The care records definition — detailed text

Read the detailed version of our care records definition, including background information and a comprehensive list of the types of information included.

On this page you'll find the types of information considered to be in the care records definition. It's important to note that information examples given are only representative of information types and are not an exhaustive list.

You can also read a plain language summary of the care records definition, and a glossary of the terms used in both.

Read our glossary of terms used

Read the plain language version of the care records definition

Why we developed the care records definition

In its interim report, the Abuse in Care Royal Commission recommended the Crown 'urgently review disposal authorities -relevant to care records and consider whether to prohibit the disposal of the care records until at least the completion of its work on records'.

Read the Abuse in Care Royal Commission of Inquiry interim report 'Redress to Puretumu Torowhānui'

To do this work, the Crown needs to have a common understanding of what the care records are.

Disposal does not always mean destruction

Disposal is the decision-making process for retaining, transferring or destroying information and records. It does not mean that the records will necessarily be destroyed. For public records, it can include transfer to Archives New Zealand or to another agency, discharge to the individual they relate to, or destruction.

Read our glossary for full definitions of terms used

How we came up with the care records definition

We've worked with the Crown Response Unit to collaboratively develop the definition using insights from the work of the Royal Commission, including:

- the Royal Commission's Terms of Reference

- survivor and advocate voices from the hearings and written evidence provided
- outcomes of engagements with care advocates, agencies and survivors
- iwi leaders
- secondary sources such as national care standards, and
- international best practice guidelines.

In early November 2023 we sought public feedback on the draft definition. The feedback received resulted in further refinement of the definition.

Find out more about how we came up with the care records definition

What the care records definition is not for

Defining which records must become archives

The information types specified in the care records definition will not necessarily need to be transferred to us to become archives. The care records to be transferred will be identified through the further review of the retention and disposal of records.

Defining which records individual care organisations must create or hold

The care records definition does not define which records must be created or held by government agencies — or other contracted care providers. The agencies responsible for care services need to determine this, in accordance with:

- legislative requirements
- the need for transparency
- accountability, and
- best practice.

For example, a non-government organisation (a not-for-profit, self-governing organisation independent of central or local government) providing care on behalf of a State care organisation — where that State care organisation provides the case work function — may not hold case work related records.

But the care records definition can be used as guidance on what types of information people who have been in care might need in the future. It can be helpful for understanding:

- which records would be useful to create and maintain
- how best to organise the data and records within information systems.

The intention of the definition is to assist with identifying information that should be considered care records. The definition is not intended to constrain iwi Māori providers or faith-based and other non-government providers in following their appropriate tikanga and customary practices regarding recordkeeping. The definition describes which records that exist are care records and does not say what should be created or how they should be managed.

The definition may change over time

The definition is not set in stone as the need for changes might be identified during the review of the disposal rules work — or as a result of the Royal Commission's final report which was published in July 2024.

Read the Abuse in Care Royal Commission of Inquiry final report 'Whanaketia.'

Temporary care records protection instruction

The Chief Archivist has issued a temporary care records protection instruction. Its purpose is to protect public office care records as defined in our care records definition while work is undertaken to review the retention and disposal of State care records.

Read more about the temporary care records protection instruction

About care records

What care records are

Care records contain information and evidence about care services. They are important to support the rights of people who are or have been in care, and they have been identified as being of value to people who have been in care. Additionally, care providers need care records to ensure their services are effective and accountable.

Care records broadly document the provision of care services to individuals (a child or vulnerable adult in or who has been in State or non-State care) by State care and non-State care organisations in certain care settings. They include information and evidence about both the individual and about the care setting, such as:

- the core identity of individuals in care — who someone is
- the services supplied — or not supplied — to support individuals in care
- how the records of an individual's care experiences are looked after
- incidents, responses and decisions affecting the safety and wellbeing of individuals in care
- the processes, rules, and histories of the care organisation over time.

Care records include information in any format

It's important to note that care records include information in any format, such as:

- braille
- audio
- child-friendly
- photographic
- digital
- paper
- film, and others.

Personal belongings

Care organisations also often hold records classed as personal belongings on behalf of people in care. These are not public records but need to be kept safe and stay with them during their time in care, and then returned to them or their whānau when they leave.

Read more about personal belongings

Why care records may not exist

Care records are created and gathered as part of care services. This means different types of records may be found depending on the types of services provided.

In some cases — where the care situation lasts only briefly — there are likely to be few records. For long-term care, there are likely to be many records.

