Maintain documentation as a community field worker in a health or disability support context

20964 V2
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Level 2 Credits 2

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Maintain documentation as a community field worker in a health or disability support context

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“All the answers in this workbook were completed by me.”

Name ................................................................................
Employer ...........................................................................
NZQA number .................................................................
Date ...................................................................................
Signed ..............................................................................
Getting started

Welcome to *Maintain documentation as a community field worker in a health or disability support context:* one in a series of workbooks especially developed for support workers in the CPQ (Career Pathway Qualifications).

Please note: in the context of this workbook, the term “client” (used consistently throughout) is understood to cover “consumer” and “the person you support”. The terms “person” and “people” are also used in a non-specific (generic) context, where appropriate.

**Look before you leap!**
Take the time to go through this workbook before starting on the activities. Read the sections and make notes as you go.

**How do I use this workbook?**
- Use highlighters to identify the important ideas.
- Take your own notes.
- Complete activities as you go through the workbook and write answers in the spaces provided.

**What will I learn about?**
When you have finished this workbook you will have learned more about:
- Consumer records in the workplace.
- What information is collected, how it will be used, and in what form it will be kept.
- Why it is important to keep records.

**Acknowledgements**
This workbook has been designed to support your learning and prepare you for the unit standard assessments.

The contents of this workbook include scenarios, learning activities and activities for general health and disability settings. They are not specific to any setting and should be used as a general guide for learning.

Careerforce would like to thank the people who have contributed their time and effort into each workbook in:
- Research and content validation.
- Advice and expertise.
- Testing of activities and assessments and their personal experiences.

And the people who have contributed a human dimension to the workbooks.
Getting started

**Trainee assessment portfolio**
The trainee assessment portfolio contains assessed activities and workplace verification, which must be completed to meet the requirements of the unit standard. These questions or tasks must be completed by you and signed by your workplace assessor in order for you to be credited with the unit standard.

**Learning activities**
These help you understand the content, and will help you with workplace verification tasks. The instructions and answer panels for learning activities have a light yellow/orange background like this.

**Stop activities**
You will also come across the pencil in places where you are asked to STOP (see the graphic on the left) and record your current knowledge or impressions, as a reference point to return to later.

**Pause and Rewind activities**
Pauses are for summarising, questioning, and reflecting as a reference point to return to later. Rewinds take you back to a PAUSE, STOP or TEST YOUR KNOWLEDGE and give you an opportunity to add to, change or validate some of your initial thoughts and ideas.
Why should you keep records?

Keeping records is an important part of your role.

It is important to know:
- Why you are keeping records.
- How long you should keep records.
- What purposes the records you keep may be used for.
- What your responsibilities are to your organisation and the people you support.

What is a record?
A record can take many different forms. It could be:
- An account of a meeting you ran.
- Notes taken during an initial meeting with a new client.
- A plan of your day.
- A documented file of vehicle usage so you can claim reimbursement.

By keeping records a community field worker can plan his/her work day and be aware of people’s needs.
Why should you keep records?

The types of records you keep will vary in accordance with your organisation’s policies and procedures.

When keeping records you need to make sure that you know:

- What the purpose of each record is.
- The audience (who you are keeping the record for).
- Your minimum requirements.

You must also understand:

- Why you are keeping records.
- How you are expected to present information within these records.
- The expectations of your organisation around the information recorded.

Some information you keep may not be an individual health record.

Things to consider when keeping records...

1: Do I have to use a designated form?
2: Where do I get the correct form from?
3: When I’ve completed the record, what happens then? Who collects, processes or files my records after I have completed them?
4: Should I use a pen (and does it have to be a black pen), or is it OK to use a pencil?
5: Is the record “just the facts” or is it about my opinion? Can it be a combination of the two?
6: Should I keep the record in note form or should it be in full sentences? What abbreviations are OK and acceptable to the organisation?
7: Do I have to take extra care over people’s privacy when I keep computer records?

A health record is:

“A record describing every aspect of healthcare provided to an identifiable consumer/patient.”

— NZS 8153: 2002 Health records definition.
Before you go any further in this workbook, think of what you know about keeping records…

TEST YOUR KNOWLEDGE

Think about your role and the people you support.
What types of records do you keep?
Why do you keep records?

<table>
<thead>
<tr>
<th>Record type</th>
<th>Reason for keeping record</th>
<th>Your responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What kind of record-keeping do you use? (For example, written, pre-printed forms, phone or electronic.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What type of records do you keep for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your organisation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The person you support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yourself and/or your family?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What are client records?
Records about clients may be:

- Health records.
  *For example, an individual medical file.*
- General information.
  *For example, demographic data or a database of clients.*
- Group information.
  *This may include records of meetings, or support group minutes.*

What is in client records?
A client record provides information about interactions between the client and the service. It may:

- Contain plans of care.
- Describe the client’s progress.
- Give an account of the services provided.
- Describe assessment, diagnosis, treatment, evaluation or procedures.

