New Zealand Speech-language Therapists' Association
Te Kāhui Kaiwhakatikatika Reo Kōrero o Aotearoa

NZSTA Member Advisory

February 2025

Best Practices for Managing Health Records

Introduction

Health records are critical to safe, effective, and professional speech-language therapy practice. Proper documentation ensures continuity of care, enhances communication between professionals, and upholds the rights and safety of clients (ngā kiritaki hauora). This advisory outlines expectations for maintaining, storing, and managing health records in accordance with New Zealand laws and professional standards.

Scope

This member advisory is directed at those who work in the health sector - and may be pertinent to those in private practice who want to ensure their management of health records is according to best practice.

Excludes: The Ministry of Education has a policy which states, '*The legal obligation to create and maintain records is established in the Public Records Act 2005. It is a collective responsibility for the Ministry and the individual responsibility of all staff.'* See also the Record keeping Guidelines for Learning Support.

Purpose of Health Records

Health records serve multiple purposes, including:

- **Ensuring safety:** Recording accurate and relevant client information supports high-quality care.
- **Professional communication:** Providing a documented record of speech-language therapy services, including why decisions were made, whether consent was obtained, what intervention was undertaken, or what services were provided. Providing a clear record of care for other professionals involved.
- **Continuity of care:** Supporting seamless transitions between practitioners or services.
- **Legal and ethical compliance:** Acting as evidence in cases of complaint, investigation, or review.

Definition

Health records: AKA case notes include all documentation containing health

information and other specific information relevant to speech-language therapy client interactions. Health records include information relating to an identifiable individual irrespective of the medium, i.e., electronic, web-based, telehealth or paper-based, made by speech-language therapists.

In this member advisory, 'health information' has the same meaning as the definition of that expression in the Health (Retention of Health Information) Regulations 1996.

Health Record Requirements

1. **Creation and Maintenance**
    - All interactions with clients must be documented, including:
        - Assessments, treatment plans, and interventions.
        - Verbal and written communications (e.g., phone calls, telehealth, and emails).
        - Cancellations, missed appointments, or third-party communications.
    - Each interaction must be a unique entry recorded at the time of or shortly after the interaction.
2. **Content of Records**
    - Health records must be:
        - Clear, accurate, and specific to the individual.
        - Sufficiently detailed for another practitioner to continue care.
        - Inclusive of cultural needs and informed consent processes.
    - Key details to include:
        - Full name, NHI number (if applicable), date of birth, gender, ethnicity, and GP details.
        - Relevant medical history, contraindications, and "red flags."
3. **Informed Consent**
    - Document all instances of verbal or written consent, including explanations provided.
    - Ensure consent records are clear and aligned with the NZSTA Informed Consent Standard.
4. **Retention and Security**
    - Maintain health records securely for at least ten (10) years (or longer if specific legislation requires).
    - Ensure compliance with the Health (Retention of Health Information) Regulations 1996 and the Privacy Act 2020.
5. **Amendments to Records**
    - Any changes must be:
        - Clearly marked, dated, and initialled by the person making the change.
        - Preserved with the original entry (never deleted or overwritten).

6. **Supervision of Students**
    - Practitioners supervising students are responsible for ensuring health records meet professional standards and must countersign student entries.

New Zealand Law

Practitioners must comply with:

- **Health (Retention of Health Information) Regulations 1996:** Governing the duration and storage of health information.
- **Privacy Act 2020 and Health Information Privacy Code 2020:** Outlining confidentiality, access, and security responsibilities.

For privacy matters, consult the **Office of the Privacy Commissioner** for further guidance.

Retaining, Storing, and Transferring Digital and Physical Health Records

Retention of Health Records:

According to the Health (Retention of Health Information) Regulations 1996, health agencies must retain health information for a minimum of ten (10) years from the last date of service provided to the individual. This applies to all health records, regardless of whether they are in digital or physical format.

Storage and Security:

The Privacy Act 2020 and the Health Information Privacy Code 2020 mandate that health agencies implement appropriate safeguards to protect health information from loss, unauthorised access, use, modification, or disclosure. This includes ensuring that both digital and physical records are stored securely. For digital records, this may involve using encryption, secure access controls, and regular security audits. Physical records should be stored in secure locations with controlled access.

Transfer of Health Records:

When transferring health records, whether digitally or physically, health agencies must ensure that the process maintains the confidentiality and security of the information. This includes verifying the recipient's identity, using secure transfer methods (such as encrypted electronic communication or secure courier services), and obtaining the individual's consent when required. The Health Information Privacy Code 2020 provides specific rules regarding disclosing health information to third parties, emphasising the necessity of maintaining confidentiality during such transfers.

