HEALTH RECORD MANAGEMENT AND RETENTION POLICY

RATIONALE

To provide direction on medical records and health information retention and disposal. To ensure records are accessible to those authorised and maintain confidentiality of information. Documentation of the Nursing interventions provided to students with chronic disease who need more complex care and management at SBS is crucial for efficient disease management and collaboration with all of the student's team members.

PURPOSE

This policy is aimed at keeping significant medical records for each child indicating medical conditions, allergies, immunization records, emergency contacts, etc. It is also to set out a period wherein these documents are to be kept in school ensuring full confidentiality.

AIMS

To ensure good quality record keeping & management is maintained and an effective cohesive procedure is followed by all users of this document. The overall purpose is to ensure accuracy of documentation and storage to minimise risk.

SCOPE

The policy applies to all staff.

PROCEDURE

Student Medical Records

- A legible, complete, comprehensive, and accurate student medical record must be maintained for each STUDENT.
- A record should include a recent history, physical examination, any pertinent progress notes, laboratory reports, imaging reports as well as communication with other student/ patient personnel.
- Records should highlight allergies and untoward drug reactions.
- Records should be organized in a consistent manner that facilitates continuity of care.
- Discussions with student/patients concerning the necessity, appropriateness of treatment, as well as discussion of treatment alternatives, should be incorporated into a patient's medical record as well as documentation of executed informed consent.
- The school health doctor or when designated, the nurse shall be responsible for the complete, cumulative school health record for each student.
- The record shall be stored in an appropriately secured location with convenient access.
- Whenever a student transfers to another school at any Grade/Year, a copy of the complete, cumulative school health record shall be transferred at the same time to the health personnel of the school to which the student is transferring or handed to the parent, as appropriate.
- The health record shall be maintained by the school for a minimum of five (5) years after the student turns eighteen (18) years of age or five (5) years after the student leaves the school.
- Only under the following specific circumstances may certain health information in the student medical records be released by the School Nurse or the school administration to school personnel or other parties:

1. To Ambulatory Health Services (AHS) health centers in the case of a referral or a temporary transfer for specific treatment or diagnostic procedures or in an emergency situation.
2. To consented school staff involved in the student's Individualized Healthcare Plan.
3. In situations of threat to public health where a failure to disclose information maexpose the student or others to risks of death or serious harm.
4. In case of formal investigations by court order.

- All other situations or requests to release health information from students' medical records must be reviewed and approved on a case-by-case basis by the school health team.
- Health records shall include information regarding but not limited to:
  - ✓ Health history, including chronic conditions and treatment plan.
  - ✓ Screening results and necessary follow-up.
  - ✓ Immunisation records
  - ✓ Health examination reports
  - ✓ Documentation of traumatic injuries and episodes of sudden illness referred for emergency health care.
  - ✓ Accident/Incident forms involving that child
- For a student with documented anaphylaxis, the parental authorization of a student's treatment for allergies and the physician's order to administer an epinephrine auto-injector shall be entered into the student's health record.
- Documentation of the health care provider's orders, if any, and parental permission to administer medication or medical treatment to be given in school by the school nurse.
- Documentation of any nursing assessments completed.
- Documentation of any consultations with school personnel, students, parents, or health care providers related to a student's health problem(s), recommendations made, and any known results.

Reporting and Data Collection Requirements

- Reporting should be structured in a manner to encourage a free flow of information between the School clinic and HRD.
- School clinic shall submit data consistent with standards set by the DHA.
- HRD shall monitor clinical performance indicators regularly.

Implementation Date: September 2019

Review Date: September 2020

Reviewed by: _____

May Ann Angeles, DHA-RN
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Approved By: _____

Zara Harrington
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