Aim Statement
Within six months 100% of outpatient Psychology and Social Work documentation meets best practice standards.

Background to problem worth solving
The majority of Psychology and Social Work (Psy/SW) counselling notes are integrated into the general eMR and may therefore be accessed by other treating clinicians in future episodes of care within the broader health service. Some information within these notes may be deemed by patients to be highly ‘sensitive’. Professional Codes of Conduct for Psy/SW specify confidentiality and informed consent in record keeping and usage. No specific guidelines currently exist to assist staff in how best to negotiate the new world of sensitive patient information. Professional Codes of Conduct for Psy/SW should be deemed by patients to be highly ‘sensitive’. Professional Codes of Conduct for Psychologists and Social Workers specify confidentiality and informed consent in record keeping and usage. No existing policies, principles and standards exist to assist clinicians to deal with this clinical information in the most appropriate manner, consistent with Privacy Principles and NSW Health Policies and, being mindful of professional registration standards, community and patient expectations.

Driver Diagram

The Problem:
Psychology/Social Work documentation of sensitive client information in eMR is highly variable and does not meet anyone’s best practice standards.

Aim: Within 6 months 100% of outpatient Psy/SW documentation meets best practice standards.

Outcome Measure: 100% of outpatient Psy/SW documentation meets best practice standards.

Primary Drivers

- Improve knowledge of impact of client, director & organisation
- Process Measure: Education Package Developed
  By when: Jun 2017

Secondary Drivers

- Improve understanding of return of sensitive personal information
- Process Measure: Best Practice Guideline Developed
  By when: Jun 2017

- Improve understanding of Psychology Code of Ethics
- Process Measure: Best Practice Guideline Developed
  By when: Jun 2017

- Ensure patient’s return understanding of eMR policies
- Process Measure: Best Practice Guideline Developed
  By when: Jun 2017

Priority Solutions

- Develop guidelines
  - Impact: High
  - Implementation: Easy
- Develop education packages with eMIS
  - Impact: High
  - Implementation: Hard
- Develop guidelines – reflective best practice
  - Impact: High
  - Implementation: Hard
- Develop a visual guide and fact sheet
  - Impact: High
  - Implementation: Hard
- Develop informed consent form
  - Impact: High
  - Implementation: Hard

Solutions

- Develop guidelines and policies
- Develop education packages with eMIS
- Contribute to eMIS training package
- Education to NSW Directors of Allied Health
- Develop a visual guide and fact sheet
- Develop informed consent form
- Use Patient Information Pocket (HIP) system
- Develop guidelines – reflective best practice
- Collate summary existing guidelines
- Education and implementation package
- Guidelines for storage of other information
- Generate guidelines for GUI & eMR note
- Generate clear guidelines for using consent
- Develop a visual guide and fact sheet
- Generate clear guidelines for using eMR notes
- Ensure sensitive patient information is appropriately processed
- Ensure appropriate information is accessible to treating clinicians
- Ensure eMR systems handle sensitive information
- Implement eMR systems for handling sensitive information

Secondary Drivers

- Ensure eMR systems handle sensitive information
- Process Measure: Best Practice Guideline Developed
  By when: Jun 2017

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Process measures

- Consumer Package developed – By Aug 2017
- Best Practice Guideline developed – By Jun 2017
- Education Package Developed – By Jun 2017
- Standardised e-solutions developed – By Jun 2018

Discussion

Counselling notes can at times contain information that the patient deems as highly sensitive. It is important within NSW Health that procedures, policies and guidelines exist to assist clinicians to deal with this clinical information in the most appropriate manner, consistent with Privacy Principles and NSW Health Policies and, being mindful of professional registration standards, community and patient expectations.

Results

- The project commenced with the ambition to raise the standards of clinical documentation in Psychology and Social Work outpatient counselling services. A particular aim was to establish and meet best practice standards for the documentation and use of sensitive patient information.
- A review of current policies, guidelines and professional standards indicated that a gap exists in providing clear best practice standards for clinicians to follow.

Clinician Practices

- A clinician survey indicated that current documentation practices vary broadly. Although NSW Health policy specifies a single contemporary medical record for documentation, 52.8% of the clinicians surveyed (Psychologists and Social Workers; N=350) reported that they use supplementary files. Reasons given included storage of working notes, case formulations, detailed histories, restricted access psychometric test materials, patient notes etc.
- 54.2% of clinicians surveyed reported that they were unaware of any specific policies or guidelines regarding documentation of sensitive patient information in medical records.

Overall Outcome of Project

- Collated and summarised a large amount of material from existing policies, principles and standards, bringing a better understanding of a complex topic.
- Increased awareness of the extent of variation in practices of documentation.
- Clinician input indicated a gap in guidance provided.
- Consumers surveyed showed a limited understanding of current eMR processes.
- Consumers preferences did not fully align with current eMR processes.