In summary, New Zealand's legislative framework requires health agencies to retain health records for at least 10 years, implement robust security measures for storing digital and

physical records, and ensure secure and confidential methods are used when transferring health information.

Collection, use, and disclosure of health information

The Health Information Privacy Code 2020 (HIPC), established under the Privacy Act 2020, sets forth specific rules governing health information collection, use, and disclosure by health agencies in New Zealand. These rules protect individuals' privacy while ensuring that health information is handled appropriately.

Collection of Health Information:

Purpose Specification: Health agencies should collect health information only if it is necessary for a lawful purpose connected with their functions or activities.

Source of Information: Where possible, information should be collected directly from the individual concerned unless exceptions apply, such as when the individual authorises collection from another source or when direct collection would prejudice the purpose of collection.

Notification: At or before the time of collection, agencies must take reasonable steps to inform individuals about the purpose of collection, intended recipients, and the individual's rights regarding access and correction of their information.

Use of Health Information:

Use Limitation: Health information collected for one purpose should not be used for another purpose unless the individual consents, the secondary purpose is directly related to the original purpose, or another exception applies, such as to prevent a serious threat to health or safety.

Data Accuracy: Before using health information, agencies must take reasonable steps to ensure that it is accurate, up-to-date, complete, relevant, and not misleading.

Disclosure of Health Information:

Disclosure Restrictions: Health information should not be disclosed unless the individual consents, disclosure is directly related to the purpose for which it was collected, or another exception applies, such as for public health reasons or to prevent a serious threat.

Overseas Disclosure: When disclosing health information to foreign entities, agencies must ensure that the recipient is subject to comparable privacy safeguards or obtain the individual's consent after informing them of potential risks.

These provisions aim to balance the need for health agencies to collect and use health information with the individual's right to privacy. For detailed guidance, refer to the full text of the Health Information Privacy Code 2020.

Access to Information

Under the Privacy Act 2020 and the Health Information Privacy Code 2020 (HIPC), individuals in New Zealand have the right to access their personal health information held by health agencies. This right ensures transparency and allows individuals to be informed about their health records.

Key Points Regarding Access Requests:

Right of Access:

Individuals can request access to their health information to understand what data is held about them and to verify its accuracy.

Making a Request:

Requests can be made verbally or in writing. While written requests provide a clear record, verbal requests are equally valid.

Agency Obligations:

Upon receiving an access request, health agencies are required to respond promptly. The standard timeframe is within 20 working days.
Agencies must provide the information unless there is a valid reason to refuse, as the Privacy Act outlines.

Grounds for Refusal:

Access may be denied if releasing the information would:

- Pose a serious threat to the individual's or others' health or safety.
- Involve unwarranted disclosure of another individual's information.
- Breach of legal professional privilege.

If access is refused, the agency must provide the individual with the reasons for refusal and inform them of their right to complain to the Privacy Commissioner.

Charges:

In most cases, access to personal health information should be provided free of charge. However, agencies may impose a reasonable fee if the request involves a significant amount of information or requires substantial effort to collate.

Correction of Information:

Individuals who believe their health information is incorrect or misleading can request corrections. Agencies must take reasonable steps to correct the information. If they choose

not to correct, they must attach a statement of correction to the record, noting the individual's requested changes.
For detailed guidance on handling access requests, refer to HIPC Factsheet 4 - Dealing with access requests.

By adhering to these guidelines, health agencies can ensure compliance with New Zealand's privacy laws and uphold individuals' rights to access and manage their health information.

Recommendations for Best Practice

1. **Use Standardised Formats:** Ensure consistency in creating and organising health records.
2. **Ensure Accessibility:** Records should be easily understood by other professionals and accessible for care continuity.
3. **Cultural Responsiveness:** Record any specific cultural considerations or accommodations made for clients.
4. **Regular Audits:** Conduct regular reviews of record-keeping practices to maintain compliance and identify areas for improvement.

Conclusion

Maintaining accurate and secure health records is an essential responsibility of speech-language therapists. By adhering to this advisory, NZSTA members can ensure the safety and wellbeing of clients while protecting themselves professionally.

For more information or support, consult the related resources below.

Related Resources

- NZSTA Principles and Code of Ethics
- Health (Retention of Health Information) Regulations 1996
- Privacy Act 2020 and Health Information Privacy Code 2020
- Privacy Commissioner