MEDICAL COUNCIL OF NEW ZEALAND

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The maintenance and retention of patient records

Introduction

Records form an integral part of any medical practice; they help to ensure good care for patients and also become critical in any future dispute or investigation.

01 Maintaining patient records[i]

(a) You must keep clear and accurate patient records that report:

- relevant clinical findings
- decisions made
- information given to patients
- any drugs or other treatment prescribed.

(b) Make these records at the same time as the events you are recording or as soon as possible afterwards.

02 Practice systems

(a) Council recommends that every practitioner has access to systems for recall of patients who need regular checks or treatment.

(b) Doctors should have systems in place to ensure that test results are acted upon in a timely manner, including notification of patients as appropriate.

03 Fees and patient records

(a) Section 22F of the Health Act 1956 states that transfer of patient records cannot be refused because of money owing or conflicting commercial interests.

(b) A patient or representative of the patient cannot be charged for copies of his or her records unless they have previously requested the information within the past year. Video recordings, x-rays and CAT scans are exceptions to this rule.[ii]

(c) Patients have a right of access to information in their records because the information belongs to the patient, whereas the record belongs to the doctor.[iii]

(d) When sending information to patients it is advisable to ask the patient what method is preferred because message services, facsimiles and e-mails are not always secure.

04 Transferring patient records

(a) It is advisable to transfer patient records using some form of registered mail so that tracing the records is possible if they go missing in the mail.

(b) The Medical Protection Society strongly recommends that medical practitioners retain a copy or summary of any patient records that are transferred, for subsequent reference, particularly if there may be disciplinary action to follow.

i Refer to *Good medical practice*. Cole's Medical Practice in New Zealand contains further guidance on record management.

ii Part III (6) Health Information Privacy Code 1994

iii There may be situations where a doctor feels it is unwise to provide access to all the information. Rule 11 of the Health Information Privacy Code 1994 provides situations where a doctor may not have to disclose all health information about the patient.

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05 Retaining patient records

How long should PHOs, private hospitals and doctors in private practice keep patient records?

(a) The Health (Retention of Health Information) Regulations (*the Regulations*) outline the legal requirements for the retention of patient records by PHOs, private hospitals and doctors in private practice. The regulations state that all records must be retained for a minimum of 10 years from the day following the last date of the patient consultation.

(b) Retention of records for longer than the minimum 10 years is recommended for children with significant problems or patients with conditions in paediatrics, psychiatry, obstetrics and gynaecology, orthopaedics or other problems likely to persist in the long-term.

(c) The Regulations state that health information does not have to be retained in any particular form. If the material on which the health information is contained will deteriorate before the minimum 10-year retention period, it is sufficient compliance for an accurate summary, or interpretation of that information to be made and retained.

How long should DHBs keep patient records?

(d) Under the Public Records Act 2005 most records held by government agencies (including patient records held by DHBs) are public records and may not be disposed of (whether by transfer, destruction, alteration, sale or discharge) without the authorisation of the Chief Archivist. DHBs should contact Archives New Zealand for information regarding authorisation for disposal of records and, in any case, once they reach 25 years of age.

Planning for retirement

(e) Meeting all the requirements for the retention of patient records can be difficult, especially for sole practitioners, who form a large section of the medical workforce. Before retiring doctors should:

- make prior arrangement for another practitioner to accept responsibility for them (through power of attorney); and/or
- arrange for patients to pick up their own records.

The important thing is to make some arrangement well before retirement.

(f) The Regulations states that when a patient dies a doctor may transfer the record to the representative of the deceased.

(g) In the situation where arrangements have not been made for the retention of patient records and the doctor dies, the Executor of the estate or Power of Attorney should endeavour to return records to the patient (the patient's family if the patient is dead), or another doctor.

06 Storage requirements

(a) The Health Information Privacy Code 1994 outlines the requirements for storage of patient records.

(b) Patient records should be filed securely and away from public areas but also be easily accessible in case a request is received for a copy. They should only be visible and accessible to appropriate members of staff. Computer files must be protected by password and have backups in case of technical difficulties.

07 Destruction of patient records

(a) Destruction of a patient record must be done in such a manner as to preserve the privacy of the patient. Burning or shredding the documents is acceptable and there are security companies that destroy documents.

Notes:

Contact the Privacy Commission for any information about the storage, transfer and privacy of patient records: 0800 803 909. *On the Record* is a useful guide about privacy of health information and is available from the Commission.

Relevant legislation

- Health Act 1956
- Health (Retention of Health Information) Regulations 1996
- Health Information Privacy Code 1994
- Code of Health and Disability Services Consumers' Rights

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This statement is scheduled for review by August 2013. Legislative changes may make this statement obsolete before this review date.