Policy Applies to: All Mercy Hospital staff who contribute to a patient's clinical record. Credentialed Specialists, relevant contractors and students' compliance will be facilitated by hospital staff.

Related Standard

Nga Paerewa Health and Disability Services Standards

Cultural Considerations

Every patient is asked about their ethnic/cultural background, and this is recorded if identified. Self-identification is established best practice in Aotearoa New Zealand.

Rationale

Mercy Hospital staff recognise that the clinical record is the primary document for ordering, recording and evaluating clinical care. It has clinical and medico- legal significance for the patient, staff and Credentialed Specialists.

Definitions

Clinical Record; information describing every aspect of the healthcare provided to a patient. This may include written or image information and can be electronic or hard copy.

NHI number; is the national health index number that is a national unique identifier for all consumers of New Zealand health services.

Objectives

A comprehensive, accurate clinical record is maintained which:

- Enables care delivery to be tracked, monitored and evaluated.
- Assists with providing effective continuity of multidisciplinary care/intervention for the patient.
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The clinical record will contain sufficient information to enable:

- Effective continuity of multidisciplinary care/intervention for the patient.
- Effective communication within the health care team, which is timely, accurate, complete and unambiguous.

All staff and clinicians are responsible for ensuring that comprehensive, accurate clinical records are maintained, and that personal health information and clinical records are protected against loss, misuse and unauthorised modification, access, disclosure or destruction. See Appendix 1, 3.

The clinical record will only be accessed when necessary for performing duties of the individual's role. This is auditable.

The Clinical records department is responsible for managing and maintaining the Mercy Hospital clinical record, including storage, scanning and retrieval Appendix 4, 5. (also see privacy and release of information policy).

The Information technology (IT) department along with all Mercy hospital users are responsible for the security of the electronic clinical record.

Implementation

- Via staff feedback.
- Documentation is part of area specific orientation for staff
- Website access to new /updated policies for Credentialed Specialists
- Via credentialing processes

Evaluation

1. Via audits of:
   - Medication charts (Pharmacist)
   - Consent forms (Clinical audits- Callaghan, McAuley, DSU and Manaaki)
   - Incidents
   - Clinical Records (Global audit)
   - access to the clinical record
2. Incident Management System
3. Monitoring of Clinical Records including tracking files removed from and returned to Clinical Records
4. Complaints
5. feedback from Cemplicity
6. Regular review of Careplans on Trendcare

Associated Documents

External:

- Ngā paerewa Health and Disability Services Standard NZS 8134:2021,
- Health & Disability Commissioner Act (Code of Health and Disability Services Consumers' Rights, 1994)
- Privacy Act 2020
- Health Information Privacy Code 2020
- Health Practitioners Competence Assurance Act 2003
- Public Records Act 2005
- The Health (Retention of Health information) Regulations 1996

- Internal:
  - Clinical Images Policy
  - Consent Policy
  - Document Control Policy
  - ICT Security Policy

- ICT Governance Policy
- Medicine Management Policy
- Privacy and Release of Information Policy
- Research Policy
- Information management policy

Any work manual or policy that requires documentation in the clinical records is impacted by this policy