

Clinical Record Management Policy

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Purpose

The clinical record is fundamental to proving informational continuity of care so that the right care is delivered to the right person at the right time in the right place. The standard to be met HDSS 2008 2.9 is “Consumer information is uniquely identifiable, accurately recorded, current, confidential, [sic secure] and accessible when required.”

Policy

The clinical record is the primary document for recording clinical care. It has clinical and medico-legal significance for the patient/client, staff members and the Canterbury District Health Board (CDHB). An accurate clinical record is necessary to support informed and co-ordinated decision making, evaluation of the care provided, achievement of effective healthcare outcomes, and retrieval of data for management information, research and medico-legal reference.

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Management of every clinical record, whether in electronic or paper form, must be in accordance with the standards set out in this policy and its appendices.

Each division must adhere to the principles outlined in this policy and develop divisional clinical records management procedures to implement the policy and principles outlined in this document.

Scope/Audience

This policy applies to all CDHB staff using or managing clinical records. It applies to all components of healthcare service delivery, including referral, admission, inpatient care, outpatient care, community delivered care, and discharge.

Associated documents

All relevant Legislation, Acts and Standards.

CDHB wide policies and procedures.

- Privacy Policy
- Release of Patient Information

Divisional Policies and Procedures

Clinical Records Management Policies
Forms Management Policies

Responsibilities

Each person making an entry into the clinical record is responsible for ensuring that the standard of their documentation complies with the requirements of this policy or any policy or procedure based on this policy.

Authorised Person

Authorised persons are those staff employed by the CDHB, or persons contracted by CDHB by management arrangement (e.g. General Practitioners, independent midwives, authorised auditors) for the purposes of supporting the provision of healthcare, or undergoing clinical training under contract or formal agreement.

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1 Clinical Record Integration

Only one main clinical record must exist for each patient/client. This may consist of more than one volume, be paper and/or electronic or have components of it held in different locations, but all such components must be cross referenced in such a way as to ensure that a functionally integrated record exists.

1.1 Temporary Supplementary Record

A temporary supplementary record may be established for the purposes of efficient provision of clinical care, but any such record must be combined with the main record when the specific purpose for which it was established ceases to exist.

Reference to the existence of any such record must be made in the Patient Management System (PMS).

1.2 Permanent Supplementary Records

A permanent supplementary record may be established by a Service/Department for the purposes of recording patient/client information which is peculiar to that Service/Department and the detail of that information is not relevant to other episodes of patient care.

Reference to the existence of any such record must be made in the main record and PMS with relevant summaries provided for filing in the main record.

The establishment and ongoing maintenance of supplementary records is subject to approval by Divisional Clinical Record Committees and must be established with all the provisions of this policy.

2 Retention of Clinical Records

Clinical Records are retained for a minimum period of ten years following the death of a client and then destroyed CDHB Clinical Records Retention and Disposal of Clinical Information policy.

3 Clinical Record Requirements

3.1 Patient Registration

Every patient/client who accesses CDHB clinical services is to be assigned a National Health Index (NHI) number using national

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processes, and have their own record. Methods of contact such as email address are to be checked at this time.

At all times current patient/client identification labels must be used and applied to both sides of the clinical record sheet. During each attendance and/or in patient/client labels must be stored within the patient record only. All unused labels must be destroyed after each patient/client discharge or transfer from a service.

3.2 Duplicate Registrations

Patients/clients must not be registered under more than one NHI number.

The staff member registering any patient/client must ensure that any duplicate registration that might exist for that patient/client is identified.

In all instances of duplicate registrations, merging into a single registration must occur.

3.3 Temporary Registration

A temporary identification number may be issued in circumstances where for whatever reason the permanent NHI number cannot be expeditiously issued.

The patient/client is to retain the temporary number until such time as a permanent number can be assigned and the clinical record safely merged.

3.4 Adverse Drug Reaction / Allergy / Alert documentation

Important patient/client information such as allergic reactions, adverse drug reactions, radioactive hazards, infection risks, significant medical conditions and advance directives must be prominently displayed in the clinical record and flagged on the PMS.

Each division must have their own process for entering and amending alerts on the PMS.

All alerts must be confirmed as still valid at each admission/visit.

3.5 Layout of the Clinical Record

The clinical record must be divided into sections to contain at a minimum:

Front of File

To contain documents that endure for more than one episode of care and the inpatient information for any current episode of care.

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Results

To contain all test results (combining both inpatient and outpatient). Results must be filed in reverse chronological order with like test results being filed together in alphabetical order of speciality.

Outpatient

To contain all Outpatient clinical notes.

Correspondence

To contain all inwards correspondence from external agencies that do not relate directly to an episode of care. Correspondence that relates directly to an episode of care is to be filed with that episode of care, either inpatient admission or outpatient attendance.

Inpatient

To contain all inpatient episodes filed in reverse chronological order.

3.6 Forms

Only forms, stationery and charts approved by the CDHB may be included in the clinical record.

