STANDARDS TO BE MET

1. Documentation

1.1. The health record must be an accurate reflection of the interaction between the healthcare provider and the patient / client and not subject to ambiguous interpretation, alteration or deletion.

1.2. Only approved abbreviations may be used in the health record (refer to BOPDHB Approved Abbreviations List).

2. **Unique Identification of the Health Record** (*Minimum Requirements of the New Zealand Health information Service*)

2.1 The following data items are required for registration of clients/patients for a NHI number:

a) Family name and first given name. Second and third given names shall also be supplied where applicable;
b) A preferred name indicator which is a flag indicating which given name the patient / client prefers to be known by;
c) Alternative names as appropriate;
d) Date of birth;
e) Gender (sex);
f) Ethnicity;
g) Usual residential address;
h) Domicile code;
i) Residency status indicating whether or not a patient / client is a permanent New Zealand Resident.

3. Content and Structure

3.1 The health record may be in either / both hard copy or electronic format.

3.2 Wherever practicable, the patient / client shall have a single, integrated health record.

3.3 The health record must be clearly identifiable as a health record, contain the patient / client's unique identifier (NHI number), and contain only information that relates to an individual patient / client.

3.4 The sequence of each health record must follow a consistent defined and specified order as set out in specific protocols.

4. Health Record Information

4.1 Each patient / client has one NHI number that is used within the organisation.

4.2 Health record information will only be released to patients / clients and third parties in accordance with the Health Information Privacy Code 1994 and any subsequent amendments.

4.3 Copying and duplication of health information concerning a patient / client is only carried out when essential.

4.4 Health records are correctly transferred when the organisation / service provider is no longer providing services.

4.5 The rights of the patient / client are maintained during the use of health records in research, audit, teaching, training and examinations.

5. Patient / Client Details

5.1 Patient / client details will be collected at the first point of contact and verified at each subsequent episode.

5.2 Collection of information from the patient / client must be in accordance with principles set out in the Health Information Privacy Code.

6. Patient Labels

6.1 Patient labels must be produced for each event, if practicable.

6.2 If labels cannot be produced, the minimum information on each page must be patient name, date of birth, NHI number and event number. These details should be verified for accuracy.

6.3 Excess labels from a previous admission must be destroyed and not be used for a current admission.

7. Tracking

7.1 The location of all patient / client health records must be identifiable at all times.

7.2 Where the patient / client is responsible for his / her own health record, this is documented.

8. Access and Privacy

8.1 Only authorised people entitled to view the information in the course of providing and evaluating services to the patient / client shall have access to individual health records.

8.2 Persons will have access to their own personal health information that is held by the BOPDHB within 20 working days of the request, when the request meets the criteria.

8.3 Third party requests (requests by other people or organisations) may also be actioned where the request meets legislative requirements and the requirements of this policy.

8.4 All BOPDHB employees will receive appropriate training relating to privacy and access of patient / client health records and information.

9. Storage and Security

9.1 The health record must be stored in a way that facilitates ease of authorised access to the information, and in conditions that preserve the medium.

9.2 Electronic storage media shall be physically protected from damage, theft or unauthorised access and the information contained disposed of in a secure and safe manner when no longer required.

9.3 The organisation will have clear guidelines and processes for preservation of confidentiality, integrity and availability of both physical and electronic health records.

9.4 Any identifiable patient / client documentation no longer required must be confidentially destroyed.

10. Transportation

Health records are transported in a manner that maintains the confidentiality of the patient / client and the integrity of the health record.

11. Retention and Destruction

11.1 Health records should be preserved in a manner that ensures they are retrievable for the minimum retention period as required by legislation.

11.2 Destruction shall be in accordance with 2.5.2 Protocol 5 Retention & Destruction of Inactive Health Information.

12. Compliance

Appropriate samples of health records held by the organisation will be subject to regular audit to determine compliance with each section of Standard NZS 8153:2002.

13. Clinical Documentation Requirements for National Data Collection

13.1 Event related data is required to be submitted to the National Minimum Data Set (NMDS) in accordance with information in the NZHIS Guide to Data Requirements. Some of the data items included are as follows:

a) Admission source code;
b) Admission type code;
c) Event start date;
d) Event end / leave date;
e) Diagnosis codes and descriptions;
f) Procedure codes and descriptions;
g) Health speciality code;
h) Health service purchaser code;
i) Health provider index code;
j) Event summary suppress flag.

Note – Patients / clients need to be made aware that it is possible to suppress diagnostic information displayed on the national event history screen on NMDS.

13.2 Organisations/providers shall also provide, where required, information to national registers including those held by the NZHIS e.g.:
a) Mental Health Information National Collection (MHINC);
b) National Booking Reporting System (NBRS);
c) National Medical Warning System (NMWS);
d) Maternity and Newborn Information System (MNIS)

Note – The information required for these systems is detailed in the Guide to Data Requirements.

14. Email / Text Communication with Service Users

14.1 Email Communication

a) Emails to service users will only be sent from BOPDHB devices
b) Email communication to and from service user's are legal, clinical documents and are required to meet clinical documentation standards: For example, emails sent to service user's must include:
   i. Date
   ii. Service users name
   iii. NHI
   iv. Staff member's signature and designation.
c) The body of the email must meet clinical documentation standards Bay of Plenty District Health Board policy 2.5.2 P2 Health Records Content and Structure
d) All email communication complies with the Code of Health and Disability Services Consumers' Rights 1996 and the Health Information Privacy Code 1994
e) If service users have provided mobile or email address this can be used for text or email communication of appointments or administrative liaison.
f) Clinical information requests (eg whole files.) are still required to be completed via medical records consent process.
g) If a staff member uses email to communicate with a service user, they will advise the person of any limits to be placed on its use. For example the service user will be advised not to use email if urgent advice is required.
h) Staff members need to consider issues of privacy, security and the sensitivity of health information whenever they correspond by email with service users / family members.
i) Double-checking all "To" fields prior to sending messages.
j) Electronic and/or paper copies of e-mail communications relevant to service users clinical care must be retained and held on the service user's health record or complaint record.

14.2 Text Communication

a) Text messages to service users will only be sent from BOPDHB issued devices.
b) Text messages to service users will be restricted to appointment scheduling and administrative matters. The use of text for clinical communication between health care professionals and service users does not meet the standard for professional communication and delivery of health care information if used inappropriately.
c) Abbreviations commonly used in text messages should not be used.
d) If service users have provided a mobile number as their preferred method of contact, this can be used for text or email communication of appointments or administrative liaison.
e) If a staff member receives a text communication from a service user that indicates or is explicitly a message of concern, the staff member will at the first practicable opportunity, phone the service user to clarify their situation
f) Text messages should be recorded verbatim in the service users' health record and should not delete any text messages either received or sent until they have been documented in the service users' health record relevant to their clinical care.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 2.5.2 Health Records Management
- Bay of Plenty District Health Board policy 2.5.1 Health Information Privacy
- Bay of Plenty District Health Board Personal Information Request (8264) – *viewable only. Order from Design & Print Centre*
- Bay of Plenty District Health Board General Disposal Authority
- Bay of Plenty District Health Board policy 2.6.6 protocol 2 Mobile Device – Acceptable Use and Security