Queensland Health

Documentation of date and time entry in the paper-based clinical record

Department of Health Standard

QH-IMP-279-2:2013

1. Statement

This standard describes the steps for documentation of date and time entry in the paper-based clinical record.

2. Scope

This standard applies to all staff. Staff are defined as employees, volunteers, contractors, consultants, and managed service providers working for the Department of Health.

It applies to paper-based clinical records managed by the Hospital and Health Services (HHSs) and/or individual health facilities.

This standard does not include corporate records (administrative and non-clinical functions).

The standard may be adopted by HHSs and re-branded as an HHS specific standard or used as a basis for a local HHS specific standard.

3. Requirements

3.1. Process of documentation of date and time entry in the paper-based clinical record

3.1.1. Documentation of date and time entry in the paper-based clinical record in a timely manner shall provide an accurate indication of when care has been delivered and the sequence of events in which it occurred.

3.1.2. The value of a clinical record is that it is made contemporaneously with the events it documents.

3.1.3. The date and time of the entry shall be recorded in the format of:

- Date of entry – using DDMMYYYY (e.g. 15/01/2024)[1]

[1] Queensland Government, Queensland Health Information Knowledgebase (QHIK), QH 0156462 v1, viewed February 2024

- Time of entry – using a 24-hour clock hhmm (e.g. 1645)[2]

3.1.4. A valid time shall be recorded as hours and minutes using a 24 hour clock.

3.1.5. Entries shall be signed by the author and include their printed name (given name and family name) and designation.

3.1.6. Entries shall be made at the time of an event or as soon as possible afterwards to maintain a sequential order of events.

3.2. Retrospective documentation of date and time entry shall be distinguished from the actual time of an event[3]

3.2.1. The date and time of entry shall be distinguished from the actual date and time of an event, incident or observation being reported.

3.2.2. A retrospective entry of an event, incident or observation being reported is to be written in the body of the entry with the actual date and time of the event, incident or observation being reported.

3.2.3. The retrospective entry is to be followed by the author's printed name (given name and family name), signature, designation and date and time of entry.

[2] Queensland Government, Queensland Health Information Knowledgebase (QHIK), QH 0156601 v1, viewed February 2024

[3] Queensland Government, The Queensland Government's Response to Coronial Recommendations 2011, Page 64, viewed January 2024

4. Human rights

Human rights are not engaged by this standard.

5. Legislation

- *Adoption Act 2009* (Qld)
- *Births, Deaths and Marriages Registration Act 2003* (Qld)
- *Child Protection Act 1999* (Qld)
- *Coroners Act 2003* (Qld)
- *Evidence Act 1977* (Qld)
- *Health Practitioner Regulation National Law* (Qld)
- *Hospital and Health Boards Act 2011* (Qld)
- *Information Privacy Act 2009* (Qld)
- *Judicial Review Act 1991* (Qld)
- *Mental Health Act 2016* (Qld)
- *Public Health Act 2005* (Qld)
- *Public Records Act 2002* (Qld)
- *Public Sector Ethics Act 1994* (Qld)
- *Public Sector Act 2022* (Qld)
- *Right to Information Act 2009* (Qld)

6. Supporting documents

Australian Standard

- Australian Standard 2828.1:2019, Health records, Part 1: Paper health records

Queensland Government Enterprise Architecture (QGEA)

- Records governance policy
- Records governance policy implementation guideline

Queensland Health

- Assignment of unique Unit Record Number standard (QH-IMP-280-3:2014)
- Clinical documentation guide
- Clinical records management policy (QH-POL-280:2014)

- Code of Conduct for the Queensland Public Service
- Management and access to documents and records Legal Branch fact sheet
- Managing the clinical records of children available for adoption guideline (QH-GDL-280-1:2015)
- Managing the clinical records of children available for adoption standard (QH-IMP-280-4:2014)

7. Definitions

Term	Definition	Source
Clinical record (also referred to as a health record)	A collection of data and information gathered or generated to record clinical care and health status of an individual or group. Health records are made up of documents such as health record forms, clinical documents, legally authenticated documents and clinical referral letters received from clinical providers. This term includes paper-based health records, clinical records, medical records, digitised health records, EHRs, and healthcare records.	Australian Standard 2828.1:2019, Health records, Part 1: Paper health records
Recordkeeping	The act of making and maintaining of complete, accurate and reliable evidence of business transactions in the form of recorded information. Recordkeeping includes: • the creation of records in the course of business activity • the means to ensure the creation of adequate records • the design, establishment and operation of recordkeeping systems • the management of records used in business and as archives.	Queensland Government Glossary
Record	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:	*Public Records Act 2002* (Qld)

Term	Definition	Source
	(a) anything on which there is writing; or (b) anything on which there are marks, figures, symbols or perforations having a meaning for persons, including persons qualified to interpret them; or (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.	

Version control

Version	Date	Comments
1.0	09 July 2013	Approved
1.1	12 June 2015	Transferred information into new template and reviewed by Clinical Information Management
2.0	04 August 2022	Transferred information into new template, content reviewed and updated. Date format has been updated to 'DDMmmYYYY'. Time format has been updated to 'hhmm'. Approved by the Information Management Strategic Governance Committee. Approved by Deputy Director-General, eHealth Queensland and Chief Information Officer, Queensland Health.
2.1	23 April 2024	Review and minor updates. Date format has been updated to 'DDMMYYYY'.