

Policy Applies to

- All Mercy Hospital staff who contribute to a patient's clinical record
- Credentialed Specialists compliance will be facilitated by hospital staff.

Related Standard

- **EQulP criterion 1.1.8** - The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care delivery
- **EQulP criterion 2.3.1** Health records management systems support the collection of information and meet the consumer / patient and organisational needs.

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:

- Enables care delivery to be tracked, monitored and evaluated.
- Assists with providing effective continuity of multidisciplinary care/intervention for the patient.
- Ensures effective communication between health care team members.
- IT is used appropriately to enhance the patient record.

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.

Implementation

- Via staff feedback.
- Documentation forms part of nursing orientation to an area
- 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 (Global audit)
 - Clinical Records (Global audit)
2. Incident Management System
3. Monitoring of Clinical Records including tracking files removed from and returned to Clinical Records
4. Complaints
5. Patient(Cemplicity)/staff feedback
6. Update and review Careplans on Trendcare

Associated Documents

External:

- Ngā paerewa Health and Disability Services Standard NZS 8134:2021, Standard 3.6
- NZNO : 1998 Documentation: A five year saga for health professionals
- Health & Disability Commissioner Act (Code of Rights)1994
- Privacy Act 2020
- Health Information Privacy Code 1994
- Health Practitioners Competence Assurance Act 2003
- Public Records Act 2005
- The Health(Retention of Health information)Regulations 1996
- Chapman Tripp Legislative Compliance Programme

Internal:

- Adverse Reaction to Medication
- Alcohol Withdrawal Guidelines – Clinical Services Work Manual
- Chaperoning Policy
- Chlorhexidine Allergy Management - Clinical Services Work Manual
- Clinical Imaging Policy
- Consent Policy
- Contacting Medical Staff Procedure – Clinical Services Work Manual
- Discharge Policy
- Early Warning Score (EWS) Vital Sign Chart

- Patient Family Violence Policy
- Information Communication Technology Governance Policy
- Information Communication Technology Security Policy
- Information Management Policy
- Latex Allergy Management – Clinical Services Work Manual
- Medicines Management Policy
- Mercy Hospital By-Laws for Accredited Professionals
 - Nursing Model of Care Policy
- Nursing Scope of Practice
- Nutritional Care Policy
- Patient Assessment Policy
- PEWS
- Privacy and Release of Information Policy
- Research Policy
- Return or disposal of Body Parts Policy
- Site Marking Policy
- Social Media Policy
- Surgical Safety Checklist Policy
- Transfer of Patients Policy

PROCESS

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Alerts, Side Effects, Drug Sensitivities, Allergies

Definitions

Alerts - highlight an issue or issues that can impact on the patients stay, e.g. impaired mobility, sensory impairment, food preference and infectious diseases

Side effects – a side effect is usually regarded as an undesirable secondary effect which occurs in addition to the desired therapeutic effect of a drug or medication. Side effects may vary for each individual depending on the person's disease state, age, weight, gender, ethnicity and general health. Side effects of medication are usually non-immunologic effect of the agent and are predictable. An example of this type of reaction is gastrointestinal effects and ulceration from NSAIDs.

Drug sensitivities - a drug sensitivity is an unusual reaction to a drug that does not involve the immune system. Drug sensitivities (also called idiosyncratic reactions or unusual adverse reactions) do not involve the immune system or the release of histamine. However, the symptoms of drug sensitivities can be very similar to the symptoms of a drug allergy. Unlike drug allergies, sensitivities often occur upon first exposure to a drug and do not lead to anaphylaxis.

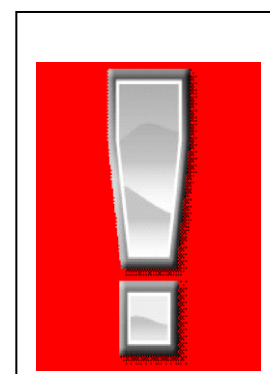
A drug allergy - is an adverse reaction to a medication, often an antibiotic that is mediated by the body's immune system manifesting most frequently in various skin reactions, bronchoconstriction and oedema. Medications which more commonly are known to induce an allergic reaction include sulfa antibiotics, penicillin, acetylsalicylic acid, allopurinol, anti-seizure medications, anti-arrhythmic.

