**Key Words:** Clinical Records, Alerts, Allergies

**Policy Applies to:**
- All Mercy Hospital staff who contribute to a patient’s written or electronic record.
- Credentialed Specialists and Allied Health professionals’ compliance will be facilitated by hospital staff

**Related Standard:**
- **EQuIP criterion 1.1.8** - The clinical record ensures comprehensive and accurate information is recorded and used in care/service delivery;
- **EQuIP criterion 2.3.1** - Records management systems support the collection of information and meet the organisation’s needs.

**Rationale:**
Mercy Hospital staff recognise that the Clinical record is the primary document for ordering, recording and evaluating clinical care and it has clinical and medico-legal significance for the patient, staff, Credentialed Specialists and Allied Health personnel.

**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 within the health care team.

**Implementation:**
- Via staff education forums.
- Documentation forms part of nursing orientation to an area
- Website access to new / updated policies for Credentialed Specialists and Allied Health Professionals
- Combined Credentialed Specialist and Mercy Hospital Meetings
- Medical Advisory Committee
Evaluation:
1. Via audits of:
   - Medication charts (pharmacist)
   - Consent forms (Clinical audits- McAuley and DSU)
   - Incidents (Global audit)
   - Clinical records (Global audit)
2. Incident forms
3. Clinical records KPI,s
   a. Accuracy of admission charts
   b. Track file returns to Clinical records
4. Complaints
5. Patient/staff feedback

Associated Documents
External:
- Health & Disability Sector Standards NZS 8134: 2008 5.1, 5.2
- NZNO : 1998 Documentation: A five year saga for health professionals
- Health & Disability Commissioner Act (Code of Rights)1994
- Privacy Act 1993
- 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:
- Research Policy – Hospital Policy and Information Manual
- Medicines Management Policy – Clinical Services Policy Manual
- Privacy/Release of Information Policy - Hospital Policy and Information Manual
- Information Security Policy - Hospital Policy and Information Manual
- Return or disposal of Body Parts – Clinical Services Policy Manual
- Discharge Policy – Clinical Services Policy Manual
- Transfer Policy – Clinical Services Policy Manual
- Consent Policy –Clinical Services Policy Manual
- Patient Assessment Policy –Clinical Services Policy Manual
- Contacting Medical Staff Procedure – Clinical Services Work Manual
- MEWS (Modified Early Warning System) procedure – Clinical Services Work Manual
- Mercy Hospital By-Laws for Accredited Professionals
Acknowledgements
Clinical Records Management Policy, Waikato District Health Board, 14th November 2008
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## Alerts , Allergies and Drug Side Effects
- Definitions
- Documentation of alerts, allergies drug side effects
- Medical Alert label
- Electronic recording of an alert
- To put an Alert, allergy or drug side effect on a patient already admitted
- Electronic Documentation of an NHI notification alert
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  Copying
  Acute transfer to another hospital
  Storage
  Tracking
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Surgical Audit

Appendices
  1. List of approved abbreviations
  2. Boarder process
  3. Clinical Records – Sequence for Patient Files
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,

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 nonimmunologic 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; sulpha 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.

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 will be made prior to a patient’s admission, by Reception initially then the Bookings Coordinator from information given by the patient on the Health Questionnaire and from the Doctor’s Admission Letter. For stay over patients the preadmission Nurse will reconfirm with the patient any alerts, allergies and side effects at the time of the preadmission phone call.

At admission the admitting nurse will also verify presence or absence of any Alerts, Allergies or medication side effects.
Allergies/adverse reaction to medicines/food/products and Medic Alert information shall also be documented in the medication chart where appropriate, the Nursing Assessment form and transcribed onto the pre-operative check list.

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

An alert sticker 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.

**ALERT LABEL**

- 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 blue Clinical Records chart.

A same name alert is managed by nursing staff on the ward i.e. label placed on ward patient census whiteboard and on the outside of patient chart.

For pre admission clinic patients who have the same name a sticker will be added to the front of the patient's notes and removed at the end of the preadmission clinic by Reception staff.
Electronic recording of an Alert
All alerts will be revalidated on each admission.
There are several Alerts setup in the TrakCare system.

If there is a Yellow Triangle on the Patient Banner there are Alerts, Allergies and/or Drug side effects and you should click the Yellow Triangle to view what Alerts have been set against the Patient Episode.

The following Alerts do not have their own Icons
- Administrative
- Community
- Challenging Behaviour
- Financial
- Health
- CJD
- Sensory Impairment
- Mobility Impairment
- Infectious Disease Risk
- Same Name
- Jehovah’s Witness – No Blood Products
- Tapes and dressings

The Alerts listed below have their own Icon – if you hover the cursor over the Icon it will tell you what the Alert is.

