Clinical Records Management

Policy Statement
The Department of Health is committed to ensuring that complete and accurate clinical records are created, managed, stored and disposed of in accordance with legislative and agreed organisational and clinical requirements.

Intent of this policy
The intent of this policy is to:

- foster an organisational culture that recognises the strategic importance and the enduring value of clinical records as critical assets of the organisation, essential to support the provision of quality health care and meet business, legislative and accountability requirements.
- develop, implement and maintain standardised clinical recordkeeping practices that promote the sharing of knowledge and support evidence based decision making to deliver high quality health services.

Scope
This policy applies to all employees, contractors and consultants within the Department of Health divisions, agencies and commercialised business units.

This policy applies to clinical records managed by facilities regardless of medium:

- Physical record (physical form such as paper, photographs, film)
- Electronic records (a record created or captured through electronic means such as computer, scanner)
- Hybrid records (a combination of physical and electronic records).

This policy can be used by Hospital and Health Services either as is, by re-branding or as a basis for Hospital and Health Service specific policy.

Principles
- Managed – Complete and accurate clinical records are made, managed and preserved for as long as they are required for business, legislative, accountability and cultural purposes. Clinical records are not managed through an electronic Document and Records Management System (eDRMS).
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- Best practice – Clinical recordkeeping responsibilities are assigned and implemented to appropriately trained and skilled staff.
- Accountable – The clinical records management systems and practices are regularly monitored, audited and evaluated for accountability, compliance and continuous improvement.
- Secure – Security provisions are implemented to maintain clinical record integrity and authenticity by preventing unauthorised access, damage, alteration or misuse.
- Trustworthy – Physical, electronic and hybrid clinical records are managed to enable reliable, timely and accurate retrieval of records.

Legislative or other Authority

- Births, Deaths and Marriages Registration Act 2003 (Qld)
- Coroners Act 2003 (Qld)
- Electronic Transactions (Queensland) Act 2001 (Qld)
- Evidence Act 1977 (Qld)
- Hospital and Health Boards Act 2011 (Qld)
- Information Privacy Act 2009 (Qld)
- Mental Health Act 2000 (Qld)
- Public Records Act 2002 (Qld)
- Public Service Act 2008 (Qld)
- Right to Information Act 2009 (Qld)
- Australian Standard 2828.1-2012 Health Records – Paper-based health records
- Australian Standard 2828.2(Int)-2012 Health Records – Digitized (scanned) health record system requirements

Supporting documents

- Retention and Disposal of Clinical Records Protocol
- Assignment of Unique Unit Record Numbers Protocol (under development)

Related policy or documents

- Queensland Government Enterprise Architecture, Department of Science, Information Technology, Innovation and the Arts (DSITIA):
  - Information Security Information Standard – IS18
  - Recordkeeping Information Standard – IS40
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- Retention and Disposal of Public Records Information Standard – IS31
- Health Service Directive – Enterprise Architecture
- Health Service Directive – Enterprise ICT Services
- Department of Health
  - Data Management Policy
  - Health Sector (clinical records) Retention and Disposal Schedule: QDAN 683
  - Information Security Policy
  - Managing the Clinical Records of Children Available for Adoption Policy
  - Records Management for Administrative and Functional Records Policy

Business area contact
Clinical Information Management, Planning, Engagement and Performance Directorate, Health Services Information Agency

Review
This policy will be reviewed at least every three years.

Date of last review: November 2013
Supersedes: Queensland Health Retention and Disposal of Clinical Records Policy

Approval and Implementation
Policy Custodian:
Executive Director
Planning, Engagement and Performance Directorate
Health Services Information Agency

Responsible Executive Team Member:
Chief Information Officer
Health Services Information Agency

Approving Officer:
Chief Information Officer
Health Services Information Agency

Approval date: 09 May 2014
Effective from: 01 March 2014

Definitions of terms used in this policy and supporting documents

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<thead>
<tr>
<th>Term</th>
<th>Definition / Explanation / Details</th>
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<tr>
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<tr>
<td>Clinical record</td>
<td>A collection of data and information gathered or generated to record the clinical care and health status of an individual or group. Also referred to as a Health Record, Medical Record, Healthcare Record.</td>
<td>Australian Standard AS2828.1 Health Records</td>
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<td>Electronic clinical record</td>
<td>A health record with data structured and represented in a manner suited to computer calculation and presentation. NOTE: The intended meaning of electronic health record is emerging. When this term is used today it implies the ability to compute the content of the record. Electronic health records are often described as records able to represent a lifetime record of health and care. Electronic health records may include records created in electronic format (born-digital records), database entries and other entities as well as digitized health records.</td>
<td>Australian Standard AS2828.2 Health Records</td>
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<td>Electronic Document Records Management Systems (eDRMS)</td>
<td>An automated system designed to manage semi-structured or unstructured content including test, images, and video content. A subset of documents managed in an eDRMS can be declared to be records. The eDRMS manages these records using a rigorous set of business rules which are intended to preserve the context, authenticity and integrity of the records.</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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<td>Recordkeeping</td>
<td>The act of making, keeping and preserving evidence of government business in the form of recorded information.</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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<td>Records</td>
<td>Recorded information created or received by an entity in the transaction of business or the conduct of affairs that provides evidence of the business or affairs and includes: (a) anything on which there is writing (b) anything on which there are marks, figures, symbols or perforations having a meaning for persons, including persons qualified to interpret them (c) anything from which sounds, images or writings can be reproduced with or without the aid of anything else, or (d) a map, plan drawing or photograph.</td>
<td>Public Records Act 2002 Schedule 2 Dictionary</td>
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**Version Control**

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<td>1.0</td>
<td>09/05/2014</td>
<td>ICT Policy, Clinical Information Management</td>
<td>Approved</td>
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