Collecting and collating information

People who are using a health and disability service have the right to be fully informed in advance about:

- What information is being collected about them.
- How it will be used.
- The form in which it will be kept.
- Who will be able to access it.

A record could be anything from a “things to do” list, to a report on a person’s health status.
Learning activity

Do you use a diary to record some aspect of your daily life? It may be a work diary or a personal “list of things to do” for each day.

- Use all your diary sources to plot out all the activities, appointments and other tasks you carried out over an eight-hour timeframe from 7am to 3pm (or for one work day) in the previous week.
- Make sure you note down travelling time.
- You may find it interesting to discover how much time you spend on certain activities. For example, this timeframe may include two hours of travelling time or half an hour of waiting in line at the supermarket.

If you don’t use a personal or work diary you can still complete this activity. Just search your memory and complete the form!

Did you keep records of any of the activities you’ve noted here? If yes, highlight the activities that required you to keep a record.

Day: Date:

7.00 am
8.00 am
9.00 am
10.00 am
11.00 am
12.00 pm
1.00 pm
2.00 pm
3.00 pm

What activity took up the most time?

What activity involved the least amount of time?
Recording daily work activities

Pauline is a community field worker supporting people who have memory loss and confusion.

Pauline also supports families and caregivers, and provides information and resources to them about Alzheimer’s and other types of dementia.

She raises public awareness of the condition by working with the media and by participating in community events wherever possible.

Each day can be very different and Pauline needs to be quite flexible about how she plans her day.

Some years ago, Pauline was appointed to her current role by the local committee.

This was a new position. She had to set up all her systems and documentation herself.

The national organisation that she works for has some reporting requirements, but Pauline had to decide how she was going to manage her paper work.
Pauline needs to account for her daily work activities.
She works unsupervised and plans her work day herself.

In her work day she:
- Makes visits to clients.
- Responds to phone calls and personal crises of her clients and their caregivers.
- Meets with health professionals.

Pauline decided to work from a daily diary.

She uses this diary to record such things as:
- Phone contacts.
- Travel.
- Visits.
- Training sessions.
- Appointments.
- Key community agencies or supports. For example, volunteers like drivers for Meals on Wheels.

At the end of each day, she transfers the information into a daily activity log.

One form of record keeping may lead to another. For example, Pauline keeps a daily diary from which she transfers relevant information over to a daily activity log.
### Recording daily work activities

A sample of a typical daily activity log:

<table>
<thead>
<tr>
<th>Date</th>
<th>Individual registration number</th>
<th>Activity or contact</th>
<th>Code</th>
<th>Type</th>
<th>Duration</th>
<th>Travel kms</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/4/07</td>
<td>07321</td>
<td>Jane Maslow</td>
<td>C</td>
<td>HV</td>
<td>1.5</td>
<td>23km</td>
</tr>
<tr>
<td>3/4/07</td>
<td>07322</td>
<td>Fred Renner</td>
<td>C</td>
<td>HV</td>
<td>.45</td>
<td>8km</td>
</tr>
<tr>
<td>3/4/07</td>
<td>05124</td>
<td>James and Muriel Jones</td>
<td>C, S</td>
<td>HV</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3/4/07</td>
<td></td>
<td>Team meeting</td>
<td>HP</td>
<td>M</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3/4/07</td>
<td></td>
<td>Ginny Watts</td>
<td>S</td>
<td>PC</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td>3/4/07</td>
<td></td>
<td>Claire Tainui</td>
<td>S</td>
<td>PC</td>
<td>.10</td>
<td></td>
</tr>
<tr>
<td>3/4/07</td>
<td></td>
<td>Office Administration</td>
<td>X</td>
<td>O</td>
<td>.30</td>
<td></td>
</tr>
<tr>
<td>4/4/07</td>
<td></td>
<td>Support Group</td>
<td>M</td>
<td>M</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>4/4/07</td>
<td></td>
<td>Shannon Williams</td>
<td>S</td>
<td>PC</td>
<td>.30</td>
<td></td>
</tr>
<tr>
<td>4/4/07</td>
<td></td>
<td>David Irvine</td>
<td>S</td>
<td>PC</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td>4/4/07</td>
<td>06489</td>
<td>Mary Geddes</td>
<td>C</td>
<td>HV</td>
<td>1.5</td>
<td>12km</td>
</tr>
<tr>
<td>4/4/07</td>
<td></td>
<td>Office Administration</td>
<td>X</td>
<td>O</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td>4/4/07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C = Client  
S = Support person  
HP = Health Professional  
x = Other  
HV = Home visit  
PC = Phone call  
T = Training  
M = Meeting  
O = Office
Learning activity

Look at the example of a daily activity log on the opposite page. Then answer the following questions.