- Custody Issues Icon
- MRSA Pending Icon  
- Alias names exist Icon
- Food Allergies Icon
- Latex Allergy Icon
MRSA Positive Note this star rotates
Boarder (see appendix 3 for process)
Drug side effect
Medication Allergies. If a patient states that they have an allergy to a medication, e.g., antibiotics make my face swell this will be denoted by the red A. The Alert Category "Allergy" is the ONLY category that will activate the red A icon on the Patient Banner.

NHI Notification Alert The NHI notification will only come up if there is an NHI notified alert. Mercy will not use this category which feeds directly into the NHI database unless we have documented proof of an actual allergy or issue that requires external reporting (eg; MRSA positive, or confirmed anaphylaxis to a specific product). In general this symbol will be externally and automatically generated into our system by the National Health Information Service (NHIS)

There are security restrictions on the following Icons – only specified security groups will be able to view/add these particular Icons.

Food Preferences Only the Super Users and the Kitchen security group can see this Icon.
Bad Debtor Only the Super Users, Reception and the Billing security group can see this Icon.

To put an Alert, Allergy or Drug Side Effect on a patient that is already admitted.

Go to the Ward Map, OT Diary or Episode List to select the specific patient
Click on the Patient Demographic Icon on the Patient Banner

This will open up the Patients Details (Demographics) Screen
Then click the Alerts, Allergies & Side Effects link on the right side of the screen.

Click New

ALERTS, ALLERGIES & DRUG SIDE EFFECTS LIST

![Alerts Allergies & Drug Side Effects List]

This will open up the detail screen to add a new Alert, Allergy or Drug Side Effect.

ALERTS, ALLERGIES & DRUG SIDE EFFECTS

ARE FOR CLINICAL CLERICAL AND AND ADMINISTRATIVE PURPOSES ONLY.

Alert Category

Date Created 19 Jul 2011

Duration of Alert

Current Status Active

Alert Message

Review Date

Closed Flag

Expiry Date

Expiry Reason

Click on Alert Category look-up (“magnifying glass” icon) and pick the Alert required.
Select the required Alert – Note: You may not see all these alerts as it is dependent on your security settings. 
Tab to subsequent fields to fill in all relevant details.

Press **Update Tab** and the Alert, Allergy or Side Effect Alert will now show on the Patient Banner. The **Alert Message** section is bolded and it is mandatory to enter free text data with specific information related to the details of any alert such as Allergen and specific reaction information including documenting MRSA.

Following discharge if an alert label is on the blue folder when the file is being collated an alert label will be placed on the front cover of the permanent file stored in Clinical Records.
Electronic Documentation of an NHI Notification Alert

The steps are similar to setting up an Alert, Allergy or Side Effect. Click on the NHI Notification Alert Link as below – **Do Not** choose the NHI Medical Warning System to document an Allergy with the National Health Information database **unless you have discussed this with a Nursing Manager.** The allergy must have been proven by blood work, skin testing or by third party evidence e.g Drs Letter. It is very important that only accurate and proven information is forwarded onto this system as this information will follow the patient to any hospital in New Zealand. A confirmed allergy must have this status recorded as both an Alert and an NHI Notification Alert on Trak Care to ensure notification of the NHI database.

Select a **NEW** NHI Notification Alert to enter new information or select **EDIT** box if you wish to amend an existing Alert.

The **New** tab takes you to the NHI Notification to MOH Details Screen

**The Nature of Reaction** Look Up opens the following table

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHI Medical Warning System</td>
<td>MWS</td>
</tr>
</tbody>
</table>

This Code will automatically update the NHI Database.
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.
- This report highlights all previous admissions to Mercy and allows old notes to be retrieved.

- 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 that are collected from McAuley Ward.

Recording of Personal/Service Information

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

- Full name, date of birth and gender. If a child, include names and addresses of both parents
- Patients current address, not a PO Box number
- Patients preferred person to be contacted in an emergency
- Patients ethnicity data
- Payer

Admission Information

Pre-admission Nurse

Most stay-over patients will have been nurse pre-admitted either by telephone or at preadmission clinic the night prior to surgery.

A nursing assessment is completed and documented on the nursing assessment form.

The nurse will pay particular attention to:

- Allergies and sensitivities and ensure these are correctly documented in the clinical notes and on Trak.
- Any questions to which the patient has answered “yes” on the health questionnaire especially in relation to smoking, alcohol consumption; cardiac history and changes in health status.
- Any factors which will impact on the patient’s care whilst in hospital
- Patient’s arrangements for discharge
- Patient’s medication. If the patient has indicated they are taking several medications, ask them to contact their GP and get a list of current medications faxed to Mercy. If admission & surgery is the following day, the DSU nurse may need to do this on or prior to admission.
The pre-admission nurse will advise the surgeon of any changes in health status in the last 2 weeks and / or as per the guidelines for preadmission nurses.