Anaphylaxis - is a severe systemic allergic reaction. True allergy to medications however accounts for only 6-10% of all adverse medication effects.

Alert Label

If the patient has an allergy to a medication, an alert label (pictured below) is placed on the patient's folder by the Clinical Records Officer prior to admission (if patient has been phone pre-admitted) or by the admitting nurse on admission

- The label identified here is to be used **ONLY** as an alert to Medical and Nursing personnel. It is designed to indicate the patient has declared that they have an allergy to a medication



- This is the ONLY alert sticker to be placed on the outside cover of patients Clinical Records chart.

Same Name Alert

A same name alert sticker is added to the patient notes by Clinical Records. A same name alert may be added to Trak by the Booking Coordinator.

Electronic Recording of an Alert

All alerts will be re-validated on each admission. Out of date alerts will be end dated by appropriate staff. The admission team will ensure all relevant alerts are added during the booking process, numerous other alerts you need to familiar with.

Clinical Records Patient File Preparation Prior to Admission

- Two days prior to a patient being admitted to Mercy an admission list is printed off Trak by the clinical records staff.
- The day prior to admission the bookings coordinator has collated all patient admission information /correspondence into a folder
- This folder is collected by the Clinical Records staff and the patient file put together with old notes, current information, and any pre-operative blood results. Note - Manaaki staff collate their own charts.

Recording of Personal/Service Information

The following information if obtained will be recorded in the clinical record

- Full name, date of birth and sex. If a child, include name(s) and address(es) of parent(s)
- Patient's current address, not a PO Box number
- Patient's preferred person to be contacted in an emergency
- Patient's ethnicity data
- Payer

Documentation of Alerts, Allergies and Side Effects

Full documentation of all patient adverse drug reactions, sensitivities, allergies side effects and other risk alerts including a description of the adverse reaction should be made prior to a patient's admission by the Admission Bookings team. This comes from information given by the patient on the Health Questionnaire and from the Doctor's admission letter. For the majority of patients the preadmission Nurse will reconfirm with the patient any alerts, allergies and side effects at the time of the preadmission phone call.

On the patient's arrival at Mercy, Reception staff check if the paper admission forms including these Alerts, Allergies and Side Effects are completed. On admission to DSU, the admitting nurse will check verify the presence or absence of any Alerts, Allergies or medication side effects.

Allergies/adverse reactions to medicines/food/products and Medic Alert information will also be documented in the medication chart by the DSU admitting nurse (medication related only & written in red), the Nursing Assessment form and TrakCare; this information will be transcribed onto the pre-operative check list and a red 'Allergy' sticker will be placed on this form

Where there are no known drug allergies this will be written on the drug chart by a NKDA and the pre-op checklist at time of admission.

Admission Information

Pre-admission Nurse

All patients will have a telephone preadmissions assessment completed by a nurse prior to their surgery. All patients are Infection Prevention screened for infectious disease symptoms and relevant history including travel and hospital inpatient care in the last 6 months. The nursing assessment is completed and documented electronically on TrakCare. All patients are screened for symptoms of Covid-19.

Note: The pre-admission nurse will advise the surgeon/anaesthetist of any changes in health status in the previous 2 weeks and/or as per the guidelines using the Red Flag System (refer to Clinical Services Manual).

Reception Responsibilities

If there are patients being seen downstairs for preadmissions, the receptionist keeps the folders behind reception and gives them to the specialists as required. Once the patient has completed their surgical/anaesthetic review the receptionist then checks the old notes and places them in the trolley.

The Reception staff are responsible for entering the patient's admission to hospital time on Trak.

On Patient Arrival:

On admission, patients report to Reception at either Manaaki or the hospital. Staff will check:

- Patients full name, DOB, Address, Email, G.p., NOK contact details
- Patient's Next of Kin will be the nominated person who will be given information on patient condition (unless otherwise indicated by the patient)
- Consent forms for surgery and anaesthetic have been signed by patient, surgeon and anaesthetist.
- COVID screening
- Move the patient into the 'foyer waiting area' on Trak Care (n/a for Manaaki)

