Queensland Health

Recording My Health Record information

Department of Health Standard

QH-IMP-396-2:2013

1. Statement

Complete and accurate health records are fundamental to the delivery of safe, high quality health care. This standard describes the mandatory steps for recording information from and/or filing My Health Record documents—if they are printed from The Viewer application, as well as for the preparation of clinical notes to capture relevant information from the My Health Record system.

A healthcare recipient controls the information an authorised user can access from their My Health Record. Authorised users need to be aware that healthcare recipients have constant access to their My Health Record, and may change the access controls, update information, or permanently delete the record at any time. When providing healthcare to a healthcare recipient, an authorised user shall extract the relevant information from the patient's My Health Record accessed from The Viewer, and file it as part of the organisation's local health record. An authorised user can do this by:

- printing and filing the relevant My Health Record documents in accordance with relevant Department of Health procedures
- printing and scanning the relevant My Health Record documents into the integrated electronic Medical Record (ieMR) or Department of Health applications
- preparing a clinical note summarising all relevant information in the healthcare recipient's My Health Record.

2. Scope

Compliance with this standard is mandatory.

This standard applies to all employees, contractors and consultants within the Department of Health divisions and business units.

This standard may be adopted by Hospital and Health Services (HHSs) and re-branded as a local HHS standard or used as a base for a local HHS specific standard.

This standard will be reviewed at least annually to ensure relevance and accuracy, particularly, where any new material or changed risks are identified and where changes in legislation or the structure of the organisation occur.

3. Requirements for retaining information for a healthcare recipient's My Health Record

3.1. While The Viewer (and other conformant applications) permit authorised users to view and print any My Health Record documents that contain health information about a registered My Health Record healthcare recipient,

authorised users must only print My Health Record documents from The Viewer if it is required by the duties of their role:

3.1.1. to support the delivery of the healthcare recipient's care

3.1.2. to explain why a particular treatment was provided

3.1.3. to ensure there is sufficient information to substantiate decisions in defence of possible medico-legal claims.

3.2. All printed My Health Record documents must clearly identify the My Health Record healthcare recipient's full legal name, date of birth, sex and healthcare recipient identifier for the organisation's local health record (i.e. Unit Record Number—URN). It is sufficient to attach a healthcare recipient's identification label on the printed My Health Record document. This identifying information must be visible on every page printed.[1] All printed/scanned My Health Record documents, including clinical notes, must be saved in the Department of Health System in accordance with relevant Queensland legislation and Australian standards.

3.3. Documents printed from the My Health Record system should be scanned and stored in the healthcare recipient's electronic record (ieMR or Department of Health application) or filed in the paper medical record, as appropriate.

3.4. Authorised users can also prepare a clinical note summarising all relevant information in the healthcare recipient's My Health Record and store it in the healthcare recipient's electronic record (ieMR or Department of Health application) or filed in the paper medical record, as appropriate.

3.5. A healthcare recipient's My Health Record information stored in Queensland Health systems can be accessed by the authorised users even if the healthcare recipient subsequently cancels their My Health Record and it is permanently deleted by the System Operator.

3.6. Once a healthcare recipient's My Health Record information, including clinical notes, have been printed and/or scanned, these become subject to legislative and regulatory requirements of the Department of Health, including privacy and confidentiality obligations, and the organisation's local health information management and retention policies.

3.7. Authorised users accessing My Health Record information must comply with this standard. Failure to do so may be a breach of the Code of conduct for the Queensland public service and may result in disciplinary action. Healthcare providers' legal obligations and responsibilities are summarised in Appendix 1.