Recording daily work activities

1. What codes (contractions, abbreviations, short-cuts) do you use and what do they mean? Try to think of at least three different examples.
   1
   2
   3

2. Why do you use codes?

3. Do you find them easy to understand and use?
   A If yes, why?
   B If no, why not?

4. How does this tracking sheet/daily log help you to:
   A Manage your time?
   B Help with accountability?
   C Collect reportable information?
## Recording daily work activities

A sample of progress notes, detailing a home visit with a client:

<table>
<thead>
<tr>
<th>Client name</th>
<th>Jane Maslow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>3/4/07</td>
</tr>
<tr>
<td>Detail</td>
<td>First visit to Jane. Her daughter contacted the organisation requesting help for her mother. Daughter present. Jane responded to queries. Provided brochures for Jane and her daughter in relation to Jane’s new diagnosis. Jane is managing her household tasks at present. Her daughter is supportive. Daughter expressed some concerns about meal preparation, however Jane is insistent that she would like to continue preparing her own meals at present. Arrangements made to visit Jane again in one month to see how she is progressing.</td>
</tr>
<tr>
<td>Signature</td>
<td>P. Wilson (F/W)</td>
</tr>
</tbody>
</table>
Learning activity
Look at the example of progress notes on the opposite page. Then answer the following questions.

1. Who is the subject (client) that the progress notes are about?

2. What was the client insistent about?

3. A family member of the client is mentioned. What relationship does the family member have to the client?

4. Who has signed the progress notes and what is that person’s role?

5. When will the client be visited again to see how she is progressing?
The records you keep may look different to the examples shown on the previous pages...

**CHECK OUT YOUR RECORDS**

Look at the records you keep for yourself and your organisation, then answer the following questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you use a diary to manage your day-to-day activities? (Tick the box.)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you use progress notes to document contacts with clients? (Tick the box.)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If no, what type of record do you/your organisation use to track contacts with clients?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Make a copy of a page of progress notes or the type of record used by you and your organisation and attach it to this page. Highlight at least one of each of the following key elements:

<table>
<thead>
<tr>
<th>Key Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factual</td>
</tr>
<tr>
<td>Signed and dated.</td>
</tr>
<tr>
<td>Accurate</td>
</tr>
<tr>
<td>Recorded as close to contact time as possible.</td>
</tr>
<tr>
<td>Complete</td>
</tr>
</tbody>
</table>
All records show accountability.
Being accountable means that you’re giving a reckoning or explanation for your actions, with the records showing that support has been provided and tasks completed.

Non-individual (group) records that show accountability include:
- Meeting attendances.
- Safety checks.
- Vehicle logs.

What are two other types of non-individual records?

Checklists include:
- Pick-up and drop-off times for clients.
- Personal care duties.

What is one other type of checklist that you can think of?
Referrals

Pauline also has some clients that she visits regularly to provide support.

Pauline needs to keep records about the individual clients whom she visits.

Each of her clients has been referred to the service by a health professional or through self referral.

When Pauline receives a written referral, she stamps it to record the date it was received at the office.

Phone referrals require her to record all the relevant information on a phoned referral form.

Pauline makes contact within one week of the referral to her service.

She allocates a reference number to each new client and logs this in to the log book and the database of clients.

All referrals should be followed up, ideally within one week of the referral being made to the service.

Referrals come in to the service in several ways:

- Faxes.
- Telephone.
- Written.
- Casual enquiries from individuals or on behalf of a family member.
- E-mails.
Learning activity
Use the information you have learned to answer the following questions.

Referrals

1. How does your organisation process referrals and enter new client information into its client database?

2. Look back at the progress notes example on page 16. How was Jane referred to the organisation?

3. Does your organisation follow different and/or additional procedures to those used by Pauline on the previous page? Use the space provided to note any differences.

Some referrals to the service are “self referrals”, meaning the person has recognised that support is needed to carry out his/her daily activities.
Individual records

Pauline has received a new referral.

Setting up an individual file
Pauline now has to put together an individual file for the new client.

She uses the referral details as the basis for the information she needs to collect, but will add further details after she has made the initial contact.

First, she makes up a hard copy file. It contains:

- The referral.
- Client profile sheet.
- Contact notes.

Client profile sheet
The profile sheet records the client’s personal information and contact details of the people who may support the client on a regular basis. Pauline will collect ethnicity data when she first visits the client—this information is collected by self disclosure.

Contact notes
After she has met with the client and the support person Pauline has more information to complete the client’s profile sheet.

She describes the contact she has made in the contact notes and includes a plan of action and intended follow up.

She also details the educational information provided to the client and the support person.

Each time that Pauline makes contact with the client, she will make an entry in the contact notes. This includes phone calls, home visits, and information given in person or by mail.

She will also note when the client or his/her carer has participated in a support group meeting.

