

Storage of patient complaints



MPS



Advice correct as of September 2016

Where patient complaints are stored will depend on the subject of the complaint, and the extent to which it relates to the health services that have been provided to an individual. Generally complaints are stored separately from the clinical file and only information that is pertinent to the patient's ongoing care would be copied into the clinical file.

Managing health information

The Health Information Privacy Code (HIPC) sets out a number of rules concerning the management of health information. The definition of health information is wide (including any information about health services that have been provided to the individual).¹

It is arguable that health practitioners are not required to retain certain complaints, such as 'the magazines in the waiting room are old' where the link to the provision of health services is tenuous.

The majority of complaints are likely to relate to the provision of health services and therefore be considered health information. Therefore, the information contained in the complaint must be managed in the same way as other collected health information.

Disclosing information around complaints and storage

Any disclosure of the information contained in a complaint (by virtue of where it is recorded on file), would also need to be only to the extent necessary, to achieve the purpose for which it was originally collected. This would mean dealing with each complaint on a case-by-case basis considering the purpose for which the information relating to the complaint was collected, rather than a blanket rule for recording complaints.

For example, if the subject of the complaint is about how care was delivered (eg, the doctor was rude to me), then retaining the complaint in the patient notes (for other doctors to view), would be an unnecessary disclosure and inconsistent with the purpose of collection.

It would however, be acceptable if the practice manager had access to this information, so as to not book a patient in with that particular doctor in future. In that case, the complaint should be stored in a separate folder but with a reference (or 'red flag') on the patient's file that such a folder exists.

However, if a patient complained about an adverse reaction to treatment, or the method in which a particular doctor applied a treatment (not voiced during a consultation), then it would be consistent with the purpose of collection to record the medical content of the complaint on the patient's notes so other doctors within the practice could avoid repeating similar approaches or treatment. However as above, the actual complaint should not be stored within the clinical notes, rather stored separately.

References

1. HIPC clause 4(1)(c)

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