**Pre-admission Clinic Coordinator**
- The Pre-admission Co-ordinator is responsible for ensuring the clinical records are returned to main reception at the end of the clinic.

**Reception**
At time of preadmission the name and NHI are checked on the old notes and that they are in the correct file. ‘Previous records attached’ sticker on the front of the folder is also signed. Once they have been seen by the anaesthetist/surgeon at preadmission, the Reception staff are responsible for entering the patient’s admission to hospital time on Trak.

Patients report to Main Reception and are taken through to DSU once reception staff have:
- Checked data on patients wrist band is correct
- Checked list of people who are able to be given information on patient condition is completed on the admission form
- Checked Consent Forms for surgery and anaesthetic have been signed by patient, surgeon and anaesthetist. If not, alert the admitting nurse by placing a “sign here” sticker on the consent form.

**Nursing staff**
- Complete nursing documentation forms.
- Undertake requested interventions noted on the Doctors Admission Letter and then sign as completed.
- Check Health Questionnaire on admission form is completed. Note and report any issues or special needs
- Check alerts, allergies and drug side effects are accurately recorded
- 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

**Diagnostic tests**
- Ensure pre-operative check list is completed including:
  - Blood tests – ordered, received and checked
  - Cross-match if required;
  - Pre-op x-rays;
Entries into the Clinical Record

The following are required elements of all clinical records at Mercy Hospital

They must:

- Complete baseline observations, i.e. T,P,RR,BP weight, SpO₂; ECG,BMI (if required). Report abnormal results to anaesthetist
- Check skin for lesions/tears.
- Note and record drug allergies or sensitivities on drug chart or record No Known Drug Allergies (NKDA). It is not acceptable to leave this blank.

- Entries into the Clinical Record

The following are required elements of all clinical records at Mercy Hospital

They must:

- Have all pages (both sides) in the patient’s records labelled with identification data that includes the patient’s NHI number.
- Be written legibly.
- Be written in permanent ink.
- Record date, time, signature, and title in a way that is legible.
- Be written in chronological order
- Be written objectively; be specific and factual
- Use the correct terminology, e.g. cyanosed instead of “blue”.
- Only use abbreviations and acronyms that are on the approved list
- Have entries recorded as soon as possible.
- Record any adverse events, complaints or incidents and record that an incident form has been completed and disclosure has been made.
- Ensure there are no blank spaces. Draw a line through unused pages or spaces on a line.
- Have any amendments noted as such and 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.
- Pharmacists only may use an approved green pen for writing on the medication chart or in the clinical notes.
- Convey effective communication within the health team.
- Have identified the reason for admission or entry to the hospital.
- Provide to the Credentialed Specialist the information required for the effective delivery of care as well as sufficient information for other personnel to assume care of the patient;
- Provide for allocation of complete and precise diagnosis and procedure codes.
- Have prominently displayed appropriate notations for any allergies and drug reactions.
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.
  - 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 late entries

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

- Clearly identify the entry as a “late entry”
- Include the date and time of the late 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 late entry

A late entry shall never be made after receipt of notice of a potential claim.

Missed entry

Where a nurse remembers that she has omitted writing in a clinical record they will either return to work or 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 late entry the next day, using the process as outlined below.
Clinical Record Content

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.

A Nursing Assessment Form –

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

This form is designed to aid nursing assessment, planning, identification of special needs and risk assessment for patient care in hospital and on discharge. The form 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 Care Path. (See [Patient Assessment Policy](#) and [Discharge Policy](#))

Each patient must have the appropriate clinical pathway commenced on admission

A Care Path that shall meet the following standard:

- There will be an entry for each shift. 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.
- If not applicable then write N/A then sign
- 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 the care plan is ended for any reason an alternative plan of care must be commenced.

**Clinical Notes:**
- Are to be used by nursing staff, credentialed specialists and other 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 are to be reported to the credentialed specialist and highlighted in the patient’s progress notes.
- 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)
- Ensure the care path reflects the patient’s response to care, 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 an incident form or complaint form whichever is the most appropriate. Any disclosure of error to be written in the notes.
- 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 patient notes. Where the photo is part of the surgical procedure consent is implied as it is used in subsequent discussion with the patient about the procedure and they receive a copy of the photo from the surgeon. Where a photo forms part of the post-operative record verbal consent must be gained and a comment to this effect written in the notes.
Patient Activities Form
This form outlines the daily plan of care for the patient and should be discussed with the patient on admission. One copy is given to the patient and a signed copy is kept in the patient’s notes.

Doctor’s Admission Letter
Nurses should check this on admission for relevant information and specific instructions. This form should then be signed and dated to indicate that the instructions have been read and carried out.