This process ensures that there is complete written information about each client and his/her involvement in the service.
Learning activity
A client's hard copy file contains:

- The referral.
- Client profile sheet.
- Contact notes.

Look at the following information and decide where it will be noted in the file. To help you with this activity, the first question has been completed.

- Contact details of people who may support the client on a regular basis.
- Record of home visits.
- Information has been sent through the mail.
- Ethnicity data.
- Client's personal information.
- Phone calls.

Contact notes detail the contact between an organisation and a consumer by recording such things as phone calls and home visits.
Reportable information

Pauline has to collect information for the national organisation and report this every three months.

She uses her diary to help her record all the required information and then transfers it to a template that has been provided for the purpose.

Pauline completes the template on the office computer and e-mails this to the national office. She does this within five working days after the end of the month in which she has collected the data.

Information is collected about:

• New referrals.
• Total number of clients in the service.
• Number of discharges from the service.
• Number of training sessions provided.
• Number of phone enquiries.
• Number of times resources have been provided to the community.
• Number of other contacts.

Information collected is for internal or external statistics. It may be used to help plan new services or identify where there are gaps in existing services.
Reportable information

An example of a quarterly statistic form:

<table>
<thead>
<tr>
<th>Regional Code:</th>
<th>Year:</th>
<th>Quarter: 1</th>
<th>2</th>
<th>3</th>
<th>4 (circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of clients at the end of the quarter:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total new referrals:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of clients discharged:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total active clients:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total contacts made in the period:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total contacts with support persons:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total education sessions provided:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Client Demographic Information:

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Male:</th>
<th>Female:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of new referrals:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 45 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46 – 54 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55 – 64 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 – 74 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75 – 84 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85 – 94 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 95 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ethnicity of New Referrals:

<table>
<thead>
<tr>
<th>NZ European</th>
<th>Māori</th>
<th>Pacific Island</th>
<th>Asian</th>
<th>Other</th>
</tr>
</thead>
</table>

Total number of people attending support person education during the quarter ________________
Total number of education sessions undertaken ________________
Pauline also prepares a monthly report for her local committee.

<table>
<thead>
<tr>
<th>Committee Report:</th>
<th>Date:</th>
<th>Field Worker:</th>
</tr>
</thead>
</table>

**Clients:**
It has been a busy month for the service with six new referrals requiring intensive support.

Two of these referrals into the service are in an advanced stage of their condition and both the clients and their families have appreciated the information provided and their increased awareness of the services available to them in the community.

In spite of such a busy period, visits have continued to existing clients in accordance with their preferred visit plans.

**Meetings:**
I have attended two meetings this month including the annual conference in Wellington—I have reported this information separately to the Committee. I would like to express appreciation for the financial support provided for me to attend these valuable networking sessions.

**Education sessions:**
The weekly education sessions have continued with good attendance at all sessions. Additional resources and brochures have been ordered to maintain a full range in stock.

**Other issues:**
The pressure on office space continues. The receptionist is working under difficulty with limited space for her to carry out her administration duties. The new computer has been a valuable addition to the service, and is now up and running. A database of clients is being developed, with all new referrals included and gradual inclusion of all active client files. This transfer of information is likely to be completed within four weeks.
Narrative Reports
The narrative report is a brief summary of the activities Pauline has undertaken in the past month.

It **DOES NOT** include names or other identifiable client information.

It is designed to give the organisation a broad idea of the level of the field worker’s activities.

Pauline keeps a copy in her file and gives the original signed and dated report to the committee secretary.

Learning activity
The records you prepare for reporting purposes may be different to those that have been discussed here.

What does your organisation ask you to do to fulfil your reporting requirements?
Your organisation may also keep an electronic record of all clients with whom it has dealings. This is called a database.

**Databases**
Mostly databases are used for reporting of statistical information.

However, some organisations may require you to keep individual client information in progress or contact notes.

**Format for client record entries**
- Date of the entry.
- Progress entry using professional language.
- Initials and signature of the person making the entry.
- Designation of the person, such as field worker.
Learning activity
Check whether your organisation keeps an electronic record of clients (such as spreadsheet) in a database.

If yes, answer the following questions.
If no, what form of record keeping does your organisation use?

1. Who has access to the information?

2. Who is allowed to enter new information and/or make changes to existing information?

3. What measures are in place to protect client privacy?
Client information can be used in various ways.

**Clinical use related to health or disability services delivery.** This means that your service may record treatments, interactions, discussions and health details in the client’s record.

**Demographic data which may be used for public health reasons.** It may or may not include individual health information. For example, a list of new referrals may not contain health information. Demographic data may require you to record the client’s ethnicity.

**Teaching and/or research purposes by the organisation or a researcher.** The client’s information can be used to teach health professionals about the condition the client has, such as through a case study or clinical review. Researchers may also use client information when they are investigating the effect of health or disability on clients’ lives.

