1. Statement
This standard describes the steps for documentation of date and time entry in the health records undertaken on behalf of Department of Health.

2. Scope
Compliance with this standard is mandatory.
This standard applies to all employees, contractors and consultants within the Department of Health divisions and commercialised business units.
This standard can be used by Hospital and Health Services either as is, by re-branding or as a base for a Hospital and Health Service specific standard.

3. Requirements
3.1 Process for documentation of date and time entry in the health record
Documentation of date and time entry in the health record shall provide an accurate indication of when care has been delivered and the sequence of events in which it occurred in the paper based health record.
The value of a health record is that it is made contemporaneously with the events it documents.

- The date and time of the entry, shall be recorded in the format of:
  - Date of entry (using ddmmyyyy).²
  - Time of entry (using a 24-hour clock – hhmm).³
- Entries shall be signed by the author, and include their printed name (given name and family name) and designation.
- Entries shall be made at the time of an event or as soon as possible afterwards to maintain sequential order of events.⁴
- The time of entry shall be distinguished from the actual time of an incident, event or observation being reported, by reporting the actual date / time of an event in the body of the entry e.g. the actual date / time of the event being reported, followed by the author’s printed name (given name and family name), signature, designation and date / time of the entry.

4. Related legislation and documents
Legislation
Relevant legislation and associated documentation includes, but is not limited to, the following:

- Public Records Act 2002
- Adoption Act 2009
- Births, Deaths and Marriages Registration Act 2003
- Child Protection Act 1999

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¹ Each registered health practitioner is required to comply with the health records section of the code of conduct / guidelines / competency standards under their relevant National Board
Commission for Children and Young People and Child Guardian Act 2000
Coroners Act 2003
Electronic Transactions Act 2001
Evidence Act 1977
Financial Accountability Act 2009
Health Practitioner’s (Professional Standards) Act 1999
Hospital and Health Boards Act 2011
Information Privacy Act 2009
Judicial Review Act 1991
Mater Public Health Services Act 2008
Mental Health Act 2000
Public Health Act 2005
Public Service Act 2008
Right to Information Act 2009

Supporting documents
- Data Management Policy
- Display of Date and Time in Electronic Systems Standard
- Clinical Data Standardisation Standard

Related policy or documents
- Australian Commission on Safety and Quality in Healthcare – National Safety and Quality Health Services Standards
- Australian Council on Healthcare Standards – EQUIP 5 Accreditation Standards and Guidelines
- Australian Council on Healthcare Standards – EQUIP National
- Australian Curriculum Framework for Junior Doctors
- 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
- HIMAA Practice Brief No.1 General Clinical Documentation and Information Requirements, December 2006
- Queensland Government Enterprise Architecture (QGEA), Department of Science, Information Technology and Innovation (DSITI):
  - Recordkeeping Information Standard IS40
  - Retention and Disposal of Public Records Information Standard IS31
- Department of Health:
  - Assignment of Unique Unit Record Number Standard
  - Clinical Records Management Policy
  - Data Management Policy
  - Data Quality Compliance Monitoring Tool
  - Data Quality Framework
  - Data Quality Framework Data Quality Self Assessment Tool Support Guide
  - Good clinical documentation – Its importance from a legal perspective - Factsheet
  - Health Sector (Clinical Records) Retention and Disposal Schedule Standard
  - Managing the Clinical Records of Children Available for Adoption Standard
  - Managing the Clinical Records of Children Available for Adoption Guideline
  - Retention and Disposal of Clinical Records Standard
5. Definitions

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<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Health 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. NOTES: 1. This includes information such as assessment findings, treatment details, progress notes, registration and information associated with care and health status. 2. The term 'health record' includes paper-based health records, clinical records, medical records, digitized health records, Electronic Health Records, healthcare records and personal health records. 3. Personal health records have specific variations which should be taken into consideration when applying this Protocol.</td>
<td>Australian Standard AS 2828.1-2012 Health records</td>
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<tr>
<td>Data</td>
<td>The representation of facts, concepts or instructions in a formalised (consistent and agreed) manner suitable for communication, interpretation or processing by human or automatic means. Typically comprised of numbers, words or images. The format and presentation of data may vary with the context in which it is used. Data is not information until it is utilised in a particular context for a particular purpose. Examples include: Coordinates of a particular survey point; Driver licence number; Population of Queensland; Official picture of a minister in jpeg format.</td>
<td>Queensland Government Chief Information Office Glossary</td>
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<td>Information</td>
<td>Information is any collection of data that is processed, analysed, interpreted, classified or communicated in order to serve a useful purpose, present fact or represent knowledge in any medium or form. This includes presentation in electronic (digital), print, audio, video, image, graphical, cartographic, physical sample, textual or numerical form.</td>
<td>Queensland Government Chief Information Office Glossary</td>
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Version Control

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<th>Date</th>
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<td>09 Jul. 2013</td>
<td>Approved.</td>
</tr>
<tr>
<td>1.1</td>
<td>12 Jun. 2015</td>
<td>Transferred information into new template and reviewed by Clinical Information Management.</td>
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