



One Clinical File Procedure

Procedure Number

CHC-MHS-0014

Version Nos:

5

1. Purpose

This Procedure outlines the process to be followed by all West Coast District Health Board (WCDHB) Mental Health Service (MHS) staff to ensure a cohesive, documented and standardised system for the physical management of the clinical file, containing the client's personal health information (PHI).

2. Application/Responsibilities

This Procedure is to be followed by all WCDHB MHS staff members.

3. Definitions

For the purposes of this Procedure:

One clinical file is taken to mean the sole clinical record that is used by MHS to collate and store PHI during each episode of care.

Episode of care is taken to mean each discrete period of contact with a MHS team, each episode commences from acceptance into the services and ends with discharge or transfer (Inpatient to Outpatient or vice-versa)

4. Responsibilities

For the purposes of this Procedure:

Community Mental Health (CMH) Team Manager:

- is accountable for the One Clinical Files of their Team's clients.
- are responsible for ensuring staff maintain the file in an orderly fashion.

Inpatient Unit Staff

- have shared responsibility for each client's One Clinical File

5. Resources Required

This Procedure requires:

- i) Episode of Care file dividers (CMH blue/IPU green)
- ii) WCDHB MHS specific forms and clinical notes
- iii) Access to WCDHB IT network shared drive/MHS folders

6. Process

- 1.00 A new clinical record is created at the time a person is first admitted to MHS:
 - Every new or subsequent admission to the service is treated as a discrete 'episode of care'.
 - Each episode of care is filed in chronological order, with the most recent episode in front.
 - Each episode of care uses a set of file dividers.



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- 1.01 Inpatient and outpatient episodes of care are identified from each other through the use of different colour dividers. The dividers have the standard file order format printed on them. This outlines what should be filed in each section of the file.
- 1.02 Once an existing file becomes too thick to manage (4.5cm thick) a new file should be created. Ideally will occur at the end of an episode of care. The new file becomes the No.2 file.
- 1.03 The MHS administration staff will set up new admission files with packs of 'required documents' clipped together ready for completion.
- 1.04 The admission packs for IPU will include the following core documents:
 - WCHDB Registration Form
 - MHS Consent to Treatment
 - Admission Form
 - Admission Checklist
 - Risk Assessment and Risk Management Forms
 - Individual Treatment and Recovery Plans
 - Blank Clinical Notes
 - HoNOS
 - WCDHB Medication Sheet
 - Nursing Baseline Recording
 - Physical Examination
 - Out-patient admission packs will include
 - WCHDB Registration Form
 - MHS Consent to Treatment
 - Risk Assessment and Risk Management Forms
 - Individual Treatment and Recovery Plans
 - Blank Clinical Notes
 - HoNOS
 - CMH Prescription Sheet
- 1.05 The comprehensive assessment is dictated using the framework, and is transcribed by the administration staff and placed in the clinical file. Each assessment is stored electronically, which allows for updating without duplication.
- 1.06 Once clinical documents are completed they are to be immediately filed in the correct section of the file. Blank documents are not to be placed into the clinical record.
- 1.07 Additional clinical information is filed as it is completed/received.
- 1.08 The Case Manager / Primary Nurse will be responsible for the removal, and shredding, of any multiple copy of the same document.
- 1.09 All entries must be compliant with both professional standards and the documentation Policies and Procedures of WCDHB.



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7. Precautions And Considerations

- A new clinical record is created at the time a person is first admitted to MHS:
- Once clinical documents are completed they are to be immediately filed in the correct section of the file. Blank documents are not to be placed into the clinical record.
- All entries must be compliant with both professional standards and the documentation Policies and Procedures of WCDHB.

8. References

NZS 8143:2001 National Mental Health Sector Standards

9. Related Documents

WCDHB MHS Service Provision Framework

WCDHB Clinical Documentation Procedure

WCDHB Personal Health Information Policies and Procedures

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