There will be a CDHB-wide Forms Management Committee to co-ordinate and oversee the activities of the CDHB and divisional forms management process.

Form design must comply with the CDHB standard as documented in Clinical Forms Policy (in preparation)

The content of the form must be signed off by the appropriate authoriser before approved as meeting the forms management process.

Each division must have a process for the review and approval of clinical record forms.

A CDHB-wide Forms Register will be established to record all forms.

Each form must have a unique number, related to its order in the clinical record, in accordance with the policy defined by the CDHB Forms Management Committee.

3.7 Entries

Entries into the clinical record must only be made by persons authorised by CDHB.

Entries must:

- Be written on documents uniquely identified for that patient/client, contain information relating to that patient/client only and provide a complete record of all aspects of the patient/client care.

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- Be recorded as soon as possible after an event has occurred. In non-urgent situations typed notes may be used but must be clearly identified, checked, signed and dated before being inserted in the clinical record.
- Be legible, non-erasable and able to be photocopied or faxed, and show the date and actual time of entry. The times of events recorded must be included in the text.
- Be chronological without gaps in the text and contain all relevant clinical information.
- Be non-ambiguous and only include CDHB approved abbreviations and symbols.
- Be signed by the person making the entry with his/her name and designation clearly annotated under the signature.

Note: Where the authorised person making the entry is a student, the CDHB staff member providing oversight will also record the assessment and care they delivered part of this process.

3.8 Amendments

Entries in the clinical record must never be erased or otherwise rendered illegible.

Amendments to the clinical record may be made if an entry is shown to be in error.

Any entry being amended must have a single line drawn through it, remain legible and be annotated as a 'mistaken entry' or 'error'.

All amended entries must show the date and time at which the correction is made, be signed by the person making the entry and have his/her name and designation clearly annotated under the signature.

If space allows a correction may be made at the place of the original entry, otherwise the correction must be entered in the continuity of the record, with cross-referencing between the entries.

Any person making an amendment must ensure that all relevant people are notified of the correction.

Once a potential claim or incident has been reported any information relating to that claim/incident must not be amended or corrected.

Patient/client requests for amendments

Information may only be amended or removed from the clinical record following consultation with the appropriate clinician, the Board and/or Divisional Privacy Officer and the Corporate Solicitor.

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The Board and/or Divisional Privacy Officer must retain a dated and signed record of this removal.

If information is not amended or removed a record of the request to do so must be included in the clinical record.

3.9 Late entries

Late entries to the clinical record may be made. All such entries must:

- Be clearly identified as a 'late entry'.
- Include the date and time of the entry, as well as the date and time at which the event being recorded occurred.
- Be added to the narrative notes and not documented in margins or between existing entries.

3.10 Third Parties

Information provided by a third party or relating to a third party must only be recorded in the clinical record if deemed necessary for the treatment of the patient/client.

If any such information is deemed inappropriate to disclose to the patient/client it should be clearly annotated to allow easy identification and removal.

3.11 Filing

Clinical records must be filed in accordance with Section 3.5 Layout of the Clinical Record.

Except as detailed below, all correspondence, received and sent, including copies of emails, must be filed in the clinical record.

Documents must be filed as they are received in the clinical location. All documents must be sighted and signed by the clinician responsible for caring for the patient/client prior to filing.

The following documents are not to be filed in the clinical record:

- Incident Reports.
- Complaints or reports relating to complaints.
- Reports requested by the Medical Misadventure Unit of the Accident Compensation Corporation.
- Reports requested by the NZ Police
- Coroners Reports.

4 Clinical Record Content

The patient/client record must be sufficiently detailed to enable:

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- Identification of the reason for admission or entry to the service.
- Implementation of the co-ordinated patient/client service plan.
- The patient/client to receive effective continuing service, treatment and care.
- Effective communication among the interdisciplinary team.
- Concurrent or retrospective evaluation of patient/client service, treatment or care.
- Allocation of complete and precise diagnosis and procedure codes where relevant.
- Peer review of the content of the record.
- Compliance with the Code of Health and Disability Services Consumers' Rights.

5 Access to Clinical Records

CDHB hospitals and community services are the legal custodians of patient/client clinical records.

The clinical record is to be handled with due care at all times to avoid damage.

Access is subject to CDHB, Christchurch School of Medicine or other appropriate approved identification.

Only individuals approved to view or access the information in the course of treating and supporting the patient/client shall routinely have access to the clinical record.

5.1 Access by Patients/Clients or their Authorised representatives

All requests from patients/clients or their authorised representatives seeking access to clinical record information are to be referred to the Board and/or Divisional Privacy Officer in accordance with CDHB "Privacy Policy" and "Release of Patient Information" policies (See Legal and Quality Manual Volume 2).

5.2 Access for Audit/Research/Education

All requests for access to clinical records for quality assurance activities, research, and/or educational purposes must be directed to the Clinical Record Department (CRD) of the appropriate division of the CDHB.

