**Marker Guide 12**

Maintain Patient Records

BSBMED303



First Edition, April 2023

Copyright ownership: Australian Institute of Professional Counsellors Pty Ltd

ACN 077 738 035

This book is copyright protected under the Berne Convention.

All rights reserved. No reproduction without permission.

Australian Institute of Professional Counsellors

Head Office

47 Baxter St., Fortitude Valley, QLD 4006.

This book is protected by copyright and may not be reproduced or copied either in part or in whole nor used for financial gain without the express approval in writing of the owner (Australian Institute of Professional Counsellors Pty Ltd (ACN 077 738 035) of the copyright.

SHORT RESPONSE QUESTIONS

Section 1

Introduction To Maintaining Patient Records

Introduction to Patient Records

1.1 Outline three (3) pieces of information that are usually included in a patient record. (Your response should be approximately 45 words)

|  |
| --- |
| Student’s response **must** demonstrate an understanding the different types of information that are included in a patient record.  Responses may include, but are not limited to:   * Personal information - patient’s name, address, date of birth, contact information. * Medical history - patient’s past and current medical conditions, including allergy information. * Clinical notes and assessments - patient’s symptoms, diagnosis, treatment plans, pathology test results. * Medication records - medications prescribed to the patient. * Consent forms and legal documents - consent forms signed for specific medical procedures and any legal documents such as advanced care directives. |

Legislation and Standards of Practice

1.2 Provide an outline of the *Privacy Act 1988*, and how it is relevant to maintaining patient records. (Your response should be approximately 75 words)

|  |
| --- |
| Student’s response must demonstrate an understanding of the *Privacy Act 1988*.  Example response below:   * Regulates how information is handled in Australia * Specifically, how private sector organisations, including health services, can use, collect, store, and disclose personal information related to the patient’s health * Health services are also responsible to maintain patient records such that the information included is accurate and most updated. * Patients also have a right to know how their information is collected and used, as well as the right to access their health information |

1.3 Identify the three (3) states and/or territories that have privacy laws that apply to the private health sector. Then, identify the name of each privacy law.

|  |  |
| --- | --- |
| Student’s response must demonstrate an understanding of the privacy laws. | |
| **State/Territory** | **Privacy Laws** |
| 1. New South Wales | * Privacy and Personal Information Protection Act 1998 (NSW) * Health Records and Information Privacy Act 2002 (NSW) |
| 1. Victoria | * Privacy and Data Protection Act 2014 (Vic) * Health Records Act 2001 (Vic) |
| 1. Australian Captial Territory | * Information Privacy Act 2014 (ACT) |

1.4 The Australian Privacy Principles are principles-based law which consists of 13 principles that cover your obligations when handling patient information.

Identify the 13 principles. (Your response should be approximately 75 words)

|  |
| --- |
| Student’s response **must** demonstrate an understanding of the 13 principles in the Australian Privacy Principles.  Responses may include, but are not limited to:   1. Open and transparent management of personal information 2. Anonymity and pseudonumity 3. Collection of solicited personal information 4. Dealing with unsolicited personal information 5. Notification of the collection of personal information 6. Use or disclosure of personal information 7. Direct marketing 8. Cross-border disclosure of personal information 9. Adoption, use or disclosure of government related identifiers 10. Quality of personal information 11. Security of personal information 12. Access to personal information 13. Correction of personal information |

Integrating your knowledge

Read the case scenario below about Dominic. Imagine you are in Dominic’s position and answer the following questions.

1.5 Dominic recently started a new role as a medical assistant in the local medical centre that provides a wide range of medical services for the local community. His team consists of four health administrative staff: Matthew, Yowanda, Dominic, and their supervisor, Jenny. Dominic did not have any experience working in a healthcare setting, hence did not have any prior knowledge about handling patient information and maintaining patient records.