**Statistics for internal or external use including for public health use.** For example, disability statistics, resources provided (information, equipment). This may be used to help plan for new services or identify where there are gaps in existing services.

**Narrative reports.** These are generally used to summarise the activities you have undertaken over a period of time. They give flavour, rather than great detail, and do not usually identify individual clients. For example, a report may cover a description of the key issues in your service, training sessions offered, or trends in attendance at support groups.
Legal and other standards

Legal and other standards affecting client records are:

- Privacy Act 1993.
- NZS 8153: 2002 Health Records

The Privacy Act 1993

The Privacy Act 1993 sets out the rules for organisations about how they hold personal information about other people.

The Privacy Commissioner administers the Privacy Act 1993 which applies to almost every person, business or organisation in New Zealand.

The Act has twelve information privacy principles which describe how each organisation should handle personal information.

These privacy principles describe:

- How information is collected.
- How information is stored and the procedures needed to protect its security.
- The need to keep information complete, up-to-date and accurate before it is used.
- How long information can be kept.
- What information can be used for.
- When information can be disclosed.
- How a person can access his/her own information.
- How information can be corrected if it is wrong.
Legal and other standards

Sometimes other laws may require information to be disclosed—these laws must be followed over and above the privacy principles.

**The Health Information Privacy Code 1994**
This Code has additional rules for health sector organisations to help protect client privacy.

This Code guides:
- How health information is collected.
- How health information is used.
- How health information is stored.
- How health information is disclosed by health agencies.

For the health sector the Code takes the place of the Privacy Act 1993 privacy principles.

**Privacy Act 1993**
Sets the rules for organisations about how they hold personal information about people.

**Privacy Commissioner**
Administers the Privacy Act.

**People, businesses, organisations in New Zealand**
Who the Privacy Act applies to.
Legal and other standards

Learning activity
Use the information on pages 31 to 32 to help you answer the following questions.

1. How may legal and other standards affect client records?
2. Who administers the Privacy Act 1993?
3. How many information privacy principles are there in the Privacy Act 1993?
4. What are the four key words that cover how the Health Information Privacy Code 1994 deals with health information?
When providing support to clients you need to ensure that you are upholding their rights.

### The Code of Rights

When providing support to your clients you need to ensure that you are upholding their rights by following The Code of Rights.

### What does The Code do?

- The Code tells people how they can expect to be treated when they access a health or disability service.
- The Code also tells organisations the things they need to do when they provide a health or disability service.

- The Code of Rights is usually referred to as “The Code”.
- There are 10 Rights in The Code.
- The Code covers paid and unpaid work.
Legal and other standards

Who wrote The Code?
The New Zealand Government wrote The Code.

Under The Code the Government appointed a Health and Disability Commissioner. This person makes sure that people know about The Code and what it means. This person also listens to people’s complaints.

The Health and Disability Commissioner may require organisations to change the way they do things, as a result of a complaint that has been upheld.

Look for copies of The Code at your workplace, in a hospital, pharmacy or a doctor’s surgery. It might be in the form of a poster or a brochure.

The Code of Rights sets out the rights of people using a health or disability service in New Zealand.

On the following pages are the 10 Rights that The Code sets out, along with examples of each Right in action.
Legal and other standards

The right to be treated with respect

1. This means you should treat all clients with respect.

Ensure that you record the information correctly in your records. For example—respecting the client’s right to a chosen title (Ms, Mrs, Miss) and spelling the client’s name correctly.

The right to freedom from discrimination, coercion, harassment and exploitation

2. This means that you make sure that you treat all clients fairly. You should not pressure clients into doing something they really don’t want to do or take advantage of them.

You should not force clients to share information they do not wish to share.
### Legal and other standards

#### The right to dignity and independence

<table>
<thead>
<tr>
<th><strong>You need to make sure that any information gathering or recording is carried out in a way which maintains the dignity and protects the independence of the client.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Talk to clients in a manner that they can understand. Don’t just talk to family or other support people and not to the client during a discussion.</strong></td>
</tr>
<tr>
<td><strong>Encourage the client to be as independent as he/she is able. You also respect clients’ worth and value as human beings by acknowledging their concerns and experiences.</strong></td>
</tr>
</tbody>
</table>

#### The right to services of an appropriate standard

<table>
<thead>
<tr>
<th><strong>This means the support you provide should be of a reasonable standard and delivered with skill. The quality of your support should meet legal, ethical and professional standards.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you are giving a client information, it is important that this information is accurate and up-to-date to help the client to make a good decision.</strong></td>
</tr>
<tr>
<td><strong>If you are meeting with a client it is important that you are on time, and act in a professional manner.</strong></td>
</tr>
</tbody>
</table>
Legal and other standards

The right to effective communication

5

This means the information has to be clear and in a way that the person understands.

This means giving clients the information they need by taking into account the best way to communicate with them. This may mean giving written as well as verbal information to a client with a communication impairment.