Quality Assurance Activities

No specific approval for access to clinical records is required for

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approved quality assurance activities (including incident and patient complaint investigations).

Research

Requests for access to clinical records for research purposes must have Regional or Multi-regional Ethics Committee approval and are subject to the terms of that approval.

Education

Only Health Professional Students of approved institutions may have access to approved clinical records. This is subject to:

- Producing approved identification.
- Producing evidence that they are a student of the approved institution.
- Producing evidence of approved patient/client consent. This record of consent must be filed in the Clinical Record.
- Only viewing records in an area designated for that purpose by the clinical record department.

These provisions do not apply to 6th year medical students (Trainee Interns) actively involved in the examination, treatment or care of patients/clients.

6 Requests for Clinical Records and/or Information

No person employed by the CDHB shall give any information concerning the status, condition or treatment of any patient/client of the CDHB, whether past or present, to any other person unless they are authorised to give it and either:

- They are required to give it, or
- The patient/client or their representative consented.

6.1 Patient/client Requests to Remove their Record

Patients/clients may request their clinical record when transferring to a residence overseas.

The original clinical record will be retained by the CDHB and a copy will be provided to the patient/client.

All such requests must comply with the provisions of the CDHB Privacy Policy.

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6.2 Movement of Clinical Records between CDHB and Other Institutions

- Requests instigated by the CDHB
All such requests must be made through the appropriate Clinical Record Department which is responsible for:
 - Requesting the clinical record.
 - Returning the clinical record.
- Requests received by the CDHB
All requests for clinical records received by the CDHB from other District Health Boards and hospitals must be directed to the appropriate Clinical Record Department which is responsible for:
 - Actioning the request.
 - Ensuring that the clinical record is returned.

6.3 Duplication of Clinical Record Information

Duplication of clinical record information is only to be undertaken when deemed essential.

All copies of original clinical records need to be clearly identified as a 'copy' and the appropriate patient identification number is to be at the top of each side of the page.

The original should be kept by the service provider except under exceptional circumstances.

If a duplicate clinical record is returned then the copy must be destroyed.

7 Removal of Clinical Record from CDHB Premises by CDHB Staff

Clinical records must not be removed from CDHB premises unless for an approved activity and then only with the knowledge of the appropriate Clinical Record Department.

7.1 Safety of Clinical Record

All clinical records removed from CDHB premises must be safeguarded against loss, theft, misplacement, unauthorised access, modification, unauthorised disclosure and/or misuse

7.2 Retrieval

The Clinical Record Department must know the location of all clinical records removed from CDHB premises and must be able to retrieve them with immediacy from that location.

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8 Safeguarding Against Loss, Damage, or Breach of Privacy

8.1 Storage of Clinical Records

Clinical records, paper and electronic, must be stored in conditions that are clean, safe and secure, with adequate provision against damage and must comply with Accreditation requirements, the Clinical Record Management Standard and, for electronic records, CDHB Policy and Procedure Manual Volume 5 – Computing and Information Services.

8.2 Clinical Records Stored in Wards and Departments

All clinical records held for the purpose of patient/client care in a clinical area must be readily available for that purpose but managed in such a way as to not be able to be viewed by or be available to unauthorised people.

Clinical records held in other than Clinical Record Departments or in patient/client care areas for the purposes of patient/client care must at all times be readily available to Clinical Record staff.

Each Department/Service holding such records is responsible for ensuring that internal processes are established to ensure that:

- 24 hour access to those records is available
- a record of the records held is maintained together with their location and means of access
- all records are in all other regards stored in accordance with the provisions of this Policy
- Clinical records must not be stored/retained outside the Clinical Record Department for periods longer than the purpose for which these were required.

8.3 Off-site Storage of Clinical Records

All off-site storage of clinical records must be with an approved contracted supplier.

An annual audit must be made of the supplier to ensure they are meeting their contractual requirements.

8.4 Tracking of Clinical Records

The location of all clinical records must be known at all times.

Only approved CDHB clinical record tracking systems are to be used and these must ensure that all movement of clinical records is monitored.

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8.5 Missing Clinical Records

A replacement record must be established to replace any clinical record that is unable to be located.

If the original clinical record is subsequently located, the appropriate Clinical Record Department must merge the two records.

8.6 Transport of Clinical Records

All clinical records must be transported in such a way as to ensure:

- the physical integrity of the record
- the integrity of the content of the record
- the confidentiality of the information contained in the record.

8.7 Transmission by Facsimile

Facsimile machines used for sending and receiving patient information must be located in secure areas with access limited to authorised personnel.

Information transmitted by facsimile must comply with the requirements of CDHB Policy and Procedure Manual Volume 2 – Legal and Quality: “Release of Patient Information – Information Forwarded by Facsimile”.

Measurement/Evaluation

Clinical Record Audit

Annual audits of clinical records are to be carried out to determine compliance with this policy using an approved audit tool.

Policy Owner	CDHB Health Information Manager
Policy Authoriser	Executive Director of Nursing
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