Over time, the types of records created have changed. This means different types of records will be found according to when the person was in care.

In the past, many records have been lost due to the recordkeeping practices of the time. As a result of this, unfortunately many of the records included in these information types may no longer be found. These recordkeeping practices can also mean records that do exist may not be well described or may be described using outdated or offensive terms, hindering access.

The care records definition

Care record information types

Below are the types of information in scope of the care records definition. Information examples given are only representative of information types and are not an exhaustive list. Note that a care record, such as a case file, often contains multiple types of information and relate to multiple care-associated activities. They can also contain both personal and business-related information.

State care organisations

For State care organisations, care records are public records and the care records definition will be mandatory under the Chief Archivist's temporary care records protection instruction. In situations where State care was provided by non-State organisations the State organisation is responsible for the records of that care provision.

Non-State care organisations

For non-State care organisations providing care services independently of the State, this document is for advisory purposes only, as non-State care records are not public records under the Public Records Act 2005.

Grouping of information types

To enable easier review and consideration, we've grouped the types of information defined into 2 main categories.

- Category 1 — Records of individuals in State and non-State care settings
- Category 2 — Records of State and non-State care settings

Category 1 — Records of individuals in State and non-State care settings have been further grouped into:

- 1.1 Core identity of individuals in care settings
- 1.2 Provision of services to individuals in care settings
- 1.3 Recordkeeping requirements of and for individuals in care settings. This relates only to recipients of care services. Records related to staff, service providers, contractors and so on are included in Category 2 — Records of State and non-State care settings
- 1.4 Complaints, allegations and incidents, responses and decisions affecting the safety and wellbeing of individuals in care settings.

Types of information included in the care records definition

Information examples given are only representative of information types and are not an exhaustive list. Care records are created and gathered as part of care services. This means different types of records may be found depending on the types of services provided.

Category 1 — Records of Individuals in State and non-State care settings	
1.1 Core identity of individuals in care settings This is information about who someone is and supports their personhood. This includes information about their **whakapapa** such as where they have been and who their **whānau** or family are.	
1.1.1	Personal identification information, including for example: • copies of birth certificates • any assigned names • the names and last-known contact details of members of the individual's family • contact details of individual if in non-residential care settings, and so on.
1.1.2	Information of an individual's identity, cultural and social needs, including for example their: • cultural identity • whakapapa • iwi affiliations • gender identity • sexual orientation • health and other needs including in relation to any disability that they have • spirituality or religion • knowledge and practice of one or more languages • mental health needs including in relation to neurodiversity • any other information that supports their personhood, and so on.
1.1.3	Information about known whānau, hapū, iwi, marae, family group and cultural connections. This includes family circumstances, known methods and limitations regarding contact with these connections, beliefs in relation to religion and political affiliation.
1.1.4	Records of an individual's personal belongings.
1.1.5	Educational histories of individuals, including for example:

	• individual enrolment records (for example, admission and withdrawal information) • school reports • academic progress records • pastoral records • Resource Teacher Learning and Behaviour (RTLB) records, and so on.
1.1.6	Medical histories and health reports of individuals and their whānau, including for example: • reports from counsellors or psychologists • family health records • dental records, and so on.
1.1.7	Records of achievements and important events in the life of the individual. The intention is that information that shows the successes, strengths, fun activities and feedback about their participation for the individual will be considered care records.
1.1.8	Records related to the reasons for the individual's placement in care settings, including for example: • copies of court orders • documents supporting the application • minutes, directions, decisions, judgments or similar documents, and so on.
1.1.9	Records of advice and assistance given to individuals to obtain official documentation for example: • photo identification (such as a passport or a driver licence) • a certified copy of their birth certificate • an IRD number • a bank account • a will • verification of their identity online to enable them to access key government services, and so on.

1.1.10	Names of people who visit an individual or a group of individuals during their time in care settings — and their relationship to the individual or group. To clarify, this includes all visitors interacting with people in care.
1.1.11	Personal information written or recorded by or for an individual, for example: • of their version of events • explaining how they are feeling at a particular placement • their response to decisions made, and so on.
1.1.12	Records of the employment of individuals in care, including pay and conditions.
1.1.13	Records of an individual's personal finances, which for example could include: • their pocket money and allowances • their earnings, and • any other income, held on their behalf, and so on. Records may include information about who holds and manages these finances on behalf of the individual, and agreements on how the individual will access their personal finances.
1.1.14	Records of connection with whānau, including for example: • information about restoration approaches with whānau • records of transition to independence plans and whānau investment in those plans • reports of lived whānau experience to balance negative care reports, and so on.
1.2 Provision of services to individuals in care settings These records are about the care services that were or were not provided to an individual, and the reason that service was provided or withheld.	
1.2.1	Records of an individual's: • admission • transfer

