images

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5.7 Storage/retention of scanned documents prior to destruction

- Scanned/imported documents are to be retained for a minimum of one month. Once scanned/imported documents have been audited to ensure they were successfully uploaded, they are to be boxed and labelled with the scanned date range. Documents must not be destroyed until a minimum of one month after they were scanned/imported.

5.8 Destruction of scanned documents

- The destruction of original or source records after copying is only permitted under GA45 where the following conditions are met:
 - *The records aren't classified as excluded records*
Excluded records are records subject to a legislative or Government policy requirement that the original record not be destroyed. Contact State Records for confirmation.
 - *The records are covered by an approved retention and disposal authority*
 - *Authentic, complete and accessible copies have been made*
Documents scanned or imported are to be quality checked at the time of uploading into the EMR to ensure that they are assigned to the correct patient, encounter and document type. Remedial action is to be taken to correct any incorrect posting of documents. Quality audits are also to be undertaken to ensure that images are of sufficient quality within the EMR and that each document has been uploaded.
 - *The copies become the official record of the business of the agency and are kept for the authorised minimum retention period*
 - *The original or source records are kept for quality control purposes for an appropriate length of time*
Refer to 5.9.
- Original clinical documents will be kept onsite for a minimum period of one month.
- Original documents which have been retained for a minimum of one month and audited to be scanned/imported successfully may be destroyed by being placed in the confidential bins or shredded and disposed of.

5.9 Quality assurance processes

- Complete quality checks are to be performed on all documents which have been scanned /imported at the time of uploading. A full audit is to be undertaken to ensure that the scanned/imported documents have been assigned against:
 - the correct patient
 - the correct encounter
 - the correct document type

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- Prior to boxing it is recommended that between 10% and 30 % of scanned /imported documents are audited to ensure the integrity of data.

6. DOCUMENTATION

- ISLHD OPS F 497 - New Request for Single Document Capture in eMR
- [eMR quick reference guide Single Document Capture \(SDC\): Scanning](#)
- [eMR quick reference guide Single Document Capture \(SDC\): Importing](#)
- [eMR quick reference guide Single Document Capture \(SDC\): Troubleshooting and Data Fixes for Errors](#)

7. AUDIT

- Ensure that all documents have been uploaded against the correct patient, encounter and document type (to ensure for accessibility)
- Verify that the copies are accurate, legible reproductions of the original or source record in its entirety
- Verify that all documents have been captured
- Ensure that only approved clinical forms are approved for scanning/importing into the eMR

8. REFERENCES

8.1 External references

- [State Records Authority of NSW GA 45: Original or source records that have been copied](#)
- **AS2828.1 Health Records Part 1: Paper- based health records**
- **AS2828.2 Health Records Part 2: Digitized (scanned) health record system requirements**
- [Ministry of Health PD2012_069 Health Care Records - Documentation and Management](#)

8.2 Internal references

- [ISLHD OPS F266 - Clinical form – Creation / Revision of](#)
- [EMR 3 QRG's](#)

9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
February 2017	0	Medical Records Manager Approved by ISLHD Clinical Forms Committee
March 2017	1	Appendix removed and published as separate document.