



interRAI Home Care (HC) & Long Term Care Facility (LTCF) record;

Access & transfer model for the National interRAI platform

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interRAI New Zealand

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1 Introduction

The following paper describes a model for the access and transfer of interRAI assessment records for the New Zealand National interRAI home care (HC) and long term residential care (LTRC) programme. This builds upon current practice and will inform practice as other interRAI tools are introduced.

This model describes the process as it applies to individual client level records, not aggregated data.

The interRAI health record is the primary document of clinical assessment and care planning information created by DHB care co-ordination centres and long term residential care facilities and as such has clinical and medico-legal significance for health service providers and their clients. The model outlines the way these organisations will share access to this record.

In basic terms, interRAI assessments created via the national system are linked to an entity (office) and are related to programmes of care e.g. home care, long term residential care.

This leads to the need to determine access and transfer rights across these entities to support continuity of clinical care¹, reduce clinical risk and maintain clinical quality during transitions of care and to ensure compliance with the health information privacy act.²

The model is based on the expanded potential for the national interRAI platform as a whole, i.e. covering home care, residential care and other modules such as acute care. It also takes into account the increasing move to more blended models of care where a 'service provider/facility' may provide a facility base for the delivery of a range of non acute community provided services. These services may cover care domains such as; home care, post acute care, palliative care, supported living and residential care.

The model provides a minimum guideline for organisations to follow. This does not preclude organisations from entering into relevant local agreements to further embed closer working and continuity of clinical care. In fact closer collaboration at the local model of care is encouraged.

This document should be read in conjunction with:

The latest version of the National interRAI Software Service Information Governance Model. This is available from Andrew Downes the National interRAI Software Service Manager email Andrew.Downes@Healthshare.co.nz

The latest version of the interNASC transfer process available from NASCA

¹ This 'facility/dhb office of care' approach may change as use of the national platform develops

² Rule 5 – Storage and security of health information, Rule 6 – Access to personal health information

2 Principles of access and transfer

The following principles of access and transfer exist;

- 1) Clients are at higher risk during transitions of care. Therefore transitions need to be managed so that information is made available in a timely way to clinical staff so that they can perform their function and to administrative staff that support clinical processes.
- 2) The need to have the record available for clinical care overrules administrative process.
- 3) Clinical staff require access to client level clinical information at the point of care when they need it in order to complete the relevant tasks they need to and to contribute to the record appropriately; *"the right information for the right person at the right time"*.
- 4) The access model will align with relevant New Zealand privacy legislation and will not reduce an individual's obligation under New Zealand privacy legislation and associated professional codes of conduct and organisational policies.

3 Givens

The following givens apply to the development of access control for the national platform;

- 1) Section 22B and 22F of the Health Act defines Health Information and describes the obligation to share Health Information.
- 2) The client record on the national system is deemed to be Health Information.
- 3) All staff, regardless of the organisation they work for, are subject to the NZ privacy legislation and will sign an appropriate access agreement prior to being given access to the national interRAI platform.
- 4) Privacy and confidentiality are the most important aspects of building patient trust. Access audit is a function of entities using the national platform and entities are obliged to perform this function to monitor access to records for people currently in their care. Any concerns raised by the audit process will be fed back to the appropriate line manager/ organisation and managed accordingly.
- 5) During transitions of care the electronic record must always be under 'control' of designated people. There will be no 'fire and forget' situations. Communication between designated people is required to confirm transfers are completed and the record is available for access by the appropriate service provider.

- 6) In the context of access and transfer, 'data' is client level assessment and care planning data at the individual client record not aggregated clinical or business data.
- 7) 'Blended' models of care cross historic boundaries between services and providers, clinician access to clinical data remains paramount and the local clinical team³ is best placed to determine appropriate access based on the local model of care.
- 8) Local organisational policies regarding the collection, use and disclosure of client level data will be in place to ensure individuals rights for both explicit and implied consent for its use is protected.
- 9) To protect the business interests of residential care facilities, individual aged residential care staff cannot access the office of another aged residential care facility on the national system unless an agreement exists between the managers of those facilities/organisations.
- 10) As per the current transfer policy, if in doubt an escalation process exists to the National interRAI Software Service Manager.

4 Scope

For clarity, the scope of information associated with this access and transfer model is the active clinical record that is stored in the national interRAI system for use in the day to day care of the assessed person. Aggregated data in the data warehouse is not in scope.