During Dominic’s first day, Jenny introduced Dominic to the team and briefly ran through his roles and responsibilities as a medical assistant, which included the following:

* Answering patient queries through phone calls and emails
* Ordering medical supplies and equipments
* Managing bills and insurance claims
* Maintaining patient records using the centre’s electronic health record system

However, after explaining the first three responsibilities, Jenny had a family emergency and quickly went through the last responsibility with Dominic before leaving for the day. Yowanda, who has been working for the centre for 14 years, was rostered to work on the same shift as Dominic.

a) Dominic wanted to summarise his responsibilities as a medical assistant but struggled to clearly understand his responsibilities with regards to maintaining patient records. Outline what Dominic should do to determine his role and responsibilities and explain why. (Your response should be approximately 60 words)

|  |
| --- |
| Student must demonstrate the ability to determine their role and responsibilities.  Example response:  Dominic should approach his team members, Yowanda, and clarify with her about his role and responsibilities as a medical assistant when it comes to handling patient information. This is because Yowanda has extensive work experience with the medical centre and will be able to provide more information to help Dominic determine his role and responsibilities.  This question requires students to apply knowledge gained throughout this section of the Study Guide. |

b) The next day, Jenny apologised for the sudden departure but continued to explain the procedures of how to maintain patient records with Dominic. She explained that they used paper forms for patients to fill in their information and Dominic is required to fill in the information collected in the relevant fields on the electronic health record system.

Later in the day, Dominic was filling in a new patient’s details but did not know where to input the patient’s allergy information. He remembered Jenny briefly mentioned it and he could not find the relevant procedure in the centre’s record management manual.

Outline what Dominic should say when he approaches Jenny. (Your response should be approximately 60 words)

|  |
| --- |
| Students must demonstrate the ability to access documented procedures for patient recordkeeping system.  Example response:  “Hi Jenny, thanks for explaining the procedures to me earlier on. I’m trying to fill in this new patient’s allergy information but I could not seem to find where I could enter this information. I’ve checked the manual but there is no relevant information inside. Could you please show me how to do it? Thanks!”  This question requires students to apply knowledge gained throughout this section of the Study Guide. |

1.6 Read the case scenario below about Clara, a new medical receptionist at Bayside Allied Health Services. Then, answer the following questions.

Clara is a medical receptionist that just commenced her new role at Bayside Allied Health Services. On her first day, she only received minimal induction and training by her supervisor, Leslie. Leslie instructed Clara to read through the practice’s policy and procedure manual to figure out her role and responsibilities as a medical receptionist. She is also required to complete a worksheet after reading the manual. Clara found the following relevant to her role as a medical receptionist:

* Greeting patients and visitors with a friendly and warm attitude
* Handling and answering patient queries over emails and phone calls
* Collecting patient information and enter it into the patient record system
* Process payments and handle insurance claims
* Ordering supplies for the practice
* Maintain patient record and archive records of inactive patients

1. Based on the roles above listed in the centre’s manual, determine the role(s) that are relevant to Clara with regards to handling patient records. (Your response should be approximately 20 words)

|  |
| --- |
| Students must demonstrate the ability to determine roles and responsibilities within the recordkeeping system.  Example response:   * Maintain patient record and archive records of inactive patients * Collecting patient information and enter it into the patient record system   This question requires students to apply knowledge gained throughout this section of the Study Guide. |

1. When Clara was reading the policy manual, she noticed that “patient records procedure manual” was mentioned frequently. She thought that this procedure manual is crucial for her to carry out her role and responsibilities effectively. However, she did not remember Leslie providing her with this procedure manual.

Outline what Clara should say to Leslie so she can read the manual to understand her responsibilities better. (Your response should be approximately 70 words)

|  |
| --- |
| Students must demonstrate the ability to determine roles and responsibilities within the recordkeeping system.  Example response:  “Hi Leslie, I was reading through the centre’s policy manual and noticed there’s a procedure manual about patient record keeping that keeps getting mentioned. Is there any chance that you have a copy of this manual or do you know how I could get access to this procedure manual? I’d love to understand how the patient record keeping system is at the centre so I could carry out my role efficiently, and not interrupt the current workflow!”  This question requires students to apply knowledge gained throughout this section of the Study Guide. |

