Health Record Policy for Mental Health and Addiction Group				
MHAPPM/8046				
Approved by:	General Manager - Mental Health & Addiction Group	**First Issued:**	March 2006	HE KAUANUANU RESPECT ĀKINA IMPROVEMENT RARANGATETIRA PARTNERSHIP TAUWHIRO CARE
Signature:	David Warrington	**Review Date:**	April 2022	
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Purpose

The purpose of this document to describe and define the minimum documentation standards and requirements for Mental Health and Addiction Group.

This document is to be used in conjunction with MHAPPM/8953 – Mental Health Service Policy which outlines the shared vision and expectations for the direction, values, principles, attitudes and ways of working to deliver a values based service.

Scope

All Mental Health and Addiction Group staff

All Non-Government Organisations (NGO) who use the DHB's patient management and clinical record systems i.e. 'Electronic Clinical Application' (ECA) and 'Clinical Portal'.

Definitions

Refer to the Mental Health Service Definitions Glossary
\\FS3\share\Public\All Users\MHS Policy review\DEFINITIONS FOR WORDS AND TERMS IN USE WITHIN THE MENTAL HEALTH SERVICE.docx.

Roles and Responsibilities

Role	Responsibility
Clinical Manager/General Manager/NGO Manager	Ensure all staff are informed of the service documentation requirements and ensure compliance to this policy
Triaging clinician	Ensure completion of first contact/registration form, at the time of the first contact Commence the 'Comprehensive Assessment'
Key Workers	Are service providers who coordinate communications and activities for the Tangata whaiora in order to meet the goals described in their plan Ensure Tangata Whaiora's documents/diagnoses/health records are accurately maintained, regularly reviewed, and are available to the right people at the right time so decision makers are properly informed Are the single or main point of contact for the Tangata Whaiora/family/ whānau, during service provision Ensure health records are completed within prescribed time limits and are available via the electronic patient management systems i.e. 'Electronic Clinical Application' and/or 'Clinical Portal'

Role	Responsibility
Key Workers (continued)	Develop the plan in partnership with the person who is using the service and his/her support people, where possible. Update the plan as frequently as indicated in the Key Worker Procedure and as outlined in this policy (refer to sub-heading 'Go to Plan' below) Ensure all applicable Outcome Measures (Health of the Nation Outcome Scale and/or Alcohol, and Drug Outcome Measure) are collected as per the appropriate information collection protocol Where a staff member has been allocated the Key Worker responsibility but is not a registered health practitioner, a registered health practitioner must also be allocated to supervise the care given by the non-registered person i.e. the Key Worker. The Key Worker must have access to all clinical documentation to ensure that comprehensive assessment is completed and a Plan is developed and implemented Ensure the Tangata Whaiora's Supplementary Consumer Records are kept continuously up to date Ensure the Tangata Whaiora's ICD Code(s)/Diagnosis(es) are recorded as per points 25, 26 and 27 below.
Mental Health Service and Non-Governmental Organisation staff	Ensure health records are kept continuously up to date

HBDHB Standards

1 The Mental Health and Addictions Service recognises that the recovery of each person using the Mental Health and Addictions Service is dependent upon excellent clinical practice and that their health record must evidence comprehensive, organised information that reflects safe, efficient and effective practice

2 Record keeping is essential in order to deliver safe and effective services that clearly identify the strengths and risks that may affect a person's recovery. All people who are referred to mental health services must have the following forms completed and stored in their electronic health record:

   a. General Information Form

   b. Comprehensive Assessment

   c. Go To Plan

   d. Outcome measures:

      i) Health of the Nation Outcome Scale (HoNOS)

      ii) Alcohol and other Drugs Outcome Measure (ADOM)

   e. ICD Code/Diagnosis(es) (International Classification of Diseases)

      i) This code (or multiple codes) must be recorded in the 'Add/Change Diagnosis' screen within the 'Primary Referral'

   f. Supplementary Consumer Records

   g. Discharge Summary Letter

3 Dependant on the needs of individual, the completion of additional documentation may also be required, examples include, but are not limited to:- Clinical Risk Assessment forms, (refer to MHAPPM/8102 - Clinical Risk Management System (CRMS) Procedure and/or Mental Health Act Forms (refer to HBDHB/CPG/073 - Mental Health Act (1992) Initiating Urgent Compulsory Assessment

4 Each document must be completed and (where applicable) reviewed (using 'Portal Forms' within 'Clinical Portal') within the following described time limits.

