BSBMED303B Maintain patient records

Modification History
Not applicable.

Unit Descriptor

| Unit descriptor | This unit describes the performance outcomes, skills and knowledge required to maintain patient records within an existing medical records management system, under supervision. No licensing, legislative, regulatory or certification requirements apply to this unit at the time of endorsement. |

Application of the Unit

| Application of the unit | This unit applies to individuals who will be assigned tasks by a senior receptionist or practice manager. They are skilled operators and apply a broad range of competencies in various medical administration contexts. They may exercise discretion and judgement in accessing and maintaining patient records while fully respecting patient privacy and the confidentiality of their details. BSBMED401B Manage patient record keeping system, covers the management of the system within which this person works. |

Licensing/Regulatory Information
Not applicable.

Pre-Requisites

<table>
<thead>
<tr>
<th>Prerequisite units</th>
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**Prerequisite units**


**Employability Skills Information**

<table>
<thead>
<tr>
<th>Employability skills</th>
<th>This unit contains employability skills.</th>
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</thead>
</table>

**Elements and Performance Criteria Pre-Content**

<table>
<thead>
<tr>
<th>Elements describe the essential outcomes of a unit of competency.</th>
<th>Performance criteria describe the performance needed to demonstrate achievement of the element. Where bold italicised text is used, further information is detailed in the required skills and knowledge section and the range statement. Assessment of performance is to be consistent with the evidence guide.</th>
</tr>
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</table>
## Elements and Performance Criteria

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>PERFORMANCE CRITERIA</th>
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</table>
| 1. Identify and clarify own role and procedures for patient record keeping | 1.1. Determine own role and responsibilities within patient record keeping system through consultation with relevant personnel or via organisational policy and procedures manual  
1.2. Access documented procedures for patient record keeping system and read for understanding  
1.3. Seek clarification with relevant personnel of unclear or ambiguous procedures |
| 2. Access patient records | 2.1. Gain access to patient records to facilitate patient visit  
2.2. Check currency and accuracy of patient demographic and personal details  
2.3. Create new records according to enterprise protocols  
2.4. Check records following patient visits, for practitioners’ instructions related to follow-up action  
2.5. Store patient files following organisational policy and procedures |
| 3. Help maintain records | 3.1. Make checks of patient files  
3.2. Carry out archiving of patient files as required  
3.3. Transfer patient files to another health facility upon appropriate request for patient information |
| 4. Monitor and review own role | 4.1. Monitor and review own role and responsibilities in maintaining patient records to identify opportunities for improvements to system and own work practices  
4.2. Make recommendations to relevant personnel for improvements to the established procedures and processes for maintaining patient records |
# Required Skills and Knowledge

## REQUIRED SKILLS AND KNOWLEDGE

This section describes the skills and knowledge required for this unit.

### Required skills

- planning and organising skills to access and maintain records
- communication skills to receive and clarify instructions
- analysis skills to identify and address gaps in own knowledge.

### Required knowledge

- occupational health and safety (OHS), for example:
  - manual lifting of materials
  - ergonomics associated with using computers and own work station
- relevant legislation from all levels of government that affects business operations, codes of practice and national standards, such as:
  - anti-discrimination legislation
  - ethical principles
  - privacy laws
  - Freedom of Information Act.
  - specific legislation related to patient records
- organisation policies and procedures related to:
  - patient record keeping
  - privacy and confidentiality
  - access to records
- filing systems and record management processes
- medical coding as required to access and maintain patient records.
### Evidence Guide

**EVIDENCE GUIDE**

The Evidence Guide provides advice on assessment and must be read in conjunction with the performance criteria, required skills and knowledge, range statement and the Assessment Guidelines for the Training Package.

<table>
<thead>
<tr>
<th>Overview of assessment</th>
<th>Evidence of the following is essential:</th>
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</table>
| **Critical aspects for assessment and evidence required to demonstrate competency in this unit** | - using record and file management systems to ensure organisation and accuracy of practice files  
- communicating with internal staff and other external health care providers to maintain accuracy of patient data  
- applying knowledge of the healthcare system, and practice policies and procedures to ensure accessibility of records. |

<table>
<thead>
<tr>
<th>Context of and specific resources for assessment</th>
<th>Assessment must ensure:</th>
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| **Method of assessment** | - access to records system  
- documented procedures  
- access to an actual workplace or simulated environment  
- access to office equipment and resources. |

<table>
<thead>
<tr>
<th>Method of assessment</th>
<th>A range of assessment methods should be used to assess practical skills and knowledge. The following examples are appropriate for this unit:</th>
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</table>
| **Method of assessment** | - direct questioning combined with review of portfolios of evidence and third party workplace reports of on-the-job performance by the candidate  
- review of new records created  
- analysis of responses to case studies and scenarios  
- demonstration of techniques  
- observation of presentations  
- oral or written questioning to assess knowledge of workplace emergencies, risks and hazards  
- observation of performance in role plays  
- assessment of archived patient files  
- assessment of recommendations made for improvements to the procedures and processes for maintaining patient records. |

| Guidance information for | Holistic assessment with other units relevant to the |
### EVIDENCE GUIDE

<table>
<thead>
<tr>
<th>assessment</th>
<th>industry sector, workplace and job role is recommended, for example:</th>
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<td>• other general administration or medical services administration units.</td>
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## Range Statement

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<th>RANGE STATEMENT</th>
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<td>The range statement relates to the unit of competency as a whole. It allows for different work environments and situations that may affect performance. Bold italicised wording, if used in the performance criteria, is detailed below. Essential operating conditions that may be present with training and assessment (depending on the work situation, needs of the candidate, accessibility of the item, and local industry and regional contexts) may also be included.</td>
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</table>

| System may include: | • print-based records management systems  
|                     | • software and hardware-based records management systems |
| Relevant personnel may include: | • administrative manager  
| | • health professionals  
| | • manager of facility  
| | • own supervisor  
| | • partners in business |
| Practitioners' instructions may include: | • filing documents in records  
| | • making further appointments with health professionals within the facility  
| | • referral to another health professional  
| | • request for a letter of referral to be prepared |
| Checks of patient files may include: | • checking on a pre-determined cycle  
| | • checking on specified dates  
| | • ensuring files are neat, tidy and correct  
| | • ensuring files are stored in correct order (alphabetical, numerical, alphanumeric) |
| Archiving may include: | • archiving on direction and under supervision  
| | • file storage using appropriate archiving options such as boxes, external storage facility, electronic scanning and imaging  
| | • identification of files for archiving  
| | • removal of files from system |
| Appropriate request for patient information refers to: | • legitimate request for patient information agreed to by patient and for purposes of furthering treatment regime with another health facility and within legislative requirements including:  
| | • approval by relevant health practitioner  
| | • Freedom of Information Act  
| | • organisational policy and procedures  
| | • Privacy Act |
### Unit Sector(s)

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<th>Unit sector</th>
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### Competency field

<table>
<thead>
<tr>
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<th>Administration - Medical Services Administration</th>
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### Co-requisite units

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