Coolock DSU Nursing Staff

- Review and or complete nursing / risk assessments on Trak and Trendcare
- Undertake requested interventions noted on the Doctors Admission Letter and then sign and date as being completed
- Check Health Questionnaire on admission form is completed. Create action plan for any issues or needs highlighted.
- Check alerts, allergies and drug side effects are accurately recorded as per medicines management policy

- Check anaesthetic assessment has been done, instructions are noted regarding the giving of usual medications and a pre-med is charted (if required)
- Check consent paperwork is completed and signed
- If relevant to the operation, check that preoperative surgical site infection prevention of nasal swabbing and presurgery washing has been completed. complete SSI monitoring paperwork, explain the purpose of infection surveillance to the patient and ask for consent for monitoring and followup. patient to sign the consent. if no consent, this is to be noted in the patients notes and on the surveillance paperwork.
- Ensure pre-operative check list is completed and signed
- Complete baseline observations, i.e. T, P, RR, BP weight, SpO₂; ECG, BMI
- Anaesthetists are responsible for checking results of the tests they have requested. Nursing staff are responsible for ensuring they are aware of abnormal preoperation test results , should a patient's condition change, and updating the Anaesthetist/RMO as able or required
- Check skin for lesions/tears, and for signs and symptoms of infection.
- Note and record drug allergies or sensitivities in red on medication chart or record No Known Drug Allergies (NKDA). It is not acceptable to leave this blank
- If there are any known allergies, put a red "Allergy" sticker on the preoperative check list

The Clinical Record

Entries to the Clinical Record

The following are required elements of all clinical records at Mercy Hospital. Some apply to paper based(PB) records only

They must:

- Have all pages (both sides) in the patient's records labelled with identification data that includes the patients NHI number
- Be written legibly
- Be written in permanent blue or black ink or be authorised if written in an EPR. Only pharmacists may use an approved green pen for writing on the medication chart or in the clinical notes
- Record date, time, signature, and designation /title
- Be written in chronological order
- Be written objectively; be specific and factual
- Use the correct terminology, e.g. cyanosed instead of "blue"
- Only use approved abbreviations and acronyms (appendix 1)
- Have identified the reason for admission or entry to the hospital
- Provide for allocation of complete and precise diagnosis and procedure codes
- Have entries recorded as soon as possible
- Record any adverse events, complaints or incidents and record that an Incident Report has been completed using Incident Management System and full disclosure has been made to the patient
- Ensure there are no blank spaces. Draw a line through unused pages or spaces on a line
- Have any amendments noted as such and be signed and dated
- Record patient care including changes in condition and the patients' response to care
- Have originals of all patient reports filed in the record Where they have been provided
- Effectively communicate information between all health team members to ensure the delivery of appropriate care
- Have prominently displayed appropriate notations for any allergies and drug reactions
- Ensure relevant Care Path Plan is used on Trendcare

Amendments to the Clinical Record

Entries in the clinical record shall never be erased or otherwise obliterated. Original entries shall remain readable.

When you have made a mistake in your documentation, there are simple rules to follow:

- Draw a single line through the incorrect entry, making sure the incorrect entry is still legible
- In the EPR a reason for correction is given, the note is edited and reauthorized.
- Describe the error, e.g. wrong date, wrong chart or incorrect entry.

- Correct the information and add the date, time, your signature plus printed name and title.

Making Retrospective Entries

There may be circumstances when a retrospective entry needs to be made to the clinical record. In such cases, the entry must be made as follows:

- Clearly identify the entry as a “retrospective entry”
- Include the date and time of writing the entry as well as the date and time the event being recorded occurred
- Be signed and dated, with full name and designation of the person making the retrospective entry

A retrospective entry shall never be made after receipt of notice of a complaint or HDC case.

Missed entry

Where a nurse remembers that they have omitted writing in a clinical record they will either return to work as soon as is practical and contact the clinical area immediately. Where a colleague notes a clinical record has not been recorded they will notify the nurse concerned immediately.

Where a nurse has omitted to complete a clinical record for a shift and;

- An action is outstanding e.g. catheter to be removed at 0600hrs .This action will be recorded by a nursing colleague into the notes with as “As per RN/EN: Name: Date & Time” The nurse who missed writing this in the notes will countersign this and complete the clinical record the following day.
- Where there is no action outstanding the nurse who missed completing the clinical record will write a retrospective entry the next day, using the process as outlined above.

