RACGP

Healthy Profession.
Healthy Australia.

RACGP *STANDARDS FOR GENERAL PRACTICES* (4TH EDITION) FACT SHEET

RACGP DEFINITION OF AN "ACTIVE HYBRID MEDICAL RECORD SYSTEM"

Answer

Where patient information in a practice is actively entered into a paper based system by one or more GPs in a clinic and into electronic files by one or more GPs in a clinic, this is considered to be an active hybrid medical record system.

Rationale

Indicator B of Criterion 1.7.1 of the RACGP *Standards for General* Practices (4th edition) states that:

"Where our practice has an active hybrid medical record system, for each consultation/interaction, our practice can demonstrate that there is a record made in each system indicating where the clinical notes are recorded".

In addition, the explanatory notes for this Criterion state that:

"There are potential risks associated with hybrid patient health record systems, where some information is recorded on a computer (eg. medicines list) and some information on paper notes (eg. past medical history). When the patient notes are stored in two areas it is possible for important issues to be overlooked, particularly if another doctor sees the patient. To make this less of a problem, a note in each system improves the continuity of these hybrid systems.

If health information about a patient is kept in two sites (as in the case of hybrid records or records held in a residential aged care facility), practices need to ensure all the information is available and accessible when needed.

In the interests of risk management, the RACGP recommends that practices with hybrid patient health record systems work toward the electronic recording of at least allergies and medications."

The intention of this Criterion is to ensure that where an active hybrid medical record system is in place – that is, where patient information in a practice is actively entered into a paper based system by one or more GPs in a clinic and into electronic files by one or more GPs in a clinic - that any GP who sees this patient, including a locum, is aware of this and knows to look at both systems in order to access all relevant information as required.

To ensure this occurs, it is not the case that entries need to be duplicated in both systems. A clearly visible note in both the electronic and paper files stating that the practice uses a hybrid medical record system and that information in both files should be considered is sufficient to meet Criterion 1.7.1 Indicator B.

In summary:

- Where patient information in a practice is actively entered into a paper based system by one or more GPs in a clinic and into electronic files by one or more GPs in a clinic, **this is considered** to be an active hybrid medical record system.
- Where a practice has moved to an electronic system of recording patient information, including consultation notes, but retains the past patient information and consultation notes in their original

paper files, **this is not considered** to be an active hybrid medical record system and Criterion 1.7.1 Indicator B does not apply. In this instance, the past patient records are referenced only at exceptional times, such as when a report is required, they are not being used actively and in an ongoing manner.

- Where a practice has transferred all information previously contained in their paper files into their electronic files, through manual data entry and/or scanning relevant documents, then **this is not considered** an active hybrid medical record system and Criterion 1.7.1 Indicator B does not apply.