First Contact and Registration Form

5 To be completed by the end of the clinicians' duty, following the first face to face contact

6 The information contained in this document is to be transferred into the person's health record in ECA

7 Once the information is viewable via ECA, then any paper version can be destroyed

General Information Form

8 To be completed by the end of the clinicians' duty, following the first face to face contact

9 This document is to be viewable via the person's NHI number in ECA (may need to be scanned and saved)

Comprehensive Assessment

10 To be completed by the registered health care practitioner:

a. Inpatients : within 24 Hours or

b. Community patients : within the first three face to face contacts (or two weeks – whichever is sooner

11 This document is to be kept continuously up to date

12 The Key Worker must review this document at least once every three months (in collaboration with the person where possible) and make an entry into the clinical notes to evidence that it has been reviewed

13 This form is to be viewable via the person's NHI number in 'Clinical Portal'

14 Once the document is viewable via 'Clinical Portal' then any paper version can be destroyed

The 'Go To Plan'

15 Community:

a. The 'Go To Plan' must be documented within the first three contacts (including any type of contact) and reviewed at least once every three months thereafter or as circumstances change

16 Inpatients:

a. The 'Go To Plan' must be documented within 24 hours and reviewed at least every day thereafter

17 The 'Go To Plan' must be updated during the two weeks prior to closing the Primary referral and must include the plan for transiting from Mental Health and Addiction Services to the care of their General Practitioner

18 This document is to be viewable via the person's NHI number in 'Clinical Portal'

Health of the Nation Outcome Scale (HoNOS/HoNOSCA/HoNOS 65+)

19 To be completed according to the 'Information Collection Protocol'

20 To be completed in the electronic patient management system (i.e. 'ECA')

Alcohol & Drug Outcome Measure (ADOM)

21 To be completed following the 2nd face to face encounter with an 'Addiction' type case team

22 To be completed according to the 'Guide for Addiction Practitioners'

23 To be completed in the electronic patient management system (i.e. 'ECA')

Supplementary Consumer Records

24 The Key worker must keep these records continuously up to date and update these records as and when changes occur

ICD Code/Diagnosis(es)

25 A minimum of one ICD code must be recorded in the 'Add/Change Diagnosis' fields by the end of the shift during which the assessment took place

26 Up to six ICD codes/diagnoses can be recorded simultaneously within the 'Add/Change Diagnosis' fields contained within the 'Primary referral'

n.b. also include all physical disorders when recording ICD codes/Diagnosis(es)

27 The person's diagnosis(es) must be kept continuously up to date as and when changes occur

Discharge Summary Letter

28 It is a requirement that each person referred back to Primary Care at the end of their mental health and/or addictions treatment receive a discharge summary letter to be handed to or mailed to the person prior to closing the Primary referral

29 The letter must also be copied to the person's General Practitioner. The summary letter should include ongoing arrangements, how to regain entry to the service and who to contact at a later date if required. (Refer NZS 8134:2021 Section 3.6 "Transition, transfer and discharge").

30 Consideration must also be given to informing the initial referrer

31 All documents must be updated as information and/or the situation changes

Measurable Outcomes

Health Records will be audited annually.

Audit results will routinely be made available to clinicians within four weeks of audit completion.

Health record audit results will inform continuous improvement.

Related Documents

MHAPPM/8953 – Mental Health Service Policy

HBDHB/OPM/033 - Privacy Policy

HBDHB/OPM/074 - Health Record Policy

HBDHB/OPM/075 - Health Record Policy - Storage Security Accessibility and Off Site Storage

Health Practitioner's Competence Assurance Act 2003

Privacy Act 2020

Health Information Privacy Code 2020

Health & Disability Commissioner (Code of Health & Disability Services Consumers' Rights) Regulation 1996

HoNOS family of measures | Using Measures to Enhance Outcomes | Te Pou

References

New Zealand Standard: Health Records 8153: 2002

HoNOS family of measures | Using Measures to Enhance Outcomes | Te Pou

Alcohol & Drug Outcome Measure (ADOM) - Guide for Addiction Practitioners

'Health and Disability Services Standard 8134-2021'

International Classification of Diseases – World Health Organisation

Keywords

Records
Record-keeping
Documentation
File

For further information please contact the
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