The right to be fully informed

6

This could mean giving a client all the information about choices and options for support.

It could also be giving a client information on what records are kept, the purpose of the records, who sees them and where they are stored.

This means helping a client to ask questions which should be answered honestly. Clients may want to check the accuracy of the information that is kept about them.
Clients may need a support person with them, especially to make choices and decisions. For example, you make all the information available so that the person can make an informed decision and give consent.

Clients are presumed to be competent to make decisions and choices about things which affect them. When clients have had enough information and time to think about it, they should be able to make an informed decision.

A client may wish to have a family member or friend present at a first meeting. It is a good practice to ask the client if he/she would like to have someone else present when you first set up the meeting.
Legal and other standards

The right to respect in teaching and research

9

This means you can support a client to ask questions and give consent to be involved in teaching and research. Clients should be made aware of their rights under The Code.

If you are teaching a new field worker about his/her role, you need to ask the client’s permission to include this person when you meet.

The right to complain

10

This means that you can help clients to make a complaint and you should take seriously any concerns they have.

You should be aware of your organisation’s policies and procedures on how to make a complaint.

If a client wants to complain, you should not try to discourage that person from doing so. You should support the client through the complaints process and provide all necessary information.
Codes, contractions and abbreviations are all terms that refer to short-cuts when a couple of letters are used to represent a complete word, term or phrase.

**TAKING SHORT-CUTS**

Abbreviations may be used in accordance with your organisation’s approved list.

<table>
<thead>
<tr>
<th>Look at your organisation’s list of approved abbreviations. Where did you find this information?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Use your organisation’s approved abbreviations to provide the short-cuts for these terms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support worker</td>
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<tr>
<td>Registered nurse</td>
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<tr>
<td>Doctor</td>
</tr>
<tr>
<td>Client</td>
</tr>
<tr>
<td>Supervisor</td>
</tr>
<tr>
<td>Do you use any abbreviations that you have made up?</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>What are they and what do they mean?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are there any you have found and might want to use? (Write a few in the table below.)</th>
</tr>
</thead>
</table>
Codes, contractions (shortening words), abbreviations and short-cuts have already been touched on in this workbook.

Look back to pages 14-15 in the *Recording daily work activities* section to refresh your memory.

You may already be familiar with using abbreviations on a daily basis, especially if you have a cellphone and use it to send and receive text messages. However, what is acceptable usage on the cellphone may not be appropriate when it comes to keeping health records.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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</table>
Who is responsible for maintaining information within your organisation?

**Maintaining information**
Your organisation will have policies and procedures about who is responsible for maintaining client records. This may be a health professional, or some other person.

You need to know what your organisation requires you to do to maintain client records.

This means you need to know how often, where and by whom entries should be made.

Your organisation will also have guidelines for completing and storing other records such as statistical and narrative information.

**Health records may be in:**
- A single file.
- Multiple files.
- Paper based (hard copy).
- Electronic (digital, audio, video).

The records may be held by an organisation, service provider or clients themselves.

**A health record may have:**
- A clinical purpose. For example—provision of care, information, monitoring progress, a diagnosis, any investigations and treatment undertaken.
- A non-clinical purpose. For example—administration, funding, legal and contractual obligations, audit.
- An additional purpose. For example—teaching or training, research, statistical reports.
Taking responsibility for records

Health records should accurately reflect the interaction between the healthcare provider and the client.

Health records may be called:
• Care plans.
• Lifestyle plans.
• Clinical pathways.
• Support plans.
• Patient records.
• Clinical records.
• Service plans.

Health records should...

- Be recorded so that alterations or additions are dated, signed and legible. White out is not acceptable.
- Be factual, consistent, accurate, legible and complete. This means that the information states all the facts, is reliable and not contradictory, and is able to be read.
- Be recorded as close to the event as possible.
- Be permanently recorded. This means not able to be erased. Written records should be written in ink.
- Include a date, signature and designation. This means the initial and surname of the person who has written the entry as well as his/her role or qualification. For example: M Butler (R/N) or J Jones (S/W).

When keeping health records, abbreviations may be used in accordance with the organisation’s approved list.
Taking responsibility for records

Terms and definitions

The terms and definitions covered on the following pages will assist you in maintaining documentation as a community field worker in a health or disability setting.

Client details

The details on file should be an accurate representation of the client.

- Some organisations may use a unique identifying number for each person. This is called a National Health Index (NHI) and the organisation will have policies and procedures about how these identifiers are used.
- The health record should contain only that person’s information.
- If your organisation collects ethnicity data, there should be a standard way of asking people about their preference.
- Ethnicity data should be collected through a self-selection process.
- People should not be asked again and again for the same information. However, accuracy of the information should be checked regularly (for example, as appropriate at each new episode or contact).
- There should be a summary of all key health information at the front of the file. This includes recording any special health alerts or drug allergies.
Taking responsibility for records

Terms and definitions

Refusing access
The Privacy Act 1993 outlines reasons why an organisation can refuse access to client records.

