Clinical Records Management Policy

Retention and Disposal of Clinical Records Protocol

1. **Purpose**
   This Protocol describes the mandatory steps for the retention and disposal of clinical records undertaken on behalf of the Department of Health in accordance with legislative and regulatory obligations.

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

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

3. **Supporting documents**
   **Authorising Policy and Standard/s:**
   - Clinical Records Management Policy
   **Procedures, Guidelines and Protocols:**
   - Assignment of Unique Unit Record Number Protocol (under development)

4. **Related documents**
   - *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)*
5. **Process for retention and disposal of clinical records**

Under the *Public Records Act 2002*, public authorities shall make and keep full and accurate records of their activities; and ownership of public records vests in the State. Disposal of public records in all formats shall be undertaken in accordance with the *Public Records Act 2002*, and this protocol describes the process for retention and disposal of clinical records.

5.1 **Clinical records shall be appraised and sentenced in accordance with the following requirements.**

5.1.1 Clinical records shall be appraised at the time of creation to identify recordkeeping requirements and appropriately manage records of continuing value.

5.1.2 Clinical records shall be sentenced using a current Queensland State Archives approved Retention and Disposal Schedule/s.

5.1.3 Clinical records shall be re-sentenced prior to disposal in the following circumstances:
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- The Retention and Disposal Schedule under which the records have been sentenced has been superseded by a later version or a new Schedule; or
- Action on the record has resulted in the record falling into a new disposal class (e.g. file requested under Right to Information or other legal process, or an issue changes from minor to major significance).

5.2 Clinical records shall be archived in accordance with the following requirements.

5.2.1 Archiving processes shall ensure inactive clinical records regardless of medium are archived and/or disposed routinely (quarterly, annually etc.) and systematically to control storage costs and manage resources, while remaining accessible and useable for their required retention period, in accordance with Queensland State Archives approved Retention and Disposal Schedule/s.

5.2.2 Archiving processes shall ensure that the privacy, confidentiality and security of the archived records are protected in accordance with legislation and the Department of Health Information Security Policy.

5.2.3 Archiving processes shall ensure that the Department of Health is not exposed to unnecessary risk. As such, a risk management approach must inform the archival strategy to ensure records are not retained for longer than required for business and legislative requirements.

5.2.4 Clinical records shall not be managed through an electronic Document and Records Management System (eDRMS).

5.3 Permanent transfer of records.

5.3.1 All requests for a permanent transfer of clinical records must be provided to the Director, Clinical Information Management, Planning, Engagement and Performance Directorate, Health Services Information Agency.

5.3.2 Permanent transfer of all clinical records including those required in Machinery of Government changes shall be recorded in a register.

5.3.3 Permanent records transferred to Queensland State Archives shall be prepared in accordance with Queensland State Archives Disposal and Transfer of Public Records Guidelines.

5.3.4 Permanent records considered for transfer to Queensland State Archives shall be appraised to determine the appropriate restricted access period.

5.3.5 The determination of restricted access periods for permanent records to be transferred to Queensland State Archives shall be assigned by the relevant Deputy Director-General, Chief Executive Officer or equivalent in accordance with Queensland State Archives Disposal and Transfer of Public Records Guidelines.

5.3.6 Access to restricted records held at Queensland State Archives must be authorised by the relevant Deputy Director-General, Chief Executive Officer or equivalent in accordance with Queensland State Archives Disposal and Transfer of Public Records Guidelines.
5.4 Clinical records shall be destroyed in accordance with the following requirements.

5.4.1 Clinical records shall be destroyed in accordance with Queensland State Archives approved Retention and Disposal Schedule/s.

5.4.2 Where an existing approved Retention and Disposal Schedule/s does not cover the disposal of a particular record class, authorisation from Queensland State Archivist, via the Clinical Information Management Unit, Planning Engagement and Performance, Health Services Information Agency, must be provided before the record is destroyed.

5.4.3 Clinical records that have met the retention requirements shall be regularly disposed of regardless of the medium that they are created or stored in.

5.4.4 The destruction of clinical data records shall be done in such a way as to render them unreadable and leave them in a form which they cannot be reconstructed in whole or in part.

5.4.5 The destruction of a clinical record shall be authorised by the relevant Deputy Director-General, Chief Executive Officer or equivalent in accordance with the approved Retention and Disposal Schedule/s.

5.4.6 Documentation evidencing the appraisal and approval for destruction of a clinical record or group of clinical records shall be retained as a permanent record and maintained at the facility. This register shall include the following.

- Identification of each record;
- Record type, class or series (where applicable);
- Date range of the records (where applicable);
- Date and method of destruction;
- Who destroyed the records; and
- Name and position of the delegate who authorised the destruction of the records

- Relevant Queensland Disposal Authority Number (QDAN).

5.4.7 Destruction methods shall be commensurate with the record’s value, business significance and sensitivity in accordance with the Department of Health Information Security Policy and the Information Privacy Act 2009.

5.4.8 If an external provider is used for the destruction of records, a destruction certificate shall be obtained and retained permanently as a public record.

