Royal Children's Hospital	POLICY: CLIENT RECORDS	Policy No:
		Issue Date: 30.08.13
Gatehouse Centre (for the Assessment & Treatment of Child Abuse)		**Review Date:** 30.08.14
		Page 1 of 4

1. Policy Statement

The Gatehouse Centre recognises the need to document all contact with Clients, both direct and indirect contact. This is to ensure accountability, continuity of care and evaluation of client progress. Whilst the sensitivity of the information provided to/gathered at the Gatehouse Centre necessitates the use of files separate from the UR, the importance of recording Gatehouse Centre involvement is acknowledged.

Client's rights to confidentiality must be respected and maintained within legal limits. The Gatehouse Centre file should only be viewed by or added to by those who are authorized.

The Gatehouse centre recognises the potential for client records to be subpoenaed for court purpose and also under the Freedom of Information Legislation.

2. Persons Affected

All Gatehouse Centre staff.

3. Definitions

Medical Records/Unit Record (UR): a manual or electronic record containing a patient's health or personal information, status and treatment.

Documentation: encompasses all written and/or computerised recording of all aspects of patient care that reflects what was communicated, planned , undertaken with or given to that patient.

4. Responsibility

All Gatehouse Centre staff

5. Procedure

- ***Regarding Recording in IBA***

Involvement of Gatehouse Centre to be recorded in IBA by administration staff following acceptance of referral.

Clinician's to view ESMR record (if one exists) at the beginning of assessment phase to assist in gathering of history.

At the end of Gatehouse involvement, file should be sent to be scanned to ESMR. Clinician to give file to admin staff.

- ***Regarding Gatehouse Centre Files***

All files should be kept in the clinician's locked filing cabinet or file compactus area.

All file notes should be written within 24 hours of contact with or regarding a client.

Record keeping procedures will be consistent with the RCH Clinical Documentation and the Documentation: Medical Records policies and will ***include the following:***

- Record information that is clear, simple and concise in language and accurate in detail.
- Be objective, non-judgemental and respectful.
- Be written in blue or black ink ONLY with NO white out, or erasures.
- All case notes in the file, whether typed or hand written should be dated and signed by the person concerned, with the person's name also clearly written in the box in the right hand corner.
- Any blank lines MUST be crossed through with a line so as to prevent any possible additional/late entries.
- All reports and correspondence, including copies, must be signed by the writer.
- All file notes to be entered on specific Gatehouse Centre paper or Gatehouse recording sheets only.

All client file notes will:

- Be recorded on official Gatehouse Centre file note paper. A template can be obtained from Admin if notes are typed.

- Have the box in the right top corner filled out completely with the **client's full name, UR, date of entry and worker's name**

All client records will include the following information:

- Completed registration sheets(s). This includes having entered the outcome of clinical meeting onto the second page of the registration sheet.

- Completed checklists.

- File notes should clearly indicate who attended/initiated call/to whom a message was left, etc.

- Brief notes of each contact re: presentation, issues discussed, activities, interventions, outcomes and future plans. Indicate on what basis any opinions/inferences have been made (eg. observation of…., fact substantiated by…., clinical experience, the literature, etc.)

- Dated entries regarding contact with others eg: family members, other professionals and services etc.

- Copies of any written reports.

- Copies of correspondence received/sent that is directly related to the child.

- Copies of consent to assessment and treatment (where treatment is provided) and for release of information forms.

- Case closure/summary

- All client files, case notes, information regarding clients will be kept in lockable filing cabinets.

Confidentiality Issues

- No identifying information should be used in case presentations/training sessions outside of the Gatehouse Centre team.

- Written consent for the release of information must be obtained from the child's parents/guardian and a copy of the consent form should be kept in the file.

- Client files should not be removed from the Gatehouse Centre except where these have been subpoenaed to Court.

6. Other Relevant References

Gatehouse Centre Confidentiality of Client Information Policy
Gatehouse Centre Correspondence and Information Received from Parents/Carers Policy
RCH Clinical Records Policy
RCH Documentation: Medical Records Policy