

## Policy Applies to:

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

## Related Standard:

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

## 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, 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 between health care team members.

## 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
- Via credentialing processes

## Evaluation:

1. Via audits of:
  - Medication charts (pharmacist)
  - Consent forms (Clinical audits- McAuley, DSU and Manaaki)
  - Incidents (Global audit)

## Clinical records (Global audit)

2. Incident forms
3. Monitoring of Clinical Records including
  - a. Accuracy of admission charts via feedback from DSU staff
  - b. Tracking files removed from and returned 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:

- Adverse Reaction to Medication Policy
- Alcohol Withdrawal Guidelines - Clinical Services Work Manual
- Chaperoning Policy
- Clinical Imaging Policy
- Consent Policy
- Contacting Medical Staff Procedure - Clinical Services Work Manual
- Discharge Policy
- Family Violence Policy
- Information Communication Technology Governance Policy
- Information Communication Technology Security Policy
- Information Management Policy
- Medicines Management Policy
- Mercy Hospital By-Laws for Accredited Professionals
- MEWS (Modified Early Warning System) procedure - Clinical Services Work Manual
- Nursing Model of Care/Clinical Handover Policy
- Nursing Scope of Practice
- Nutritional Care Policy
- Patient Assessment Policy
- Privacy/Release of Information Policy
- Research Policy

- Return or disposal of Body Parts Policy
- Site Marking Policy
- Social Media Policy
- Surgical Safety Checklist Policy
- Transfer 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,

**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; 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 should be made prior to a patient's admission, initially by Reception staff at the main hospital, then by the Bookings Coordinator 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 admission, the admitting nurse shall 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 (medication related

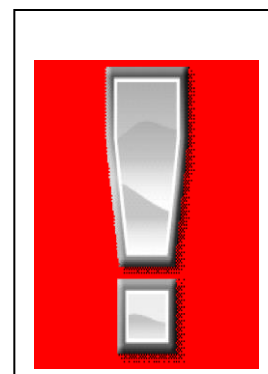
only & written in red), the Nursing Assessment form and TrakCare; this information shall be transcribed onto the pre-operative check list.

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

### **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 is managed by nursing staff on the ward i.e. label placed on ward patient census whiteboard and on the outside of patient chart. A same name alert may be added to Trak by the Booking Coordinator.

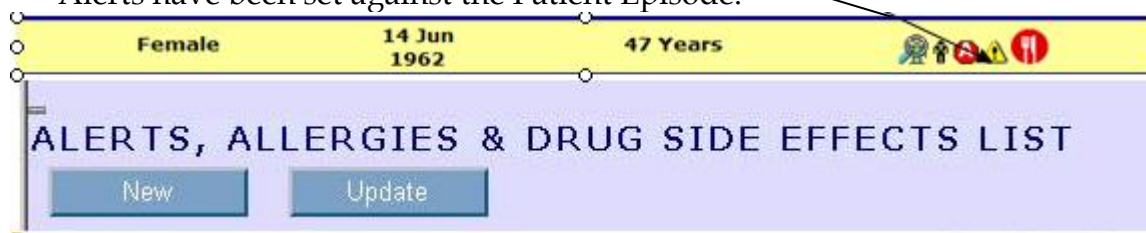
For pre admission clinic patients who have the same name a sticker will be added to the front of the patient's notes and removed at the end of the preadmission clinic by Reception staff.

**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 Trak icons**











- Administrative
- Community
- Challenging Behaviour
- Financial
- Health
- CJD
- Sensory Impairment
- Mobility Impairment
- Infectious Disease Risk
- Jehovah’s Witness – No Blood Products
- Possible Day Case or Stayover
- 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.