Clinical Record Content

Nursing Assessment

This may be a hard copy (Nursing Assessment form) or an electronic version. Prior to obtaining the nursing history, the following considerations MUST be adhered to:

- Verbal consent is to be obtained prior to any interview about the patient’s health history.
- Only relevant information is to be collected.
- If being undertaken in hospital the nurse shall maintain the patient’s privacy as much as is practicable which may include taking the patient to another room.
- The nurse collecting personal information should ensure that the patient is told the purpose for which the information is being collected and the importance of having all information to ensure the most appropriate level of care

The nursing assessment is designed to aid planning, identification of special needs and risk assessment for patient care in hospital and on discharge. The assessment should be completed, signed and dated, either at pre admission or as soon as possible following admission. Any individualised needs or issues identified should be addressed in the Trendcare- Care Pathway. (See the Patient Assessment Policy and Discharge Policy)

Care Pathways

Each patient must have the appropriate clinical care pathway commenced on admission.

A Care Path shall meet the following standards:

- There will be an entry for each shift either manual or electronic in the Clinical Record.
- An entry may simply be completing the care path. Only by documenting and or signing off actions/outcomes can you ensure that others know what you saw and what action you took at any given time.
- Outcome goals are completed on line on a daily basis. If not met select the most appropriate reason from the on-line variance list so that accurate variance data can be captured.
- Every action or outcome must be initialled or signed electronically.
- If not applicable then write N/A and sign. In the EPR, this is left blank and signed.
- If there is a variation to an action/outcome initial the column with a V and report on the variance in the clinical notes.
- Document all changes in condition either as a variance or write in the clinical notes.
- If extra action/outcomes are required then add them into the additional action/outcome section e.g. Diabetic - diabetic diet, 4/24 blood sugars
- Ensure all Discharge Outcome goals are met and recorded as being met prior to discharge.
- Ensure the care path is indicative of the care delivered following your evaluations, e.g. the addition of new actions or outcomes if required.
- If a care path has ended or changed the reason needs to be documented and an alternative care path selected.

Clinical Notes

- Are to be used by nursing staff, credentialed specialists and allied health professionals to document progress or changes in a patient's condition; they should not duplicate information on the care path.
- Document when a credentialed specialist has been notified of a change in condition and subsequent orders that are given. Include who was notified and time of contact.
- Any abnormal diagnostic results should be reported to the nursing and medical staff involved in the patients care
- If your clinical notes finish midway along a line draw a line from your last word to the end of the line, e.g. vital signs now stable _____ (signature & designation).
- In the EPR, the entry status is changed to 'authorised' once completed. If the entry needs to be changed or updated, then the status is changed to 'amended' to allow for

the change. The entry must then be authorised again. There is an edit trail which allows for monitoring of this.

- Ensure the care path reflects the patient’s response to care, daily progress, medication and education. Write in clinical notes as appropriate.
- Ensure the clinical notes provide evidence of supervision and delegation as required.
- Ensure the clinical notes record consent for student participation in care
- Document any complaints from the client and their family in the notes and on the incident management system or complaint form whichever is the most appropriate. Any disclosure of error shall be written in the notes
- Photos: refer below re: consent for and use of photos.

Patient Activities Form (Does not apply to Manaaki patients)

This form outlines the daily plan of care for the patient and is discussed with the patient on admission. It is given to patients on the ward post-operatively and used by the patients and nurses in their plan of care.

Doctor’s Admission Letter

The Doctors admission letter which is signed by the admitting specialist includes:

- (a) Provisional diagnosis
- (b) Treatment/surgery plan
- (c) Patient medical history including current medications and allergies
- (d) Length of Stay
- (e) Specific / individualised nursing requirements
- (f) There is written evidence of a relevant physical examination

In the case of gastroenterological procedures a copy of the General Practitioner’s referral letter to the medical consultant is an appropriate alternative to a “Doctor’s Admission Letter”

Consent form

(see the Consent Policy)

Preoperative check list

Will be completed for all patients who are going to Theatre

Site marking policy (see Site Marking Policy)

Will be adhered to prior to going into Theatre

Surgical Safety Checklist (see Surgical Safety Checklist Policy)

Shall be completed for every patient undergoing a procedure in Theatre

Surgical Count (see Surgical Count Procedure)

Shall be completed for every patient where appropriate.