1. After Clara reviewed the practice manual, she is unclear of how to update a patient’s contact details. She can only find information on how to create a new patient record in the manual but not updating a current patient’s record. Outline what Clara should say to Leslie to help her better understand this procedure. (Your response should be approximately 55 words)

|  |
| --- |
| Students must demonstrate the ability to seek clarification regard patient recordkeeping procedure.  Example response:  “Hi Leslie, I read through the practice manual but I have something I’d like to clarify with you. I can’t seem to understand how I could update a patient’s contact details in the system, the manual only shows me how to create a new patient record. Could you show me how to do it? Thanks!”  This question requires students to apply knowledge gained throughout this section of the Study Guide. |

Section 2

Accessing Patient Records

Accessing patient records to facilitate patient visit

2.1 Answer the following questions about clinical coding system.

a) Provide a brief outline of *ICD-10-AM*, including its full name and purpose. (Your response should be approximately 40 words)

|  |
| --- |
| Students must demonstrate an understanding of the clinical coding system.  Example response:  The full name is The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification and it is a clinical coding system that is most commonly used in Australia. It is a manual that has a classification of diseases based on the World Health Organisation International Statistical Classification of Diseases and Related Health Problems (ICD-10). It helps healthcare professionals across different fields to understand medical terminologies and concepts by using standardised codes. |

b) Explain how an allied health assistant can make use of the coding system. (Your response should be approximately 40 words)

|  |
| --- |
| Students must demonstrate an understanding of the clinical coding system.  Example response:  While allied health assistants are not expected nor responsible for coding patient records, it can help them to retrieve patient records faster. Further, it can help to minimise and reduce human error when entering a patient’s health information into the patient’s records. |

Creating New Patient Records

2.2 Summarise how you can create a new patient record. (Your response should be approximately 80 words)

|  |
| --- |
| Students must identify the key steps of creating a new patient record.  Responses may include, but are not limited to, reference to:   * Collect patient information via a physical form, including information such as their name, contact details, date of birth, and medical history. * Enter the information collected into the practice’s record management system by creating a new patient profile. * Review and check if the information is entered in the correct fields and check against the physical form for any error. * Assign any relevant unique patient tag or ID on the record management system to help facilitate retrieving their record in the future. |

Integrating your knowledge

2.3 Refer to question 1.5 to answer the following questions.

Around 10am, Dominic received a phone call from Brett, who wants to see his general practitioner, Dr. Stacey, regarding his medical condition. Brett informs Dominic that he’s available throughout the day today and tomorrow and has been told by Dr. Stacey to see her again after his blood test two weeks ago. Dominic then asked to verify Brett’s information before scheduling an appointment tomorrow at 3pm with Dr. Stacey. The practice has a protocol whereby all patient appointments need to be confirmed the day before. Dominic is also expected to check if there are any follow-up instructions to action after each patient’s visit. The practice also requires staff to store patient records in a locked cabinet that is located behind the reception desk. They also ask that staff make sure the reception area is only accessible to those who are authorised, and to ensure that patient records cannot be viewed by other patients attending the centre.

a) Outline two (2) actions Dominic should take to help facilitate Brett’s visit. (Your response should be approximately 40 words)

|  |
| --- |
| Students must demonstrate the ability to check Brett’s record to facilitate his visit.  Student responses may include:   * Confirm Brett’s appointment for 3pm the next day with him * Access Brett’s patient record to obtain his blood test results so that Dr. Stacey can access it prior to Brett’s visit to have a more efficient workflow. |

b) At 2.45pm the next day, Brett arrived at the centre for his appointment. According to the practice’s policy, when patients arrive for their appointment, staff need to verify their information. Specifically, the policy requires you to check that the patient’s contact details are accurate and up to date. Below is Brett’s information saved on the record management system:

* + - Patient name: Brett Hills
    - D.O.B.: 17 September 1963
    - Gender: Male
    - Address: 87 Convale Avenue, Herston, QLD, 4006
    - Phone number: 0495683840