- Alias Names Exist 
- Allergy  General Allergy excluding Food and Drug Sensitivities which have their own category
- Boarder  (see Appendix 3 for process)
- Custody Issues  Designates prisoners with guards
- Drug side effect 
- Food Allergies 



- Food Intolerances 
- Food Preferences 
- Latex Allergy Icon 
- Lymphoedema  Note the Laterality of the affected limb
- MDRO Pending  **Note:** this star rotates and changes colour
- MDRO Positive  **Note:** this star rotates and changes colour
- Possible Day case or Stayover 
- Privacy/Restricted Visitor Access 
- Soaps & Detergents  **Note:** this Star does not rotate or change colour!
- Same Name 

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

- Bad Debtor  Only the Super Users, Reception and the Billing security group can see this Icon.
- NHI Notification Alert 

The NHI notification will only come up if there is an NHI notified alert. Mercy staff 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 e.g. MDRO 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 Index (NHI) from the Ministry of Health (MOH)

## Automatically Generated Alerts

At Manaaki, there are a number of icons that are generated by scoring on Assessment Questionnaires. These include:

VTE	VTE Risk	webemr/red_star.png	★
SM	Smoker Heavy	webemr/stop.gif	Ⓢ
FR	Falls Risk	webemr/redtrafflight.gif	●

### 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. NB 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 gender. 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

### Pre-Admission

#### *Pre-admission Nurse*

Most 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 or in the patient's electronic patient record (Trak Care) as per the Patient Assessment Policy.

- The pre-admission nurse will advise the surgeon/anaesthetist 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.

### Admission

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

- Data on patients wrist band is correct
- The list of people who are able to be given information on patient condition is completed on the admission form
- Consent forms for surgery and anaesthetic have been signed by patient, surgeon and anaesthetist. If not, they will alert the admitting nurse by placing a "sign here" sticker on the consent form.
- Move the patient into the 'foyer waiting area' on Trak Care (n/a for Manaaki)

### *Nursing staff*

- Review and or complete nursing / risk assessments.
- 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. Note and report any issues or special needs
- 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
- Ensure pre-operative check list is completed and signed.
- Complete baseline observations, i.e. T, P, RR, BP weight, SpO<sub>2</sub>; ECG, BMI (if required). Report abnormal results to anaesthetist.
- Check skin for lesions/tears.
- 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.

### **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 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 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 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.
- 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.

### **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 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 retrospective entry the next day, using the process as outlined above.

### **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***

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 Care Path. (See [Patient Assessment Policy](#) and [Discharge Policy](#))

### Care Path

Each patient must have the appropriate clinical care pathway commenced on admission; this includes a printed pathway and selection of the correct pathway in TrendCare

*A Care Path shall meet the following standards:*

- 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 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 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 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 patients 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).
- 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, 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 shall be written in the notes
- Photos: refer to next page 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. The form is signed by the patient and is kept in the clinical record.

### *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) Specific / individualised 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 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 (see consent policy).

***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 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, 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***

Provides a record of a patient assessment through recording of;

- A patient's haemodynamic status
- Pain and sedation score
- Peripheral perfusion
- Interventions e.g. O<sub>2</sub> 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 Work Manual)

### *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.

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.

### **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 information for Trak, TrendCare, Provation (Manaaki) 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.
- 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. 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.

- Laboratory staff record and sign in the register in each department, for all specimens taken.
- During the day, laboratory results are usually received by the departmental receptionist and are either placed on a clip or are placed in the inside pocket of the patient's clinical record.
- It is the Nurses responsibility to check the results and notify the Credentialed Specialist of any abnormal results.
- Any abnormal results are to be highlighted in the patients progress notes

### **On Admission**

- 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, and
- Any abnormal results shall be phoned through to anaesthetist or surgeon immediately.
- The nurse shall document the abnormal blood results in the progress notes.
- **NB:**Normal Range as found on Blood Report forms.

### **Filing of Blood Results**

- It is the Credentialed Specialists responsibility to check and sign off blood results prior to filing.
- Reports may then be filed by Ward Receptionist / Hospital Aid.

## 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.

### *SDHB Contract Cases*

- All notes pertaining to the contracted procedure for this group of patients are returned to Dunedin Hospital. (See Appendix 5 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. Observation 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 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***

The Public Records Act 2005 identifies the minimum retention period for clinical records. At Mercy Hospital clinical records are 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.