	• removal • change in placement or status of placement (including foster placements, holiday placements, work placements, private placements and so on) • discharge • death in care. Relevant information includes the physical address of those placements, photographs of those placements and the rationale for the placement decision. Example records include transit sheets.
1.2.2	Records of day-to-day provision of care to an individual. Example records include: • handover documents • pastoral records • punishment registers (used in the 20th century) • daily diaries • photographs • reviews of individual's progress • educational reports from schools • counselling or social worker reports • minute books of committees of management • documents regarding the supervision of individuals • social worker case notes (for example about home visits), and so on.
1.2.3	Records of medical treatments given to individuals, irrespective of the location these were given. For example: • medication • drugs • electroconvulsive therapy (ECT) • surgery, and so on. The intent is for all records relating to medical treatments an individual in care settings receives during their time in care — including the decisions made and rationale regarding providing or withholding treatments — will be considered care records.

1.2.4	Case management plans and associated assessment and review, for example: • Care plans • Accommodation plans • Finding employment plans • Education plans • Health plans • Behaviour support plans • Case plan reviews • Cultural plans • Leaving care plans • Aspiration support plans • All about me plans • Family group conference plans, and so on.
1.2.5	Needs assessment and support plans, which reflect the views, wishes, concerns and worries, aspirations and strengths of the individual— and the views of their whānau or family, hapū and iwi.
1.2.6	Records of assistance provided to an individual, either as a result of a plan (refer 1.3.4 and 1.3.5) being actioned, or on an ad-hoc basis. This includes decisions made and rationale regarding providing or withholding assistance.
1.2.7	Records of formal talks and interviews with an individual, including recordings or summarised notes. For example, interviews by caseworkers or other care professionals.
1.2.8	Records of when and how **whānau** and family of individuals were informed or consulted about the individual's care, decisions made and rationale regarding sharing or withholding information, and the information provided.
1.2.9	Correspondence or summarised notes of formal meetings and substantive discussions or decisions with, for example: • parents • other whānau members • support people • caregivers

	• care professionals or those in care support roles to and from institutions and to and from State organisations, and so on.
1.3 Recordkeeping requirements of and for individuals in care settings This is information about how the records of an individual's care experiences are looked after and what has been done to keep the records safe, accurate, and up to date. It includes individuals currently in care and those who have been in care.	
1.3.1	Records of access to — and the transfer between placements of — the records of an individual. Example records include transit sheets.
1.3.2	Records of information requested by and provided (or not) to individuals in the care settings, including the rationale for the care setting's response to the request.
1.3.3	Records of consent sought from individuals to share their personally identifiable information with external parties, and the individual's response to the request.
1.3.4	Records of 'core identity documents' ownership agreements between individuals and the care settings.
1.3.5	Requests by individuals, including the request, the care setting's response to the request, and the length of time between request and response: • to access their care records — including where no records are able to be located • to limit access to their care records — including when consent of individuals should be sought • to annotate, modify, or add to records about themselves • to dispose of records about themselves, and so on.
1.3.6	Records of the information provided to individuals about the recordkeeping practices of a care setting, including **NGO** service providers. For example: • retention and disposal decisions • information and data sharing agreements • developing and maintaining a life story

	• use of technology apps or tools for recordkeeping and developing a life story, and so on.

1.4 Complaints, allegations, incidents, responses and decisions affecting the safety and wellbeing of individuals in care settings

Complaints and allegations may be about incidents, including for example:

- grooming
- inappropriate behaviour
- assault
- neglect
- abuse
- false imprisonment
- unlawful searches, or
- any other incident relevant to individual safety and wellbeing, and so on.

The intention is that all records of complaints or allegations raised, incidents identified about something that has or may have happened to an individual that affects their safety and wellbeing, and how the care setting responded to them, are care records.

This is irrespective of severity, as 'small' incidents may indicate a pattern or a broader issue. For example, information about:

- where the incident occurred
- the persons involved in the incident
- the investigation and reports on the outcome and findings — irrespective of whether it was received by a care setting or another Government organisation, and so on

will be considered as care records.

Records of complaints or allegations about an individual in care who has or may have affected another person's safety and wellbeing are also care records, covered by 2.4 or 2.5.