• A client must be given a reason why the record is withheld and has the right to complain to the Privacy Commissioner about this if he/she is not satisfied.
• While the information legally belongs to the client, the medium (paper, disc, film, tape) is the property of the service.

Verbal communication
Relevant information from verbal communications should be documented in the record.

Access to health records

• Only authorised people are entitled to view information about a client. There must be a legitimate reason for them to do this.
• People who are not involved in health care may also have access to the files under the law, for example the Coroner or ACC officers. Clients are entitled to have their information cared for in a confidential manner.

Your organisation will have procedures about how a client can access his/her individual record.
Taking responsibility for records

Terms and definitions

Client-held records
Sometimes clients will be responsible for their own records.
- Your organisation will have a system to make sure these records are kept up-to-date.

Tracking
The location of records should be known at all times.
- If records are removed for any purpose, then a tracking system should be in place such as an in/out log and location.

Release
Information can be released to a client or a third party in accordance with the Health Information Privacy Code 1994.
- Your organisation will have policies and procedures about this process.
- The Health Information Privacy Code gives people the right to request changes to records they consider inaccurate, incomplete or misleading.
- If the organisation does not want to act on a request to make alterations, it must still attach documentation on to the file of the client’s request so that there is evidence of the client’s concern.
Terms and definitions

Copying
Copying or duplicating records should only occur if really necessary.

• The information should clearly indicate that it is a copy.
• New information should not be added to a copy.

Transfer
Records can be transferred to a new provider.

• This may occur if the service provider ceases service or practice or if the service is sold.

Storage
Your client files should be easily identifiable and organised into logical sections. The record should be stored in a way which keeps it in good condition.

Although the information here relates to maintaining health records, it also includes practices which are considered Best Practice.
Taking responsibility for records

Terms and definitions

Electronic security
Your organisation will have policies and procedures describing:

- How electronic information about clients is accessed.
- How access is monitored.
- Back up of the information (including for laptops and PDAs as well as intranet systems).
- How and where the backup is stored.

Retrieval

- Records should be available from storage whenever they are required.
- Only authorised people should be able to access these records.

Retention

- Health records should be preserved in a manner that ensures they are available to the person to whom they relate for the minimum period as required by legislation.
- Individual health records should be retained for a minimum of 10 years from the date of the last entry in the record.
Taking responsibility for records

Learning activity
Refer to the information on pages 44 to 50 to help you answer the following questions.

1. What are your organisation’s policies and procedures on releasing information?
2. What are the grounds for refusing to release information?
3. What policies and procedures does your organisation have in place regarding electronic security?
4. How does your organisation monitor who has access to electronic records?
Statistical information

Statistical information is usually general (rather than detailed) and not identifiable to any one person. Your organisation may collect information for internal and external use.

The information you keep may be about:
- New clients in the service.
- Number of clients discharged from the service.
- Number of visits made and travel time.
- Follow-up visits.
- Referrals made to other services.
- Meetings attended or held.
- Training attended.
- Phone calls made or received.
- Time taken undertaking aspects of the service.

Reporting statistical information

Your organisation will also have to have a consistent way to report statistical information at regular intervals. It may be:
- A paper record.
- An electronic template.
- A table.
- Summary report.

You will need to have a system to record statistical information. Check how your organisation wants you to keep these records. Your system may use a diary, day sheet, log or database to record the necessary information.
Taking responsibility for records

Narrative information

Narrative information may include a history and sequence of events, or present statistical information in a descriptive form.

Many organisations require field workers to provide a regular report on their activities, which, like statistical information, is general rather than specific in nature. Information gained from statistical and narrative reports is collected by the organisation for its own use or reported to other organisations, for example funders of the service.

Information may be used to:
- Show the organisation is delivering the services that it is paid to provide.
- Show whether there are gaps in the services provided.
- Provide information about where and what services are needed now or in the future.
- Meet external reporting requirements, such as for the Ministry of Health.
- Show the employing organisation that the field worker is fulfilling requirements.
- Provide accountability to a committee or board.

Narrative reports also allow the field worker to:
- Make recommendations.
- Offer an opinion.
- Add a wider range of information than an entirely statistical report can do.

Some organisations require both types of information to be reported.

This is an account or description of an activity to do with a client and/or your service.
Taking responsibility for records

Other documentation

Some field worker roles include group work or teaching sessions.

Group work or teaching sessions
Apart from attendance records, these sessions are unlikely to require specific client information to be recorded. However, you may need to keep some records of your activity.

Documentation of the sessions is likely to have:

- A session outline.
- Resources required—teaching aids, data projector, refreshments.
- Timeframes.
- Costs such as travel, hire of equipment and location, advertising.
- Safety issues or environmental assessment.