5 Access and transfer model

The model for the national platform will be structured as follows:

- 1) DHB clinical staff can access records in aged residential care facility 'offices' that are within the local DHB geographic region. The DHB is best to determine which staff this applies to as this could be restricted to those staff for which this is relevant. As a courtesy measure this should be communicated/agreed with the local facility managers.
- 2) Aged residential care staff can access records in the DHB 'office'; again this could be restricted to relevant staff and communicated/agreed with the DHB.
- 3) The system clinician role has access to all DHBs per host site but only LTC facilities local to their own DHB unless agreements are in place. (Note that these roles do cover for each other from time to time and so a level of access is required from time to time).

³ This refers to any key clinical stakeholder group across the local model of care, ie including a residential care clinical nurse manager, a GP or a clinical rehabilitation team

- 4) Where available, local admin/clerical staff are best placed to manage DHB <> residential care facility transfers within the local DHB geographic area. This should become part of the normal administrative process currently associated with these sorts of transfers. If available and by agreement, residential care admin/clerical can support this process too.
- 5) Inter DHB transfers are managed by system clinician staff and onward transfers to local facilities managed by accordingly e.g. admin/clerical staff.
- 6) Host to host transfers have to be managed by the IT service desks. The 'pushing' DHB should initiate the transfer request in conjunction with their system clinician.
- 7) As per current policy, prior to transfer the clinical record must be clinically reviewed to ensure the record is as up to date and as accurate as possible.
- 8) When transferring a client between offices clinicians should liaise as appropriate⁴ with each other to ensure that records are transferred in an appropriate state, at a minimum;
 - a. Assessments signed off where this is possible⁵
 - b. Care Plans are up to date and 'active'
 - i. This refers only to those organisations that use the care planning module on the national system.
 - ii. The module is only used for detailing care focuses generated by an assessment and does not relate to specific in house policy/process/intellectual property that may belong to any ARC facility.
 - iii. Organisations will be advised at engagement to the project that if organisations choose to use the care planning function in the national system then the care plan will be transferred as part of the single clinical record for the client and to support clinical transfer of care.
 - iv. Any other care plans/relevant clinical information associated with the client that exists in other electronic systems or paper systems used by any organisation are out of scope
 - c. Forms and other notes are signed off
 - d. The case is 'closed' via the case activity tab (home care) or discharged via the ADT tab (residential care) and notes written on that tab (in the comments section) regarding the transfer i.e. who requested the transfer and the name of the person receiving the record if known
- 9) Communication between organisations for transfer requests should be cognisant of local policies and procedures as they relate to the Privacy Act and the Health Information Privacy Code and should aim to protect Health Information.

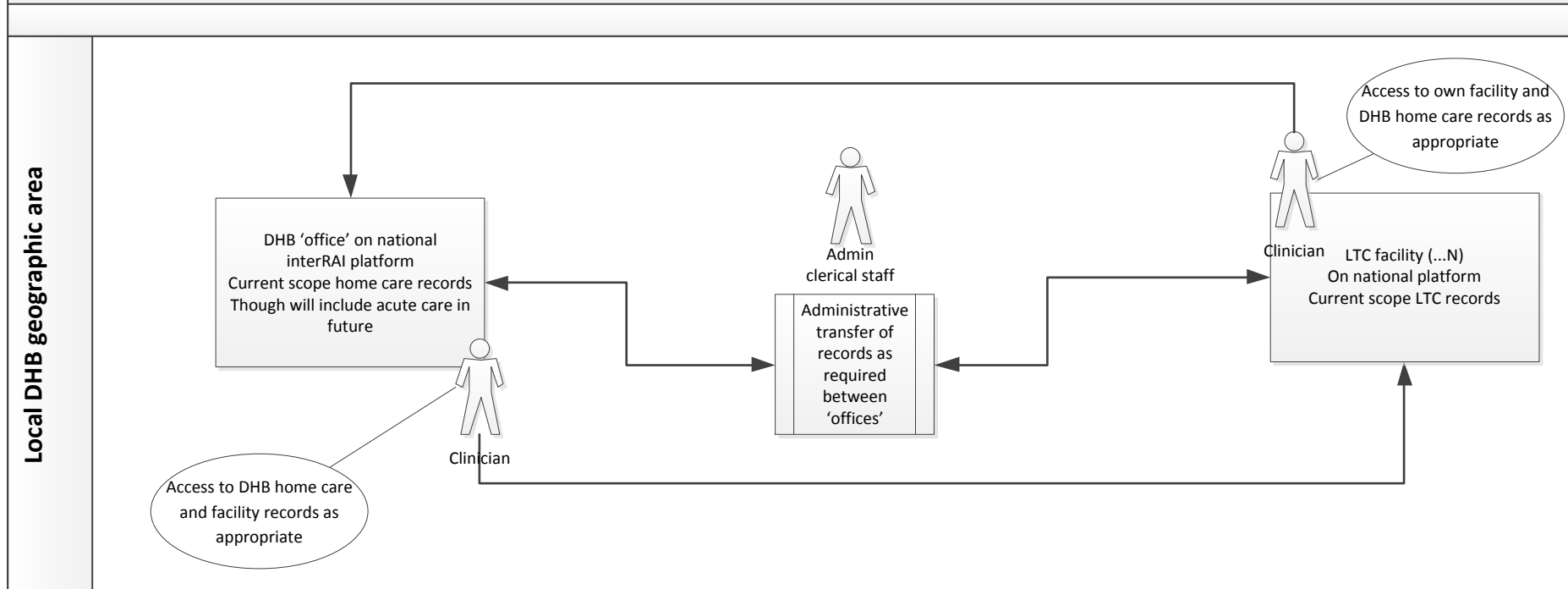
⁴ It is acknowledged that in some cases the transfer of records needs to occur quickly to allow assessments to occur. In this case the transferring system clinician will make all reasonable efforts to ensure that the record is transferred in an appropriate state, this may include a review of the record post transfer.