[1] Australian Standard AS 2828.1-2012 Health records

4. Legislation

Relevant legislation and associated documentation include, but is not limited to, the following:

- *Healthcare Identifiers Act 2010* (Cth)
- Healthcare Identifiers Regulations 2010 (Cth)
- *My Health Records Act 2012* (Cth)
- My Health Records Regulation 2012 (Cth)
- My Health Records Rule 2016 (Cth)
- *Privacy Act 1988* (Cth)
- *Hospital and Health Boards Act 2011*
- *Human Rights Act 2019*
- *Information Privacy Act 2009*
- *Public Records Act 2002*
- *Right to Information Act 2009*
- Code of Conduct for the Queensland public service

5. Supporting documents

Supporting documents

- My Health Record system participation, Department of Health policy
- My Health Record system participation standard
- National Healthcare Identifiers Policy (under development)
- National Healthcare Identifiers Implementation Standard (under development)

Related documents

Department of Health

- Clinical Records Management Policy
- Corporate Records Management Policy
- Corporate Records Roles and Responsibilities Standard
- Creation of Corporate Records Standard
- Data Management Policy
- Digitisation Disposal of Corporate Records Standard
- Health Sector (Clinical Record) Retention and Disposal Schedule
- Information Security Standard
- Legislation compliance internal breach reporting Guideline
- Managing general legislation compliance Standard
- My Health Record Change of Consent Form
- Privacy Plan
- Use of Corporate Records Standard
- Use of ICT Services Policy

Health Service Directive

- Enterprise Architecture

- Enterprise Information, Communications and Technology (ICT) Governance

Queensland Government Customer and Digital Group

- Information Access and Use Policy (IS33)
- Information Security Policy (IS18:2018)
- Records Governance Policy

Other

- Australian Commission on Safety and Quality in Health Care – National Safety and Quality Health Service Standards
- Australian Curriculum Framework for Junior Doctors
- Australian Standard 2828.1-2012 Health Records – Paper-based health records
- Australian Standard 2828.2(INT)-2012 – Health records, Part 2: Digitized (scanned) health record system requirements
- Queensland Government General Retention and Disposal Schedule for Digital Source Records

6. Definitions

Term	Definition
Access flag	An information technology mechanism made available by the My Health Record System Operator to define access to a healthcare recipient's My Health Record. Source: My Health Records Rule 2016
Healthcare identifier	A number assigned by an authorised service operator that is used to uniquely identify a healthcare provider or a healthcare recipient. Source: Adapted from *Healthcare Identifiers Act 2010*
Healthcare Identifiers Service Operator	Chief Executive Medicare Source: *Healthcare Identifiers Act 2010*
Healthcare provider organisation	An entity or part of an entity that has conducted, conducts, or will conduct, an enterprise that provides healthcare (including healthcare provided free of charge). Source: *Healthcare Identifiers Act 2010*
Healthcare recipient	An individual who has received, receives, or may receive, healthcare. Source: *My Health Records Act 2012*
integrated electronic Medical Record (ieMR)	A secure statewide hospital computer system in Queensland that replaces paper based clinical records. It allows a patient's healthcare team to simultaneously document and access the patient's medical information in real-time. Source: Queensland Health factsheet
My Health Record system	A national public system for making health information about a healthcare recipient available for the purposes of providing healthcare to the recipient. Source: Adapted from *My Health Records Act 2012*

Term	Definition
My Health Record System Operator	Australian Digital Health Agency Source: My Health Records Regulation 2012
Network hierarchy	A network hierarchy operating in the My Health Record consists of one seed organisation and one or more network organisations. Source: Roles and responsibilities in the My Health Record system, My Health Record website
Network organisation	A subordinate organisation to the seed organisation that is linked to, and provides services to the seed organisation, and can be a separate legal entity from the seed organisation. Note: HHSs are network organisations within the Queensland Health system. Source: Adapted from *Healthcare Identifiers Act 2010*
Responsible Officer	A person with authority to act on behalf of a healthcare organisation with respect to the Healthcare Identifiers Service, as defined in the *Healthcare Identifiers Act 2010*. Source: *Healthcare Identifiers Act 2010*
Seed organisation	National healthcare systems (such as the Healthcare Identifiers Service and the My Health Record system) use this term to describe the principal organisation which provides or controls the delivery of healthcare services. Note: HHSs are network organisations within the Queensland Health system. Source Adapted from *Healthcare Identifiers Act 2010*:
The Viewer	Application that collates data from multiple Queensland Health systems, enabling healthcare professionals, including general practitioners, to access patients' information quickly, without having to log in to different systems. Note: general practitioners do not have access to the My Health Record via The Viewer. Source: Queensland Health factsheet