Records of the care setting's policies, procedures and process relating to how it will deal with complaints, allegations and incidents are covered by 2.8.2.

1.4.1	Records of complaints received, allegations made, incidents, or near misses identified relevant to individual safety and wellbeing, including for example:

	• the complaint or incident, the care setting's response to the complaint or incident and the length of time between complaint or incident and response, for example records of adverse event reviews and recommendations • evidence regarding the complaint, allegation or incident in any format, for example photographic, audio recording, written or typed notes • resolutions, police reports, charges, details of police investigations, records of court cases and those involved, including files, dossiers and vetting information, and so on.
1.4.2	Records about the investigation or assessment conducted — whether conducted by the care settings themselves or by an independent body such as Independent Children's Monitor, Independent Police Complaints Authority, Grievance Panels or Inquiries. For example, these include: • how and when the care setting or other organisation conducted the investigation or assessment • who the care setting or other organisation talked to and worked with (externally and internally) and when • where and when the care setting or other organisation requested information from, for example, schools and police, and who they shared information with through the course of the investigation or assessment • records of case consult meetings with other staff and professionals • how the care setting or other organisation risk assessed and came to their finding (for example, risk assessment templates and tools used) and when, and so on.
1.4.3	Evidence in relation to complaints received, allegations made or incidents raised in relation to individual safety and wellbeing, in any format. This includes photographic evidence of, for example: • assaults • injuries • abuse or neglect • the care setting environment, or • any other incident, and so on.

1.4.4	Records of current and historic claims relevant to the safety and wellbeing of an individual in care settings, including for example: • claim records, assessments, reviews and appeals for individuals • interventions, support or compensation and attempted or successful redress • counselling, mediation and medical records, and supporting information such as description of residences and historical practice, and so on.
1.4.5	Records of how complaints, allegations or incidents — and the outcome and findings of investigations into these — was communicated to the individual and/or their whānau and when, and how the individual and whānau were supported through this process.
Category 2 — Records of State and non-State care settings This category is about the processes, rules, and histories of the care organisations over time. This includes records of who staff and caregivers were, and what training and support they got.	
2.1	**Records that depict the care settings environment over time** This includes, for example: • photographs • building plans • formal communications about the care setting (for example annual reports (if they are not held elsewhere), newsletters and bulletins, and so on. Note: this is not about a specific **individual's** time in that care setting. For that, refer to 1.4.3 Evidence in any format… and 1.2.1. Records of an individual's admission, transfer, removal…
2.2	**Agreements between the State care and non-State care organisations relating to the provision of care on behalf of the State, and the requirements/expectations regarding documentation of that care, and records of monitoring of those agreements**.

2.3	**Records of care setting employees, caregivers, other care professionals, and others in care support roles** These include, for example: • their names, position description and role (including changes to these and the reason for the change) • qualifications relevant to providing care services • supervision documents • the individuals they worked with and for how long, and so on. The intention is to enable individuals in care to understand their life story of being in care.
2.4	**Records of care setting employees, caregivers, care professionals, and others in care support roles who may pose risks to an individual's safety and wellbeing.** This includes information relating to allegations or incidents of neglect or abuse of individuals. For employees and other care professionals, this includes, for example: • information about disciplinary actions • investigations and outcomes • resignations or dismissals from employment, and so on. For caregivers and others in care support roles, this includes, for example: • assessments • approvals • reviews, and so on.
2.5	**Records of individuals in care settings who may pose risks to the safety and wellbeing of other individuals in care settings.** This includes information relating to allegations or incidents of neglect or abuse of individuals.
2.6	**Advice and guidance developed for individuals about recordkeeping, and recording their life story**. For example: • the use of technology apps • creating scrapbooks

	• writing a journal, and so on.
2.7	**Records enabling audit of criteria set out in applicable health and disability services standards.** This includes, for example: • plans and other records with evidence of equity of access and Māori and Pacific-centred services • recognition of the value of Māori health models • participation in decision-making • cultural safety and other criteria, as well as records of monitoring of these criteria, and so on.
2.8	**Policies procedures and processes.** Records about all policies, procedures and processes that have been in place over time.
2.8.1	All policies, procedures and processes that have been in place over time relating to managing the core identity of individuals. This includes policies, procedures and processes regarding the ownership of 'core identity documents' — including annotations to records by individuals. The intention is to ensure the policies, procedures and processes in place at the time an individual was in care will be considered care records to help clarify the practice of the time.
2.8.2	All policies, procedures and processes that have been in place over time relating to the provision of care services. For example, this includes policies, procedures and processes: • for informing an individual about the decisions made about their life while in care settings • for placement of individuals into any care setting • relating to the treatment of individuals held in care settings • relating to management of financial contributions received from parents or family and **whānau** and money (benefits) received