Briefly outline what Dominic should say to Brett when he arrives at the centre. (Your response should be approximately 40 words)

|  |
| --- |
| Students must demonstrate the ability to check patient details against their record.  Student responses may include:  “Good afternoon, Brett and thanks for coming in today! Can I just double check some information to see if it's current? Is your phone number still the one ending 840? And you’re still living at Convale Avenue?” |

c) After Brett’s appointment with Dr. Stacey, Dominic looked at Brett’s patient record to update it on the system. The following extract was from Brett’s record:

*“Brett mentioned he has chest pain, which is a new symptom. His blood pressure was higher than previous visits and may need to review his high blood pressure medications in three months’ time. Meanwhile, Brett will get another blood test that tests for more items, which we will organise the referral for him. Brett also requested a referral letter to see a new psychologist.”*

According to Dr Stacey’s note, identify any instruction(s) that requires Dominic to follow up. (Your response should be approximately 30 words)

|  |
| --- |
| Students must demonstrate the ability to follow instructions by the practitioner following Brett’s visit.  Example response:  Dominic needs to organise a referral letter to request a blood pathology test for Brett, as well as organise a referral letter for Brett to see a psychologist. |

d) Earlier on, when Dominic was checking with Brett about his details, he realised Brett had changed his phone number and home address. Dominic passed a change of details form for Brett to fill in, which he then updated Brett’s physical patient record accordingly.

Outline two (2) things Dominic has to take into consideration when storing Brett’s patient record. (Your response should be approximately 30 words)

|  |
| --- |
| Students must demonstrate the ability to store patient record approrpiately.  Student responses may include:   * Ensure the file cabinet is locked after he keeps Brett’s patient record * Ensure that nobody is in the reception area except for authorised staff * Ensure that nobody saw the information in Brett’s patient record when Dominic was updating it. |

2.4 Refer to Question 1.6 to answer the following questions.

Yesterday afternoon, Clara received an appointment request with Dr. Aviral, the practice’s general practitioner. When Clara checked the patient record system, she could not find any relevant patient record so she needed to create a new patient record for Jane. According to the centre’s policy, new patients will be instructed to fill in their details using an iPad, which the receptionist will then transfer the details on to the centre’s electronic record management system. The centre also has a patient ID tagging system whereby patients aged 25 years and above are labelled “yellow”, while those aged under 25 years are tagged with “white”.

The extract below shows some information that Jane filled in on the iPad:

*Title: Mrs*

*First name: Jane Last name: White*

*Preferred name: Jane Gender: Female*

*Contact email:* [*janewhite31@gmail.com*](mailto:janewhite13@gmail.com) *Mobile number: 0428485853*

*D.O.B.: 31 March 1986*

*Address: 7, Holland Street, Capalaba, QLD, 4157*

*Preferred contact method: Text through mobile phone*

During the appointment, Jane also mentioned to Dr. Aviral that she has a severe allergy towards cashews and almonds. She is also currently on low blood pressure medication.

1. Fill in Jane’s detail in the correct fields using the template below.

|  |  |
| --- | --- |
| Students must demonstrate the ability to create new patient record. | |
| First name: Jane | Last name: White |
| Birth date: 31 March 1986 | Title: Mrs |
| Email: janewhite31@gmail.com | Mobile: 0428485853 |
| Address: 7, Holland Street, Capalaba, QLD, 4157 | Preferred contact: Mobile phone |
| Allergy information: severe nut allergy, cashews and almonds | Current medications: low blood pressure medication |
| Patient ID tag: yellow | |

1. After Clara has finished creating a new patient record for Jane, she needs to make sure that the privacy and confidentiality of Jane’s information is protected.

Outline two (2) actions Clara can take to ensure Jane’s electronic information is stored in a safe and secured manner. (Your response should be approximately 30 words)

|  |
| --- |
| Students must demonstrate the ability to store patient records appropriately.  Responses may include, but are not limited to, reference to:   * Make sure the form on the iPad is reset and cleared of Jane’s information before passing it to the next client to fill in their details * Ensure that the data is backed up on the practice’s drive to prevent data loss * Ensure that Jane’s information is encrypted and only authorised persons have access to it. |

Section 3

Maintaining Patient Records And Monitoring Own Role

Integrating your knowledge

3.1 Refer to questions 1.5 and 2.3 to answer the following questions.

According to the centre’s protocol, Dominic’s responsibilities include making the required checks of patients records to ensure patient privacy is protected. Dominic needs to make sure that the file cabinet is locked during closing, and that every week or so, he has to make sure that patient data is backed up correctly and is encrypted. Further, every month, the administrative team has to come into the practice on a Sunday to archive patient records that are inactive. 