Photos

- Any photos taken of a patient during a hospital admission by Mercy hospital staff or credentialed specialists must be dated and labelled with a patient label and then placed into the clinical notes with the patients consent (see consent policy).
- All photos taken using Mercy Hospital cameras/phone and/or emailed should be deleted once printed and a copy placed in Clinical Record and/or attached to the relevant record in the Incident management system

Trak record

- Time in and out of theatre
- Start and end of anaesthesia on Trak
- Time in and out of PACU on Trak
- Surgical preferences
- Anaesthetic preferences
- PACU preferences

Nursing and Anaesthetic Assistant Peri operative Record

This form should reflect the surgical procedure and shall include documentation of any products/medications inserted into the patient and provide sufficient detail to allow safe use or removal. This form includes

Nursing:

- Patient positioning
- Body Supports and pressure area prevention plan
- Skin check pre and post op
- Local anaesthetic
- Diathermy pad placement
- Wound drains, catheters, packs, blood loss, tourniquet time, dressings
- Specimens taken - noted on Perioperative record and Trak
- Circulating Nurse signature

Anaesthetic:

- Allergies
- Airway management
- IV therapy
- Invasive Monitoring
- Temp maintenance
- Pain management
- Anaesthetic Technician/Nurse signature

Surgeon Operation Record

Includes:

- (a) Diagnosis;

- (b) Statement and details of operation performed;
- (c) Post-operative instructions
- (d) Documentation of products remaining as implants, type, make, serial number
- (e) Surgeon's signature.

Anaesthetic Record

This includes:

- (a) Evidence of pre-operative assessment by anaesthetist;
- (b) Anaesthetic drugs, narcotics & antibiotics including doses and routes of administration;
- (c) Monitoring data;
- (d) Intravenous fluid therapy, if given;
- (e) Post-anaesthetic instructions where appropriate;
- (f) Signature of attending anaesthetist.
- (g) PACU data and appropriate ward handover information
- (h) Record of any problems encountered during anaesthetic

Medication Chart (see [Medicines Management Policy](#))

Fluid Balance Chart

It is the responsibility of every nurse caring for a patient who requires a FBC to ensure that the chart is complete. A FBC shall be an accurate reflection of all fluid in and out for a 24 hr period. Once a day the totals will be tallied and put onto the fluid status summary on the back of the observation chart by the nurse caring for the patient on that shift.

Observation Chart

(Includes adult, paediatric and neurological observation charts)

Provides a record of a patient assessment through recording of;

- A patient's haemodynamic status
- Pain and sedation score
- Peripheral perfusion
- Interventions e.g. O2 therapy, blood glucose
- EWS score determined with every set of observations
- Level of consciousness
- Oxygen requirement
- Score for IV lines
- A Registered Nurse must sign the observation chart on any shift where an Enrolled Nurse has been delegated the care of a patient.

Vital sign recordings must be at frequent enough intervals to reflect the complexity of the surgical procedure and to ensure any change in a patient's condition is detected, recorded, acted upon

Intervals must increase if;

- The patient is in the immediate post-operative period- first 4 hours

- Any of the recordings change substantially
- Patient becomes clinically unstable
- EWS (early warning system) score is 1-2 or greater

Where the patient's condition is causing concern a PEWS or EWS must be calculated and acted upon (see EWS Clinical Work Manual)

Discharge Summary (see [Discharge Policy](#))

Every patient receives a discharge summary either on line or as a copy for themselves, and their GP. Where manually provided a copy stays in the patient notes.

This summary outlines:

- The procedure that was undertaken,
- Any postoperative comments;
- Medication on discharge
- Follow up arrangements,
- Nursing comments
- Contact details in the event of the patient requiring any further advice or care.

The above list of documentation is not exhaustive. All other Mercy Hospital, MCC & MHC forms (some of which are area specific) and electronic data, require completeness, legislative compliance and accuracy.

Clinical Record Management

Filing

Filing of information in the clinical record must be kept up to date.

Filing shall comply with the relevant Clinical Records – Sequence for Patient Files as documented in Appendix 4.