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) Specific nursing requirements
   (e) 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 Consent Policy)

Preoperative check list
Shall be completed for all patients who are going to Theatre

Peri-Operative Documentation
Site marking policy (see Site Marking Policy)
Shall 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 or a patient’s surgical site during the operative procedure are to be dated and labelled with a patient label and then placed into the patient notes.
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 Perioperative Record
This shall include documentation of any products 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, antibiotic 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
Provides a written 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
- MEWS score determined with every set of observations
- 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 ensure any change in a patient’s condition is detected, recorded and acted upon. Intervals must increase if;
- The patient is in the immediate post-operative period
- Any of the recordings change substantially
- Patient becomes unstable
- MEWS (modified early warning system) score is 1-2 or greater
Where the patient’s condition is causing concern a MEWS must be calculated and acted upon (see MEWS Policy)
**Discharge Summary (see Discharge Policy)**

Every patient receives a discharge summary, a copy for themselves, their GP and 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.

This list of documentation is not exhaustive. All other Mercy Hospital forms and electronic data require completeness, legislative compliance and accuracy.

**Paper work specific to Mercy Cancer Care (MCC)**
- MCC oncology consent form is specific to a chemotherapy protocol and type of cancer being treated. This incorporates consent for blood products, in line with the Mercy Hospital consent form.
- MCC oncology assessment form for chemotherapy session.
- Oncology Chemotherapy Care path from Trendcare printed after each chemotherapy session for clinical records.
- Oncologist clinic notes Suite 22 pre chemotherapy cycles are in clinical records.
- Oncology Education Checklist is pre chemotherapy only.
- Oncology chemotherapy patients only do one detailed admission form as they come in 2weekly to 3 weekly. This is only updated if there is a change in any detail or situation

**Filing**

Filing of information in the clinical record must be kept up to date. From February 2012 storage of any files at Crown storage are those records is prior to 2003.

Filing shall comply with the relevant Clinical Records – Sequence for Patient Files as documented in Appendix 2.

**Electronic 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 per above, again via secure login to all systems.
• Controlling access to information for Trak, Trendcare and Incisive (MCC) 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.

**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. SCL print results automatically to a printer as well as being on demand at McAuley Reception and then form part of the printed Clinical Record.

All diagnostic results will be recorded in the patient’s clinical record

• Responsibility for checking results and reporting any abnormalities rests initially with the nurse caring for the patient on each shift.
• Laboratory staff record and sign in the register on each ward, all specimens taken.
• Any abnormal results are to be highlighted in the patients progress notes and reported to the relevant credentialed specialist
• Nurses/reception staff to be alert to receiving results.
• Where blood results are not in the patients notes at time of admission DSU staff to print off a copy of the results for the notes
• Any abnormal results to be phoned through to anaesthetist or surgeon immediately.
• The nurse should then make a note of abnormal blood results in the notes.
• **NB:** Normal Range as found on Blood Report forms.
• It is the Credentialed Specialists responsibility to check and sign off blood results prior to filing.
• Reports to then be filed by Ward Receptionist. – Nursing Staff collect these during the day off a clip as required/received. If time allows the receptionist will file into front of patient chart.
Use of Abbreviations
It is the responsibility of any person making an entry into the clinical record to ensure that only Mercy authorised abbreviations are used (see Appendix 1)

Clinical Records Security

Access to clinical records
- 24hr access to clinical records is available through the Clinical record 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

SDHB Contract Cases
- All notes pertaining to the contracted procedure for this group of patients are returned to Dunedin Hospital. (see Appendix 3 for process regarding accessing SDHB 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. Obs. chart and Fluid Balance chart.
- 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 folder. Inform ward receptionist or Clinical records office if notes have left the hospital.
- All Trak data must be completed prior to discharge

Storage
Currently all clinical records less than 8 years old are kept on site in a secured room. Clinical records greater than 8 years (from 1992 to December 2006) and deceased records are kept off site in a storage facility at Crown Records Management.
**Tracking**

- All records removed from Clinical Records for viewing by Credentialed Specialists etc. must be recorded 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 file must be signed off as patient progresses through the hospital:
  - Pre-admission
  - Admission
  - Theatre
  - PACU
  - Ward
  - Discharge

**Retention / Destruction**

The Public records Act 2005 identifies the minimum retention period for clinical records. At Mercy Hospital clinical records are currently kept indefinitely and are not destroyed. Where an electronic record is deemed to be part of the clinical record this information will also be kept indefinitely.

**Forms**

All forms used in the Mercy Clinical Record will be authorised by a member of the Clinical Services Team.

**Surgical Audit**

A report is generated from this data by the IT Department and sent to Credentialed Specialists for surgical audit purposes every month.