1. Based on the centre’s protocol, outline the required checks that Dominic has to conduct. (Your response should be approximately 30 words)

|  |
| --- |
| Students must demonstrate the ability to check patient records appropriately.  Responses may include, but are not limited to, reference to:  i. Daily: make sure the file cabinet containing patient records is locked during closing  ii. Weekly: check that patient data is backed up correctly and the information is encrypted  iii. Monthly: archiving patient records that are inactive |

According to the centre’s policy, a patient record is considered inactive when it meets one of the criteria below:

* + - 2 years since the last data entry
    - 2 years since the patient last visited the centre
    - Death of a patient

Archived patient records are stored off-site at a nearby secured storage area, and the administrative staff has to document the archival process in the centre’s archival register.

1. Outline the steps that Dominic needs to take to archive patient records. (Your response should be approximately 45 words)

|  |
| --- |
| Students must demonstrate the ability to archive patient records appropriately.  Responses may include, but are not limited to, reference to:   * Check whether a patient record fits the criteria to be archived * Compile the relevant documents and files of the patient and tie them together. * Move the patient record to the storage area * Fill in the archival register for accountability purposes. |

1. During Brett’s follow-up appointment, Dr. Stacey suggested to Brett he should start seeing a nephrologist to help with his kidney issues. After Brett found a suitable nephrologist, they put in a request to access Brett’s patient record at Dominic’s centre.

Outline the steps Dominic should take to ensure that Brett’s record is transferred in a safe and secured manner. (Your response should be approximately 100 words)

|  |
| --- |
| Students must demonstrate the ability to transfer patient records appropriately.  Responses may include, but are not limited to, reference to:   * Verify Brett has provided written consent for the nephrologist to access his patient record * Check with Dr. Stacey about the relevant information to be released to the nephrologist * Conduct the transfer in a safe and secure manner such as making sure the information is encrypted before sending it * Document the transfer details, including who the record was transferred to, when the transfer was done, and what information was transferred. * Inform Brett that the transfer has been done. * Verify with the nephrologist that the correct patient record has been transferred. |

1. During Dominic’s weekly practice reflection, he notices when he is the only one around the reception area, he sometimes forgets to lock the computer screen.  He thinks that a quick two-minute toilet break is nothing and can cause no harm or compromise a patient's privacy.

Evaluate whether Dominic’s work practice can be improved. Then, provide a suggestion to help improve his work practice. (Your response should be approximately 70 words)

|  |
| --- |
| Students must demonstrate the ability to reflect on own work practice and improve accordingly.  Responses may include, but are not limited to, reference to:   * Dominic seems to have some room for improvements with regards to his work practices about patient privacy. * Dominic should lock his computer with a strong password when he intends to step away from his desk to avoid unauthorised access to patient records. * Dominic can put up a sticky note on his desk to remind himself of this action, so that he does not compromise the patient's privacy. |

3.2 Refer to questions 1.6 and 2.4 to answer the following questions.

Clara was informed by Leslie that the centre conducts a centre-wide archival process every six months, and the next one is happening in three weeks’ time. According to the Bayside Allied Health Services’ policy, a patient record is considered inactive when it meets one of the criteria below:

* + - 3 years since the last data entry, including phone calls or test results
    - 3 years since the patient last visited the centre
    - Death of a patient

When Clara was archiving patient records, she came across the following patient records:

* + Mrs Penny Jameson - last data entry of her x-ray results 40 months ago
  + Mr Clement Tan - last visited the centre 24 months ago
  + Miss Selina Williams - last visited the centre 38 months ago
  + Mr Keith Smith - last visited the centre 40 months ago
  + Mrs Julie Smith - passed away 2 months ago

a) According to the Bayside Allied Health Services’ record archival protocol, determine the patient record(s) that Clara needs to archive.

|  |
| --- |
| Students must demonstrate the ability to archive patient record appropriately.  Responses may include, but are not limited to, reference to:   * Mrs Penny Jameson * Miss Selina Williams * Mr Keith Smith * Mrs Julie Smith |

b) Other than the archival process, part of Clara’s role is to conduct weekly checks on the record management system that the centre uses and the drive that patient information is stored.