Version control

Version	Date	Comments
1.0	12 September 2013	New standard.
1.1	09 April 2015	Transferred information to new template and reviewed by the National eHealth and Information Coordination Unit (NeHICU).
2.0	17 May 2016	Updated to align with the *My Health Records Act 2012* and My Health Records Rule 2016 and a general review

Version	Date	Comments
2.1	06 September 2017	Transferred information to new template and updated to reflect change to System Operator and general review. Approved by the Architecture and Standards Committee.
3.0	07 August 2019	Updated to reflect legislative amendment, also includes edits and updates to supporting documents and definitions. Approved by the Architecture and Standards Committee
4.0	09 December 2020	Standard transferred to a new template. Following minor updates made: Title: Standard renamed to comply with the instructions in the template Scope: 'annually to ensure relevance and accuracy, particularly where any new material or changed risks are identified and where changes in legislation or the structure of the organisation occur'. Edits and updates to supporting documents and definitions. Approved by Architecture and Standards Committee.
4.1	09 December 2021	Supporting documents updated and minor editorial changes. Approved by Architecture and Standards Committee.
4.2	01 Februsary 2023	Appendix 1 Responsible Officer updated to Deputy director-General, eHealth Queensland. Approved Architecture and Standards Committee. Approved to publish Deputy direcor-General, eHealth Queensland.

Appendix 1 – Legal Obligations and Responsibilities

Misuse of a person's health information is a serious legal matter. The potential for damage (whether personal damage to an individual or reputational damage to a healthcare provider organisation) is significant and this is reflected in current professional and legal obligations on persons such as healthcare providers to protect patient information.

The *My Health Records Act 2012:*

- Stipulates that the My Health Record system is a system for making health information about a healthcare recipient available for the sole purposes of providing healthcare to the recipient. It is also stipulated that the My Health System Operator must be notified of an actual or potential data breach of healthcare recipient's health information in the My Health Record system. Department of Health staff with access to the My Health Record should be aware of their personal responsibilities. Using a person's My Health Record for a prohibited purpose may result in significant civil fines and/or criminal penalties of up to five years' jail time for the individual responsible for the breach.
- Permits Department of Health to retain health information where it has been originally downloaded from the My Health Record system, i.e. stored in Queensland Health systems, and to continue to use this information if it can be obtained other than by means of the My Health Record system. Staff can download/print the relevant information from the patient's My Health Record or prepare a clinical note summarising relevant health information from the My Health Record to be stored in Queensland Health systems. Staff should capture all information from the My Health Record system required to provide healthcare to the patient, and to explain why particular treatment was provided (even if the healthcare recipient's My Health Record is subsequently deleted).

Several obligations have been incorporated into the My Health Records Rule 2016 including:

- ensuring that any record uploaded is accurate, up-to-date and not defamatory or misleading
- notifying the My Health Record System Operator of non-clinical, My Health Record system-related errors, in records that have been accessed via, or downloaded from, the My Health Record system
- providing assistance to the My Health Record System Operator in relation to inquiries or investigations.

Position	Responsibility	Audit criteria
Deputy Director-General, eHealth Queensland–Responsible Officer (RO)	Is authorised to act on behalf of the Department of Health—seed organisation and the HHSs—network organisations—in dealing with the My Health Records System Operator. Communicate the My Health Records policy to all its employees and healthcare provider organisations.	

Position	Responsibility	Audit criteria
	Provide a copy of the My Health Records policy to the System Operator if requested within seven days of receiving the request.	
Organisation Maintenance Officer (OMO)	Officers at eHealth Queensland will be the OMOs for the Department of Health. Responsible for maintaining information about the Department of Health within the Healthcare Identifiers Service as defined in the *Healthcare Identifiers Act 2010*; required for accessing the My Health Records system. Establish and maintain with the Service Operator accurate and up-to-date record of the linkages between the organisations within the network hierarchy. Coordinate OMO activities with HHSs (network organisations). Review and adjust access flags as required.	Department of Health records maintained in the Healthcare Identifiers Service
System Operator	Responsible for the operation of the My Health Record system, including: • establish and maintain an index service, for the purposes of the My Health Record system • establish and maintain access control mechanisms • operate a National Repositories Service that stores key records that form part of a registered healthcare recipient's My Health Record.	