Electronic Patient Records

The principles of electronic record keeping are the same as for paper records. This includes;

- Information security within Mercy as defined by security within Active Directory for access to files on the F Drive. Patient Administration System (PAS) security is defined by the role of the user and maintained by the TrakCare Super User administrators.
- Physical access to the organisation's information as above, again via secure login to all systems.
- Controlling access to on line patient information is defined by your position in the organisation and your role.
- Obligation of employees to protect and use information appropriately as defined by the Hospital Policies related to information and security.

- How to mitigate the effects of major systems failures as per Emergency Plan, Business Recovery Documentation and Disaster Recovery Documentation within the ICT Policies.
- If necessary, the electronic record shall be printed and placed in the patient notes e.g. providing information as part of transfer to a higher level of care.
- Documentation referring to the electronic records will be placed in the patient chart where applicable.

Diagnostic Tests and Results Recording and Reporting

Every diagnostic test will have recorded the name of the person responsible for the request, and all the recipients of the report. Electronic results sit on the external providers servers i.e. Southern Community Laboratories (SCL) and Otago Radiology and are accessible on demand via the internet. If printed they form part of the printed Clinical Record

- Laboratory staff record and sign in the register in each department, for all specimens taken.
- It is the responsibility of the credentialed specialist to review the results of tests that they have ordered. If a nurse is made aware of abnormal results it is expected that they notify the credentialed specialist
- Any abnormal results are to be highlighted in the patients progress notes.

Use of Abbreviations

It is the responsibility of any person making an entry into the clinical record to ensure that only Mercy approved abbreviations are used (see Appendix 1)

Clinical Records Security

Access to clinical records

- 24hr access to clinical records is available through the Clinical Records staff, the Senior Nurse on call and McAuley nursing staff.
- Requests for access to records for research purposes must have ethics approval and are subject to terms of that approval (refer [Research Policy](#))
- Requests for access to records from the other providers are managed by Clinical Records as per the [Privacy Policy](#).
- Physical access is restricted to the clinical records area by the use of security tags and/or keys held at Reception and McAuley ward.

Te Whatu Ora Contract Case Notes

- All notes pertaining to the contracted procedure for this group of patients are returned to Dunedin Hospital. (See Appendix 5 for process regarding accessing **Te Whatu Ora** records).

Copying

If a patient requires transfer or discharge to a long term care facility (excludes acute transfers)

- All relevant notes will be photocopied.
- All Trak data will be completed prior to discharge.

Acute Transfer to another Hospital

- All notes and x-rays are to accompany the patient. Also include other relevant patient documentation e.g. Observation chart/MEWS scores, Fluid Balance chart and drug charts.
- Clinical records are to remain in the blue folder.
- A Mercy Hospital sticker stating “Please return to Mercy Hospital Dunedin ASAP” must be attached to the front of the folder.
- Inform ward receptionist or Clinical Records office if notes have left the hospital.
- All Trak data must be completed prior to discharge.

Storage

Patient files from the preceding 6 years are held at Mercy in the Clinical Records Department; older files are stored off-site at Crown Storage facility.

Tracking

- All records removed from Clinical Records Department for viewing by Credentialed Specialists etc. must be recorded on a log in the Clinical Records office and signed back in when returned.
- All documents sent to Credentialed Specialists etc. must have a covering form attached requesting notification of any contents that have been photocopied.
- All records awaiting verbal order signatures on McAuley ward must be recorded in Clinical Records on the tracking form as to whereabouts and then and signed in when returned.
- All current records that have previous records attached to the file, must be signed off as patient progresses through Mercy Hospital:
 - Pre-admission or Pre-admission Manaaki
 - Admission
 - Theatre
 - PACU
 - Ward
 - Discharge

Retention /Destruction

- Records are stored for the appropriate timeframe as set out in legislative requirements
- Patient Health Records: Minimum of 15 years (Retention of Health Information Regulations 1996) General Disposal Authority for DHBs DA262, (excluding paediatric records)

- Financial Records (7 years): (Companies Act 1993; Tax Administration Act 1994; Goods and Services Act 1985; Holidays Act 2003; Employment Relations Act 2000)
- Human Resources Records (7 years)
- Controlled Drug Record (10 years) Misuse of Drugs Regulations 1977

Where an electronic record is deemed to be part of the clinical record, this information will also be kept indefinitely.