	from the State to support the care and wellbeing of an individual, and so on. The intention is to ensure the policies, procedures and processes in place at the time an individual was in care will be considered care records to help clarify the practice of the time.
2.8.3	All policies, procedures, and processes that have been in place over time relating to the recordkeeping requirements of and for individuals. For example, this includes policies, procedures and processes: • to enable individuals to access, annotate, modify, or add to records — or request disposal of records — about themselves • for managing gaps in records concerning an individual's time in a care setting • for sharing of information about individuals both internally and with other organisations, including preventing, identifying, and responding to unauthorised sharing and improper use of information obtained under information sharing agreements • for care records access and usage including about decision-making on redacting, appeal or review of access decisions, how individuals' information will be used within the organisation or shared with others, and so on. The intention is to ensure the policies, procedures and processes in place at the time an individual was in care will be considered care records to help clarify the practice of the time.
2.8.4	All policies, procedures, rules, standards, and processes that have been in place over time relating to complaints, incidents, responses, and decisions affecting an individual's safety and wellbeing. For example, this includes policies, procedures and processes: • for raising concerns or making complaints about neglect or abuse in care, including recordings of allegation of neglect or abuse, the care setting's response and the length of time taken to respond • that may be relevant to instances of neglect or abuse (for example, hygiene and sanitary facilities, food, availability of activities, educational opportunities, access to others, consideration of and access to cultural practices and language,

	management of personal finances, disciplinary measures, and the provision of health services) • for handling and responding to concerns or complaints, including response timeframes, and their effectiveness — whether internal investigations or referrals for criminal or disciplinary action • of disciplinary, policing and judicial organisations for responding to reports of instances of neglect or abuse and claims for redress, and so on. The intention is to ensure the policies, procedures and processes in place at the time an individual was in care will be considered care records to help clarify the practice of the time.
2.8.5	All policies, procedures and processes that have been in place over time relating to the records of State and non-State care settings, including those created by the State specifically for **NGO** care settings. For example, this includes policies, procedures and processes for: • carrying out self-monitoring against and reporting on compliance with care settings regulations • vetting, recruitment, training and development, approval and review or performance management, and supervision of care setting employees • assessing, authorising, or supervising, caregivers and others in support roles involved in the provision of care • internal and external monitoring of care practices against regulations and requirements • training and support in good recordkeeping practices, including the recordkeeping requirements of the care setting • training in the use of technology and tools used in the provision of care • confidentiality and privacy, including sharing of information about care setting's caregivers, employees, other care professionals, and others in care support roles, both internally and with other organisations, preventing, identifying, and responding to unauthorised sharing, and improper use of information obtained under information sharing agreements • assessing, endorsing, and reviewing technology apps and tools for recordkeeping and developing an individual in care setting's life story • financial management in relation to the provision of care

	• financial management in relation to the personal finances of individuals in care • implementation of **Disposal** actions on any care record • implementation of **Disposal authorities**, including sentencing decisions and disposal registers • internal and external monitoring of recordkeeping practices against requirements, and so on. The intention is to ensure the policies, procedures and processes in place at the time an individual was in care will be considered care records to help clarify the practice of the time.
2.8.6	Records of training in implementation of policies, procedures and processes outlined in 2.8.1 to 2.8.5 above that have been in place over time. This includes training and implementation material developed. The intention is to ensure that the way caregivers, employees, and others in care support roles were trained or not trained in the implementation of policies, procedures and processes in place at the time an individual was in care are considered to be care records to help clarify the practice of the time.
2.8.7	Records about implementation of or deviation from policies, procedures and processes outlined in 2.8.1 to 2.8.5 above that have been in place over time. These include, for example: • the decision-making regarding deviation from the policies, procedures and processes • information sharing agreements with other organisations • responses to requests for sharing of care records with third parties • carrying out of self-monitoring against care settings regulations • reviews of — and updates to — policies, procedures and processes as a result of internal or external reviews, for example from outcomes of complaint investigations, care service monitoring, external support or training services, general reviews of policies, procedures and processes

	• internal and external monitoring of care services and recordkeeping practices, and so on.