

 <p>BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI</p> <p>HEALTH RECORDS PROTOCOL</p>	<p>HEALTH RECORD - CONTENT AND STRUCTURE</p>	<p>Policy 2.5.2 Protocol 2</p>
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STANDARD

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

OBJECTIVE

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

CONTENT OF HEALTH RECORD

1. Wherever practicable, the patient / client shall have a single, integrated health record.
2. The health record may be in either / both hard copy and electronic format.
3. Where not practicable, any health record maintained for patients in individual locations within Bay of Plenty District Health Board (BOPDHB) must be accessible to other health practitioners (as appropriate).
4. The Patient Management System will indicate those services maintaining a health record for a patient outside the main health record, including the current location of their health record.
5. Primary health records will be held only in the following locations:
 - 5.1 Tauranga Hospital
 - 5.2 Whakatane Hospital
 - 5.3 Mental Health
 - 5.4 Maternity and Newborn
 - 5.5 Allied Health
 - 5.6 Community Health and Disability
6. The location of every health record must be known at all times by record on the tracking system of the local patient management system.
7. Whenever a health record is physically moved around the organisation, it will be tracked to its new location.
8. The health record must be clearly identifiable as a health record, contain the patient's unique identifier, and be organised into designated sections.
9. Primary health records will consist of, but not limited to, the following components:
 - 9.1 Consumer patient details
 - 9.2 Key health information summary
 - 9.3 Consents
 - 9.4 Outpatient / inpatient care episodes
 - 9.5 Referrals – received and sent
 - 9.6 Correspondence
 - 9.7 Assessment(s)
 - 9.8 Investigations and results
 - 9.9 Diagnoses
 - 9.10 Treatment / care / management plans
 - a) Treatment / care provided

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HEALTH RECORDS
PROTOCOL

- b) Evaluation of treatment / care provided
 - c) Medication orders and administration documentation
 - d) Information that is provided to the consumer about available options, and the risks, benefits and side-effects of those options
 - e) Consumer / patient consent to treatment / care
 - f) Peri-operative / operative / post-operative and anaesthetic records
 - g) Advance directives
 - h) Other procedures and therapies
- 9.11 Progress / review
 - 9.12 Education
 - 9.13 Discharge letter(s) / summary
 - 9.14 Follow up
10. The sequence of each record must follow a defined and specified order as set out in a protocol for each area where primary health records are held.
11. Hard copy primary health records must not reach a thickness of more than 5-7 cm per volume. Once this size is reached, the record must be split into volumes according to the protocol. Where more than one volume exists, it will be identifiable on BOPDHB's patient management system.

ENTERING INFORMATION INTO HEALTH RECORDS

1. Entries into health records must only be made by a health professional or those who have been authorised to do so.
2. Each entry must include the following information:
 - 2.1 Accurate date and time
 - 2.2 Full signature (if not easily identifiable, the name should be printed alongside each entry – this may be done electronically for electronic requests, reports and records)
 - 2.3 Designation of the health professional
3. Documentation should occur as soon as practicable after any event / interaction with the patient.
 - 3.1 Health professionals should document as frequently as indicated by the clinical condition of the patient / client.
 - 3.2 They should document each patient / client contact or one entry per shift, whichever is more appropriate.
 - 3.3 If any information cannot be recorded, reasons for this must be documented.
 - 3.4 If information is received from another health professional, the source of the information must be stated. Name, designation and relationship to patient must also be recorded.
4. Each entry must be:
 - 4.1 Factual, consistent, accurate, legible and complete.
 - 4.2 Objective, relevant, and understandable and not include meaningless or misleading phrases, irrelevant speculation and inappropriate subjective statements.
 - 4.3 Recorded wherever possible in consultation with the patient/client or their nominated representative.
 - 4.4 Recorded in a manner that the text cannot be erased
 - 4.5 In blue or black permanent ink or typed text (only pharmacy may use green permanent ink to annotate on medication charts).

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4.6 Chronological within each section

4.7 Compliant with generally accepted standards for the profession

5. Errors are to be indicated by one line through the entry with “**Error**” written above the entry and signed in full in the margin adjacent to the error.
6. Chart an omission as a new entry. Do not backdate or add to previously written entries.
7. Blank spaces are not to be left in any section. If a space is not filled, a line must be drawn through the space across the section – this must then be signed and dated.
8. Record the date, time, participants and content of all telephone patient-related communications with health professionals.
9. Whenever a legal responsibility is discharged, this must be documented e.g. notification to the Medical Officer of Health of an Infectious disease.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 2.5.2 Health Records Management
- Bay of Plenty District Health Board policy 2.5.2 Protocol 1 Health Record - Standards
- Bay of Plenty District Health Board policy 2.5.2 protocol 3 Health Record - Access to Personal Health Information
- Bay of Plenty District Health Board policy 2.5.2 Protocol 4 Health Record - Transportation by BOPDHB Staff
- Bay of Plenty District Health Board policy 2.5.2 Protocol 5 Health Record - Retention and Destruction of Inactive Health Information
- Bay of Plenty District Health Board policy 2.5.2 Protocol 7 Health Record - Inpatient Care Pathways
- Bay of Plenty District Health Board policy 2.5.2 protocol 8 Health Record - Abbreviations List
- Bay of Plenty District Health Board policy 2.5.1 Health Information Privacy
- Bay of Plenty District Health Board Personal Information Request (8264)
- Bay of Plenty District Health Board Policy 6.3.5 Falls - Risk Reduction and Management of Inpatient Falls
- Bay of Plenty District Health Board General Disposal Authority

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