Sessions are:

- Described.
- Summarised.
- Reported.

These principles are followed in accordance with the organisation’s policies and procedures.
Field worker Pauline is responsible for organising a regional planning day. It is the first time she has been asked to organise the event. As a guideline she has looked up the session planning form from the last time. She has been notified that two of those attending are affected by hayfever and airborne pollens; a permanent whiteboard has been installed in the meeting room; and morning tea will not be required.

Use the session plan to help answer the following question.

What items can Pauline delete from the Resources required section?

---

**Regional Planning Day: A Clinical Update**

**Date:** 29th March, 2007

<table>
<thead>
<tr>
<th>Duration:</th>
<th>9am – 12 midday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources required:</td>
<td>Overhead projector</td>
</tr>
<tr>
<td></td>
<td>Extension Cord</td>
</tr>
<tr>
<td></td>
<td>Brochures and Pamphlets, Booklets</td>
</tr>
<tr>
<td></td>
<td>Tea &amp; Coffee, 3 pkts biscuits</td>
</tr>
<tr>
<td></td>
<td>Milk, Sugar</td>
</tr>
<tr>
<td></td>
<td>TV and Video Player</td>
</tr>
<tr>
<td></td>
<td>Whiteboard, Pens and Duster</td>
</tr>
<tr>
<td></td>
<td>Roll of Newsprint</td>
</tr>
<tr>
<td></td>
<td>Pens</td>
</tr>
<tr>
<td></td>
<td>Jug of Water &amp; Glasses</td>
</tr>
<tr>
<td></td>
<td>Tissues</td>
</tr>
<tr>
<td></td>
<td>Flowers</td>
</tr>
</tbody>
</table>

**Session outline:**

9am - Greeting and Introduction to session
9.15am - Group introductions
9.30am - Research findings
10am - Clinical update
10.30 - 10.45 am - Morning Tea
10.45 am - 11.45 - Workshop
11.45 am - Feedback
12.00 - Close and Farewell
Taking responsibility for records

Confidential information

Each field worker will keep records as required by the organisation.

Regardless of what information is required, it is important to ensure that the information is stored securely at all times (see access to health records).

Your organisation will have policies and procedures to guide how this storage should occur.

However, in general terms, you need to consider security of information:

Confidentiality considerations

Your diary:
- What information is recorded. Is it health information or contact details?
- Where the diary is kept when in use and when not in use. Is it taken away from your office base or to your home? Is it left in your car?
- If in electronic format, who has access to it?

Your client files:
- Access to filing cabinets. Remember to take care of keys and combinations.
- Are the client files taken off site, for example, to a person’s home?
- How are files transported?
- Are the records copied for any purpose?

Your reportable information and statistics:
- Does this identify any particular clients?
- Where is this information retained?
- Who has the authority to look at it?
- Who do you report it to?
Taking responsibility for records

Miscellaneous forms
There may be other documentation you are required to keep.

Ordering of supplies:
Your organisation will have procedures to follow when you order supplies for your service.
- This could be office supplies, paper and stationery, tea and coffee for groups, educational resources such as brochures and fact sheets, and meeting supplies.
It is likely you will use a template or form to make these orders. You will need to keep a copy of items ordered and follow a sign-off process when these items are received. The record will then be used to confirm the goods have been received and payment authorised.

Donations or subscriptions:
Sometimes a person may offer you a cash or cheque donation to help support the work of the organisation.
- Your organisation will have policies and procedures to guide you in how you should handle money.
- The process should include the issue of a receipt.
- Check how your organisation requires you to handle money in your service.

Mileage book/vehicle log:
If you use your own or a service vehicle for your work, you will be required to keep a record of the travel you do.
- The log will record each trip you make and the distance you have travelled.
- In addition, you will need to record any fuel purchases and keep any receipts of the purchases. This will assist your organisation to account for the travel expenses.
- Check how your organisation requires you to deal with making and receiving orders.

Miscellaneous considerations
my notes

Maintain documentation as a community field worker in a health or disability support context
Do you agree with your initial thoughts and ideas?

yes / no

no

yes

If yes, do you have anything you would like to add?

If no, what would you change?

If you have any more questions, what could you do or who could you ask to find the answers?
You have come to the end of:

**Maintain documentation as a community field worker in a health or disability support context**

Check the following:

☑️ Please **check over all the activities** to make sure you have completed them.

☑️ Complete the trainee assessment portfolio and remember to **sign your assessment portfolio in the place provided**, verifying that you are the one who has completed all the assessments.

When you have completed the trainee assessment portfolio and have been signed off as competent by your assessor, your assessor will complete a Certificate and give it to you.

If you wish, you could frame it for display or mount it in a record book.
You have now completed

20964 V2 Maintain documentation as a community field worker in a health or disability support context:

part of a Careerforce learning series designed for support workers in a health or disability setting.

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