Chinese Medicine Council of New Zealand

Clinical Records Standard

Purpose

This standard sets the minimum requirements for creating and maintaining clinical records and maintaining health information privacy. Clinical records are essential for the provision of quality health care services and support enhanced outcomes for tangata whai ora. This Standard should be read in conjunction with the Councils Clinical Records Guidance document available on the Council website.

Documenting and maintaining comprehensive, complete, and accurate clinical records is important for the following reasons:

- Clinical records provide an accurate record of therapeutic events and ensure the safety of tangata whai ora;
- In the event of a dispute or investigation, clinical records provide vital information;
- Clinical records may also be used in forensic investigations, complaint resolution, and in quality review and audit processes;
- Clinical records assist practitioners to provide safe, effective, and complete care; and
- Clinical records enable practitioners to collaborate and communicate effectively, and in a standardized way, with their colleagues and other health practitioners to enable continuity of care.

The standard applies to clinical records and health information regardless of its form and location and covers paper-based and digital records.

Legislative context

Chinese Medicine (CM) practitioners must be familiar with the law governing this area of practice including but not limited to;

- The Health Information Privacy Code 2020
- The Health (Retention of Health Information) Regulations 1996
- The Code of Health and Disability Services Consumers' Rights

Content of clinical records

Clinical records must be kept in a document or file specific to that individual and contain the following:

- Key demographic data: full name, NHI number (if available), date of birth, gender, ethnicity, contact details, and, where needed, residency status and name of the Primary Health Provider
- Emergency contact
- The date (and in some instances time)
- The presenting complaints
- The principal/primary diagnosis
- Relevant associated conditions or additional diagnoses
- Relevant family or personal history
- Medications
- A comprehensive subjective and objective assessment
- Analysis of clinical signs and symptoms
- Relevant outcome measurements
- Treatment goals and management plan
- Information given to tangata whai ora
- A record of a signed consent form or refusal

- Treatment provided including (if acupuncture) details of treatment; retention; other techniques; herbal formula/prescriptions (for more detail refer to guidance section on 'Safe prescribing of herbal medicines')
- The dates of all treatment/s, referrals, and any other interventions
- Progress made and discharge plan
- Letters and reports to, or from, referring health professionals or other involved parties, and any clinical photographs and/or digital images. These need to be dated
- Note of risks and/or problems that have arisen and the action taken to rectify them, and
- Electronic authentication or printed name, signature, and designation of the CM practitioner responsible.

Disputes or complaints

In the event of a dispute or a complaint, the clinical record may be the key source of information about events that occurred in the clinical encounter, and a copy may be requested by disciplinary bodies. It is, therefore, imperative to maintain appropriate, intelligible, legible (handwritten or computer generated), high-quality and detailed records to recall why decisions were made, whether consent was obtained and what treatment/s were undertaken. Such high-quality clinical records are therefore important for the safety of both tangata whai ora and the CM practitioner. Where records are maintained in a language other than English, on occasion it may be necessary to provide translated information to a third party, it should be translated by a certified translator or by a practitioner with no conflict of interest.

Ownership of clinical records

While clinical records (paper or digital) are owned by the CM practice owner(s), tangata whai ora are entitled to access and correction of their health information. They are entitled to request copies of their original records, a copy of which must be given or transferred to them, subject to a small number of specific grounds for refusal[1], or removal of irrelevant material by permanent black pen. Tangata whai ora do not have the legal right to take away original records. If requested by tangata whai ora, clinical notes must be provided in English.

Collection of Health Information

The collection of the health information of tangata whai ora is only for lawful purposes connected with a practitioner's professional services and activities. Practitioners must collect only the information they need and intend to use.

There are certain situations when collection of information from someone other than tangata whai ora may be appropriate, this includes:

- When the tangata whai ora, or their representative, authorises collection of information from someone else, for example, a medical practitioner or another health professional;
- When the collection of information from tangata whai ora could prejudice their own safety or interests, for example, when they have limited cognitive ability; or
- When information collection is not practical, for example, when a person is unconscious.

[1] outlined in sections 49-53 of the privacy Act

In these situations, the person who provides the information is known as the 'representative'. The practitioner must record the source of information collected from anyone other than the tangata whai ora concerned and verify the accuracy of the information with them as soon as practically possible.

A representative, in relation to an individual is defined in the Health Information Privacy Code (HIPC) as:

- That individual's personal representative (for example, the executor, or administrator of the estate) when the individual is dead; or
- That individual's parent or guardian when the individual is under the age of 16 years; or
- A person appearing to be lawfully acting on the individual's behalf or in his or her interests, when the individual, not referred to in paragraphs (a) or (b), is unable to give his or her consent or authority or exercise his or her rights.

The practitioner must collect health information lawfully and fairly and ensure that it does not intrude into the personal affairs of tangata whai ora. Practitioners must be mindful of the sensitive nature of personal information, and its importance to those concerned.

Storage and security of clinical records

- All health records must be retained for a minimum of 10 years from the day following the last dated clinical consultation;
- Retention of records for longer than the minimum 10 years is recommended for children or tangata whai ora with ongoing conditions likely to persist long-term;
- The HIPC regulates how health agencies and health providers collect, hold, use, and disclose health information about identifiable individuals. Practitioners are obliged to keep all collected information private and secure;
- The HIPC requires practitioners to take 'reasonable security safeguards' to protect health information. This means keeping the information safe from **loss**, as well as from unauthorised access, use, modification, or disclosure.

Sharing information

All access and retrieval of clinical records should be undertaken by identifiable authorised personnel. Tangata whai ora have a right of access to information in their records. The practice is acting as the custodian of individual's health records.

Third party access to health records/information can only be provided:

- With written consent (except when permitted or required by law);
- By a Court Order; or
- As part of an existing signed arrangement with the funder or insurer.

Do not give health records to third parties to hand deliver (such as relatives or friends) unless authorised, preferably in writing, by the tangata whai ora concerned, or by the nominated representative.

The CM practitioner must seek legal advice if there are concerns regarding the right to access confidential health information.

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