⁵ It may not be possible to sign off historic assessments where the original assessor has since changed employment

Access and transfer model – high level

Clinical staff have access to the client record where ever client is – local areas can agree extent of access ie all clinical staff or some

Local DHB area transfers managed by local DHB admin/clerical staff and potentially facility admin/clerical staff if available

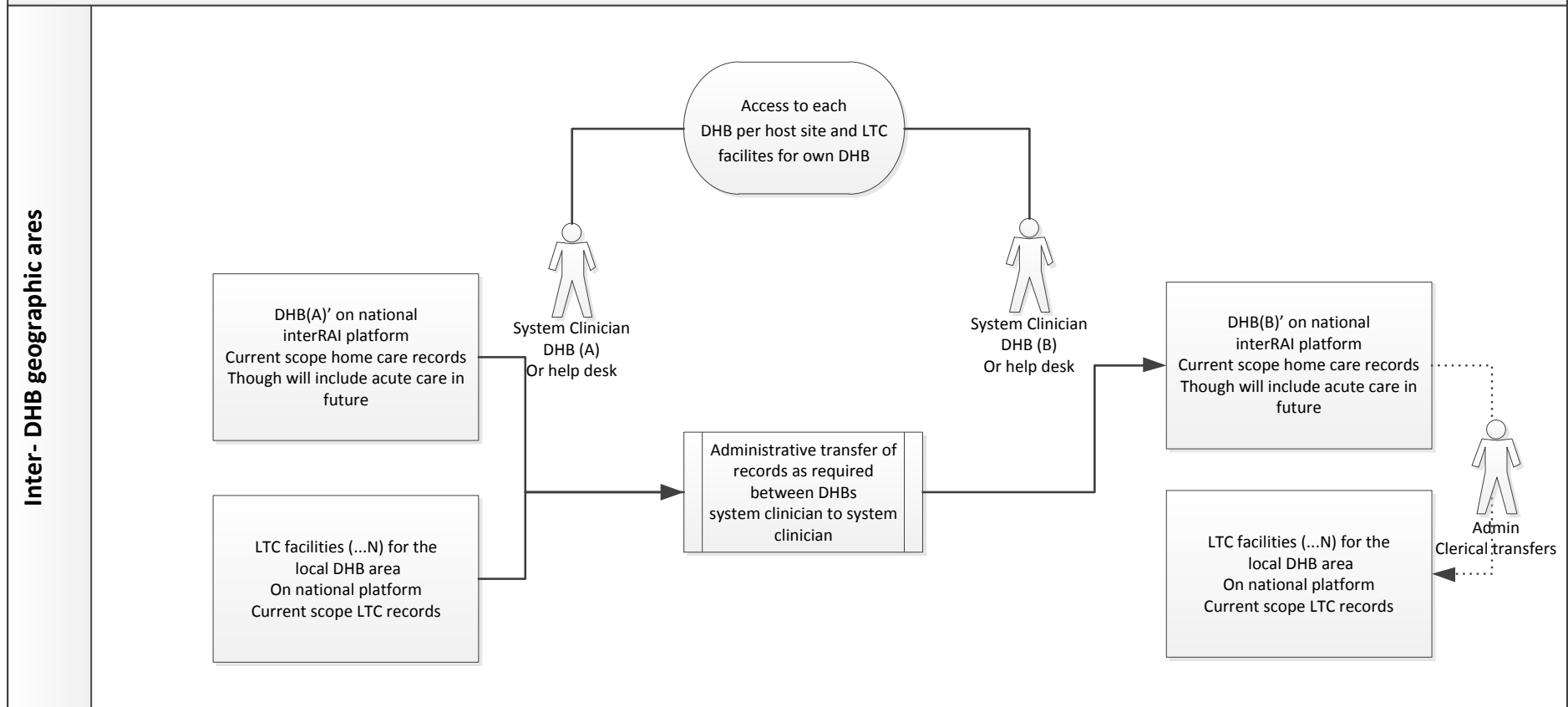


Access and transfer model – high level

System clinician staff have access all host DHBs and all LTC facilities local to their DHB

inter DHB area transfers managed by systems clinician DHB to DHB and then to LTC facilities as required

Host to host transfers must come via service desk



6 Scenarios requiring transfer of interRAI assessment records

DHB to ARC facility

Example; an individual with a home care assessment record requires an admission to a long term residential care facility

ARC facility to DHB

Example; An individual with a long term residential care assessment record is discharged home from a long term residential care facility

DHB to DHB

Example; An individual with a home care or a long term residential care assessment record relocates or is transferred to a facility in a different district health board

ARC facility to ARC facility

Example; An individual with a long term residential care assessment record is transferred to another facility

7 Affected roles

Lead practitioners

Lead practitioners lead the use of the training and development of the assessment methodology within a DHB. The position is held by an expert in interRAI assessment methodology and is a resource for interRAI competent assessors to continually improve their assessment practice and to manage assessment competencies. The lead practitioner, like assessors in general must have assessment as part of their scope of practice and are bound by their professional codes of conduct to ensure that assessment data is accurate.

Systems clinicians

Systems clinicians are experts in the use of the software and lead the development of processes and the use of analysis to improve the quality of assessment and ultimately service planning and improvement initiatives.

interRAI assessors

interRAI assessors are clinicians for whom patient/client assessment is part of their scope of practice and who has received or is currently in training on the interRAI methodology and software.

District health board administrative staff

Administrative support staff within each DHB office that perform a variety of support and administrative duties that could include the transfer of interRAI assessment records to the required dhb offices or LTRC facilities

LTRC Facility administrative staff

Administrative and office support staff within each facility who may already perform tasks related to the creation of interRAI assessments such as adding new residents, admission, transfer, discharge, updating demographic information