Outline two (2) actions Clara should take during her required checks, such that she ensures the patient’s privacy is protected. (Your response should be approximately 30 words)

|  |
| --- |
| Students must demonstrate the ability to check patient records appropriately.  Responses may include, but are not limited to, reference to:   * Ensure that patient records are backed up correctly in a secured location * Ensure that patient records are saved in a password-protected drive and the information are encrypted |

1. One of the centre’s patients, Katie Kim, moved interstate recently, and would like to transfer their patient record to their new medical centre in another state electronically. According to the centre’s protocol, Clara is authorised to conduct the transfer, but must first seek approval from Leslie.

Outline the steps Clara should take to ensure that Katie’s record is transferred in a safe and secured manner. (Your response should be approximately 100 words)

|  |
| --- |
| Students must demonstrate the ability to transfer patient record appropriately.  Responses may include, but are not limited to, reference to:   * Verify Katie has provided written consent for the new medical centre to access their patient record * Check with Leslie and seek for their approval for the transfer request * Conduct the transfer in a safe and secure manner such as making sure the information is encrypted before sending it * Document the transfer details, including who the record was transferred to, when the transfer was done, and what information was transferred. * Inform Katie and Leslie that the transfer has been done. * Verify with the new medical centre that the correct patient record has been transferred. |

1. One of the key pieces of information that was transferred to the new medical practice was Katie’s diagnosis, which was recorded using a clinical coding system. Briefly outline how this clinical coding system can benefit Katie’s new medical team. (Your response should be approximately 30 words)

|  |
| --- |
| Students must demonstrate the ability to explain how coding system can help maintain patient records.  Responses may include, but are not limited to, reference to:   * Universal across all Australia and health care professions * Can be understood easily by other health professionals * Efficient process for new practitioner to learn about the patient’s condition |

1. When Clara was reviewing her responsibilities when doing patient record keeping, she notices that the password used to access the backup drive is “Password123”, and that everyone working at the centre has access to this password and uses the same login details.

Determine one (1) area of the centre’s procedure regarding the patient recordkeeping system that can be improved. (Your response should be approximately 10 words)

|  |
| --- |
| Students must demonstrate the ability to reflect on own work practice and improve accordingly.  Responses may include, but are not limited to, reference to:   * The password is too short and simple for everyone to guess * The password should not be made known to all the staff   This question requires students to apply knowledge gained throughout this section of the Study Guide. |

1. Based on the identified issue above, provide one (1) suggestion that you could recommend to Leslie to improve the current recordkeeping system procedure. (Your response should be approximately 30 words)

|  |
| --- |
| Students must demonstrate the ability to reflect on own work practice and improve accordingly. Note that student’s response must be logical and relevant to the area of improvement identified in question 3.2e.  Responses may include, but are not limited to, reference to:   * Set up a longer and more complicated password using a combination of symbols and alphanumeric characters to prevent someone to guess it easily * Set up individual login details to keep track of who accessed the drive, and only authorised staff can access the drive to retrieve patient records.   This question requires students to apply knowledge gained throughout this section of the Study Guide. |

3.3 Read the case scenario about Jared and answer the following questions.

Jared is a medical receptionist who just started his new role at Hillsville Medical Centre. During his first day, his supervisor, Eloise, explained to him how to access patient records and maintain the records using the centre’s practice manual. Upon reading the practice manual, Jared finds it confusing as to how long a patient record should be archived before disposed of. A section of the manual indicated that a patient’s record should be kept for at least ten years, while another section of the manual explains the procedure to dispose a patient’s record after archiving it for seven years.