6. Review

This Protocol is due for review on: 01 January 2017

Date of Last Review: New document

Supersedes: N/A
7. **Business Area Contact**

Clinical Information Management, Planning, Engagement and Performance Directorate, Health Service Information Agency

8. **Definitions of terms used in the policy and supporting documents**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition / Explanation / Details</th>
<th>Source</th>
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<tbody>
<tr>
<td>Appraisal</td>
<td>Appraisal is the process of evaluating business activities and records to determine which records need to be captured and how long those records need to be kept to meet business needs, accountability requirements and community expectations.</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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<tr>
<td>Archiving</td>
<td>The process of transferring inactive information, including records from an active system, to a repository for longer-term storage, preservation and access.</td>
<td>Queensland Government Chief Information Office Glossary</td>
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<tr>
<td>Capture</td>
<td>A deliberate action which results in the registration of a record into a recordkeeping system. For certain business activities, this action may be designed into electronic systems so that the capture of records is concurrent with the creation of records.</td>
<td>National Archives of Australia Glossary</td>
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<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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<tr>
<td>Continuing value record</td>
<td>Any record that has administrative, business, financial, legal, evidential or historical value to the Department.</td>
<td>NSW Health Protocol Records Management Protocol</td>
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<td>Destruction</td>
<td>The process of eliminating or deleting records that do not have continuing value, beyond any possible reconstruction (such as incineration, shredding, pulping or deletion).</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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<tr>
<td>Digitized health record</td>
<td>Health record in computer readable form. NOTE: Digitized and scanned health record is synonymous in this Standard.</td>
<td>Australian Standard AS2828.2 Health Records</td>
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<td>Disposal</td>
<td>The action concerning the fate of the records. Disposal includes: (a) destroying, deleting or migrating a record or part of a record, and (b) abandoning, transferring, giving away, donating or selling a record or part of a record. or A range of processes associated with implementing appraisal decisions that are in accord with approved retention and disposal authorities. These include the retention, deletion or destruction of records. They may also include the migration or</td>
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<td>NSW Health Protocol Records Management</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 text, 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>Hybrid health record</td>
<td>A health record comprising paper, digitized and electronic formats. A hybrid health record is created and accessed using both manual and electronic processes. NOTE: A Transitional health record is often representative of a system in transition from digitized format to full electronic health record.</td>
<td>Australian Standard AS2828.2 Health Records</td>
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<td>Inactive Records</td>
<td>Records no longer required for the conduct of business and which may therefore be transferred to intermediate storage, archival custody or destroyed.</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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<td>Information</td>
<td>A collection of data in any form that is maintained by an agency or person and which may be transmitted, manipulated, and stored. Records are the subset of information that constitutes the evidence of activities.</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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| Medico-legal action                       | Includes an action that has begun, or where an intention to make a claim/action has been stated, or where it is determined by the Director General, a Chief Executive, a Medical Superintendent or another authorised Senior Health Professional that there is a potential for legal action. The definition of medico-legal action covers matters of sexual assault. Medico-legal includes:  
  - Right to Information Act Request  
  - Information Privacy Act Request  
  - Evidence Act Request  
  - Medical Report  
  - Subpoena                                                                                     | Queensland Health                                                      |
### Permanent Records
That small proportion of records that will be required for permanent retention because the evidence of the transactions they document will always be required. Examples of this category would be records of births, Cancer Registry and IVF records. Some records may also be kept permanently for historical and cultural reasons. The Hospital and Health Services must keep a register of these records. Records with high archival value which cannot be destroyed and must be retained indefinitely by either the agency or Queensland State Archives. Permanent records may be transferred from agencies to Queensland State Archives.

### QDAN (Queensland Disposal Authority Number)
The unique number allocated to each Retention and Disposal Schedule approved by Queensland State Archives.

### Recordkeeping
The act of making, keeping and preserving evidence of government business in the form of recorded information.

### Records
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:

- anything on which there is writing
- anything on which there are marks, figures, symbols or perforations having a meaning for persons, including persons qualified to interpret them
- anything from which sounds, images or writings can be reproduced with or without the aid of anything else, or
- a map, plan drawing or photograph.

### Retention and disposal schedule
A document issued by the State Archivist authorising the disposal of public records. It defines the temporary or permanent status, retention periods, disposal triggers, and consequent disposal actions authorised for classes of records described in it. There are three main types of schedules:

- Public authority-specific retention and disposal schedule, which is based on the functions of a public authority, and authorises the retention and disposal of records unique to that authority.
- General retention and disposal schedule, which is based on functions common to many public authorities and authorises the retention and disposal of records.
Department of Health: Retention and Disposal of Clinical Records Protocol

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<td>administrative records common to more than one authority. (c) Sector retention and disposal schedule, which is based on functions common to like public authorities and authorises the retention and disposal of records of similar public authorities (for example, local government, universities).</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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<td>Retention period</td>
<td>The minimum period of time that records need to be retained before their final disposal.</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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<td>Sentencing</td>
<td>The process of identifying the disposal class a record belongs to and applying the disposal action specified in the relevant Retention and Disposal Schedule to the record. Sentencing is the implementation of decisions made during appraisal.</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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<td>Temporary records</td>
<td>Records with limited archival value that can be sentenced for destruction on the expiration of the authorised minimum retention period.</td>
<td>Queensland State Archives Glossary of Archival and Recordkeeping Terms</td>
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9. 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

Version Control

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