8 Access Audit

The interRAI system contains two access audit reports (v 118.0204), these are audit reports by NHI and by user. In the release due October 2013 there will be an additional audit report available, that audits access to an organisation on the system.

To encourage collaborative 'custodianship' of client level data at the local model of care level, DHBs and Residential Care facilities are encouraged to agree a regular audit programme. For example, DHBs meet regularly with contracted providers e.g. on a quarterly basis. An agenda item could easily be a review of a sample of audit reports, whereby the managers are asked to review random access audits for a few clients or staff and if anything untoward is seen then this can be investigated further as required and reported back.

The system clinician function can ensure this activity is completed. A local policy could be written and all entities that access the system could become 'co-signatories'.

This type of low level on-going surveillance should not be seen as threatening but used to assure external parties that there is good custodianship of client information.

Although not yet scoped or approved, it is envisaged that in the future the national interRAI system will be able to have a full time 'Privacy Officer' that could, amongst other duties, ensure each DHB and its local contracted providers have appropriate processes for regular access audit programmes.

Appendix 1 – Background Information

Some background information that may be of interest on the Privacy Act and associated HIPC and Health Act.

The Privacy Act <http://www.legislation.govt.nz/act/public/1993/0028/latest/DLM297408.html> refers to the specific case of Health Information.

Health Information is defined by the Health Act as:
<http://www.legislation.govt.nz/act/public/1956/0065/latest/DLM306584.html>

The Health Information Privacy Code <http://privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code/> sets specific rules for agencies in the health sector to better ensure the protection of individual privacy. The code addresses the health information collected, used, held and disclosed by health agencies.

The purpose of the NHI as a unique identifier is noted on page 72 of HIPC

“The national unique identifier for health consumers is known as the National Health Index (or NHI) number. Rule 12 also applies to the unique identifiers assigned or demanded by health agencies, such as the identifier assigned by registration bodies to health practitioners.

The use of unique identifiers, in conjunction with other appropriate security practices, may help protect personal information when it is being transferred between providers (eg. from a hospital to a specialist or from a laboratory to a health professional). The use of a unique identifier allows a name and address to be removed from the Transmission”.