a) Outline what Jared should say to Eloise to clarify the archival procedure. (Your response should be approximately 70 words)

|  |
| --- |
| Students must demonstrate the ability to seek clarification regard patient recordkeeping procedure.  Example response:  “Hi Eloise, I read through the practice manual but I have something I’d like to clarify with you. I can’t seem to understand how long should wait till we dispose of a patient record. One section of the manual says at least ten years while another section indicates seven years. Could you clarify this for me so I do not make a mistake and dispose of a record when I shouldn’t?”  This question requires students to apply knowledge gained throughout this section of the Study Guide. |

b) On 25 May, Jared received a phone call from a patient, Maria, who wants to double check her next appointment time and whether there are any tests to be done prior to the appointment. After verifying Maria’s identity, Jared accessed her record and found the following note left by her GP, Dr. Truman:

“*Maria is due for a blood test and urine test by 10 June and she needs to schedule an appointment at least a week after for her results*.”

Outline what Jared should reply Maria to help facilitate her visit. Hint: Jared should also offer to schedule an appointment for Maria. (Your response should be approximately 70 words)

|  |
| --- |
| Students must demonstrate the ability to access patient record to facilitate patient visit.  Example response:  “Hi Maria, thank you for your patience! I can see here that Dr. Truman left a note saying you are due for a blood test and a urine test by 10th of June. You also need to schedule an appointment at least a week after that for that you can discuss your test results with Dr. Truman. Would you like me to schedule an appointment for you then?”  This question requires students to apply knowledge gained throughout this section of the Study Guide. |

c) According to the centre’s protocol, Jared must check with patients who visit the centre regarding the accuracy and currency of their contact details, specifically their mobile number and home address. Below is Maria’s information saved on the record management system:

* + - Patient name: Maria Santiago
    - D.O.B.: 3 March 1997
    - Gender: Female
    - Address: 388 Orchid Boulevard, Mount Victoria, NSW, 2786
    - Phone number: 0485677422

Outline what Jared should say to Maria when she presented herself at the centre for her appointment to check her patient details. (Your response should be approximately 40 words)

|  |
| --- |
| Students must demonstrate the ability to check patient details against their record.  Student responses may include:  “Hi Maria, thanks for coming in today! Can I just double check some information to see if it's current? Is your phone number still the one ending 422? And you’re still living at Orchid Boulevard?” |

d) After Maria’s appointment with Dr. Truman, Jared looked at Maria’s patient record to update it on the system. The following extract was from her record:

*“Discussed Maria’s blood and urine test result with her. She is presenting with anaemic symptoms and require further blood test in two months’ time to monitor her iron level. She would like a reminder for this test. Maria also mentioned she is sleepless at night and would like a referral to see a sleep specialist for insurance purposes.”*

According to Dr Truman’s note, identify any instruction(s) that requires Jared to follow up. (Your response should be approximately 45 words)

|  |
| --- |
| Students must demonstrate the ability to follow instructions by the practitioner following Maria’s visit.  Example response:  Jared needs to organise a blood test request for Maria to test for her iron level, and schedule a reminder for Maria to get her blood test in two months’ time. Jared also needs to organise a referral for Maria to see a sleep specialist. |

1. Recently, Jared notices that he has trouble finding physical copies of patient records, especially when he is filling patient’s test results. He realises the centre does not have a filing system. He also notices all patient records are kept in an unlocked cabinet at the centre’s hallway that is accessible to anyone.

Provide two (2) suggestions that you could recommend to Eloise to improve the current recordkeeping system procedure. (Your response should be approximately 30 words)

|  |
| --- |
| Students must demonstrate the ability to reflect on own work practice and improve accordingly..  Responses may include, but are not limited to, reference to:   * Implementing a barcode system or tagging system to file the patient records. * File the patient records according to their last name/family name to make the recordkeeping system more efficient. * Move the cabinet into a secured area that is only accessible to authorised staff * Lock the file cabinet with a secured lock and only authorised staff can access the key to the lock.   This question requires students to apply knowledge gained throughout this section of the Study Guide. |