STANDARD

The client / patient health record will be organised in a logical, consistent and easily retrievable manner, consistent with national standards and recognised best practice.

OBJECTIVE

To ensure health records managed by the organisation are maintained according to national standards, and wherever possible are continuous, integrated and organised in a consistent manner.

STANDARDS TO BE MET

1. Content of Health Record

1.1 Wherever practicable, the patient / client shall have a single, integrated health record.

1.2 The health record may be in either / both hard copy and electronic format.

1.3 Where not practicable, any health record maintained for patients in individual locations within Bay of Plenty District Health Board (BOPDHB) must be accessible to other health practitioners (as appropriate).

1.4 The Patient Management System will indicate those services maintaining a health record for a patient outside the main health record, including the current location of their health record.

1.5 Until a fully integrated health record is available all primary health records will be held only in the following locations:

a) Tauranga Hospital
b) Whakatane Hospital
c) Mental Health & Addiction Services (currently being uploaded)
d) Maternity and Newborn (with the exception of the CTG these notes could be uploaded to the electronic record now and the CTG's could be stored separately if a means of uploading them is not currently available)
e) Allied Health
f) Regional Community Services Community Health and Disability

1.6 The location of every health record must be known at all times by record on the tracking system of the local patient management system.

1.7 Whenever a health record is physically moved around the organisation, it will be tracked to its new location.

1.8 The health record must be clearly identifiable as a health record, contain the patient's unique identifier, and be organised into designated sections.

1.9 Primary health records will consist of, but not be limited to, the following components:

a) Consumer patient details
b) Key health information summary
c) Consents
d) Outpatient / inpatient care episodes

e) Referrals – received and sent
f) Correspondence
g) Assessment(s)
h) Investigations and results
i) Diagnoses
j) Treatment / care / management plans
   i. Treatment / care provided
   ii. Evaluation of treatment / care provided
   iii. Medication orders and administration documentation
   iv. Information that is provided to the consumer about available options, and the risks, benefits and side-effects of those options
   v. Consumer / patient consent to treatment / care
   vi. Perioperative / operative / post-operative and anaesthetic records
   vii. Advance directives
   viii. Other procedures and therapies
k) Progress / review
l) Education
m) Discharge letter(s) / summary
n) Follow up

1.10 The sequence of each record must follow a defined and specified order as set out in a protocol for each area where primary health records are held.

1.11 Hard copy primary health records must not reach a thickness of more than 10 cm per volume. In the event of a space / weight problem in any storage system it may be necessary to reduce the size to no more than 5 - 7 cm per volume. Once this size is reached, the record must be split into volumes according to the protocol. Where more than one volume exists, the latest volume will be identifiable on BOPDHB's patient management system as the current inpatient file.

2. Entering Information Into Health Records

2.1 Entries into health records must only be made by a health professional or those who have been authorised to do so.

2.2 Each entry must include the following information:
a) Accurate date and time
b) Printed name – use of a stamp if available – with the full signature. This may be done electronically for electronic requests, reports and records.
c) Designation of the health professional or other authorised user

2.3 Documentation should occur as soon as practicable after any event / interaction with the patient.
a) Health professionals should document as frequently as indicated by the clinical condition of the patient / client.
b) They should document each patient / client contact or one entry per shift, whichever is more appropriate.
c) If any information cannot be recorded, reasons for this must be documented.
d) If information is received from another health professional, or any other third party, the source of the information must be identified and clearly stated, including the name, designation and relationship of the source to the patient.

2.4 Each entry must be:
- a) Factual, consistent, accurate, legible and complete.
- b) Objective, relevant, and understandable and not include meaningless or misleading phrases, irrelevant speculation and inappropriate subjective statements.
- c) Recorded wherever possible in consultation with the patient/client or their nominated representative.
- d) Recorded in a manner that the text cannot be erased.
- e) In blue or black permanent ink (hard copy record) or typed text (only pharmacy may use green permanent ink to annotate on medication charts).
- f) Chronological within each section
- g) Compliant with generally accepted standards for the profession

2.5 Errors are to be indicated by one line through the entry with "Error" written above the entry and signed in full in the margin adjacent to the error (hard copy).

2.6 Chart an omission as a new entry. Do not backdate or add to previously written entries.

2.7 Blank spaces are not to be left in any section of hardcopy notes. If a space is not filled, a line must be drawn diagonally through the space across the section – this must then be signed and dated.

2.8 If both sides of a page are blank and there is NO patient label on either side the page can be removed and destroyed by Health Records prior to scanning and uploading.

2.9 Record the date, time, participants and content of all telephone patient-related communications with health professionals.

2.10 Whenever a legal responsibility is discharged, this must be documented e.g. notification to the Medical Officer of Health of an Infectious disease.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 2.5.2 Health Records Management
- Bay of Plenty District Health Board Approved Abbreviations List
- Bay of Plenty District Health Board policy 2.5.1 Health Information Privacy
- Bay of Plenty District Health Board Release of Personal Information Request form
- Bay of Plenty District Health Board Policy 6.3.5 Falls - Risk Reduction and Management of Inpatient Falls
- Bay of Plenty District Health Board General Disposal Authority