nzmii
Inihua Rata O Aotearoa

FACTSHEET

Maintaining patient records

Maintaining clear and accurate patient records is a crucial part of good medical practice and continuity of care. This factsheet covers how to properly maintain and correct patient records, and what to do when a patient asks for health information to be left off their clinical record altogether.

When dealing with patient records it should always be remembered that health information is confidential and sensitive. The health information privacy code 2020 (HIPC) contains 13 rules which set out how health information should be handled. Doctors should be familiar with these rules.

Maintaining clear and accurate patient records

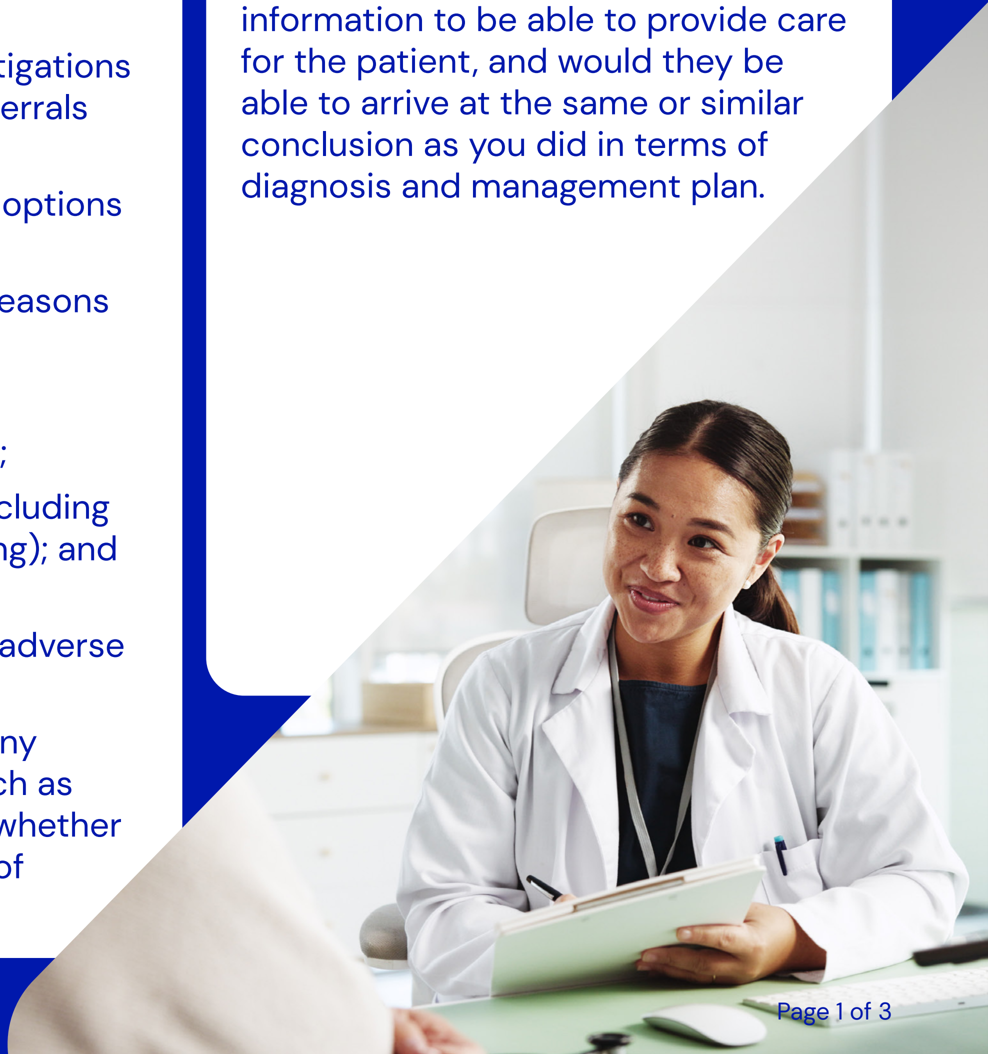
Doctors have a professional obligation to maintain clear and accurate patient records. MCNZ's guidance provides that patient records must include:

- Clinical history;
- Relevant clinical findings;
- Results of tests and investigations ordered (including any referrals made);
- Information provided and options discussed;
- Decisions made and the reasons for them;
- Consent given;
- Any requests or concerns;
- The management plan (including advice about safety netting); and
- Medication or treatment prescribed, including any adverse reactions.

It is also recommended that any other relevant information, such as the patient's donor status, or whether they have an enduring power of attorney, is recorded.

To ensure the accuracy of the record, notes should be made contemporaneously, or as soon as possible afterwards, and they should be clear and coherent.

A good rule of thumb is to consider if another doctor was to read your notes, would they have sufficient information to be able to provide care for the patient, and would they be able to arrive at the same or similar conclusion as you did in terms of diagnosis and management plan.



Maintaining patient records

Amending patient records

If, on reviewing a patient's records, you consider that the record is inaccurate, incomplete, or potentially misleading, it may be appropriate to correct it.

When amending a record, it is important that the earlier entry is not deleted or changed. The amendment should appear as an addition to the relevant note and should state who amended the note and when. You should also consider whether there are other health practitioners (for example other practitioners involved in your patient's care) who need to be made aware of the correction.

Under no circumstances should you amend a patient's record following receipt of a complaint. Even if done innocently, it begs the question of why you made the change and implies you may have had something to hide.

Requests by patients to access clinical records

As provided for in rule 6 of the HIPC, patients have the right to access their clinical records. A request to access must be responded to within 20 working days.

Generally speaking, agencies cannot charge a patient for such a request. There are some limited exceptions to this that apply to private sector agencies, for example if the request is for a copy of something like an x-ray, or if the individual has requested the same health information previously within the last year. The charge must of course, be reasonable.

If records are to be provided to a patient, care should always be taken to first verify the individual's identity, before making them available.

nzmii
Inihua Rata O Aotearoa

FACTSHEET

Maintaining patient records

Requests by patients to correct clinical records

Rule 7 of the HIPC provides that patients have the right to request a correction of their health information if they believe it to be wrong. The agency or health practitioner will need to determine whether the correction is appropriate to make. If it is, the process for correcting records (discussed above) should be followed. If the decision is made not to correct the information, a note of the request and the response will need to be recorded in the relevant clinical record, if the patient requests it.

Requests by patients to omit information from clinical record

There can be occasions where a patient will request that health information be left off their clinical record altogether. As a general rule, such requests should be declined. An inaccurate patient record may jeopardise the provision of care to the patient, for example by compromising the continuity of care.

In very limited circumstances, with the informed written consent of the patient, it may be appropriate to exclude certain health information from the record. Very careful consideration would need to be given before a decision such as this could be made however, and it would be essential to seek legal advice through your medical indemnifier first.

In summary, doctors should always be guided by the requirement that patient records are clear and accurate. When making any addition, amendment, or deletion from a patient record, doctors should always consider whether in doing so, the record will still comply with those requirements. For further guidance, check the **MCNZ statement managing patient records**.

Contact Us

NZMII are here to help!

nzmii.co.nz
0800 102 220
general@nzmii.co.nz

@nzmedicalindemnityinsurance