Managing the clinical records of children available for adoption

Standard

QH-IMP-280-4:2014

1. Statement

This standard describes the mandatory requirements for the management of clinical records of children available for adoption and children identified for possible adoption. This standard outlines the requirements for sharing and release of information relating to clinical records for adopted children and children identified for possible adoption.

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 Establishing a clinical record for a child for adoption

3.1.1 A clinical record shall be established in the birth name (both given name and family name) for all children, including those identified for potential adoption.

3.1.2 The clinical record of a newborn child for adoption shall be established using the birth mother's family name as the baby's family name, unless instructed otherwise by the birth mother. The baby's given name should be recorded as identified by the birth parents. If no name has been decided, use Baby of xxx (xxx is the mother's given name).

3.1.3 The clinical record of a child for adoption shall remain in his or her birth name until the child is placed with adoptive parents under an interim or final order.

3.1.4 The clinical record of a child shall not be unnamed, de-identified or in the name of a foster carer. [1]

3.1.5 Staff shall seek and record in the clinical record as much information as possible about the medical background of parents who are considering the placement of their child for adoption.

3.1.6 Staff shall send a copy of the relevant hospitals clinical record of all children identified as potentially being placed for adoption to Adoption Services, Department of Communities, Child Safety and Disability Services, upon their discharge from hospital.

3.2 Registration of birth for a child for adoption

3.2.1 Staff shall facilitate registration of birth for all children for adoption in his or her birth name, in the same manner that other children are registered who are not being adopted.

3.2.2 A newborn child for adoption shall be registered using the birth mother's family name as the baby's family name, unless instructed otherwise by the birth mother. The baby's given name should be recorded as identified by the birth parents. If no name has been decided, use Baby of xxx (xxx is the mother's given name).

3.3 Release of information

3.3.1 All requests for access to the clinical records in the birth name of adopted children shall be directed to Adoption Services, GPO Box 806, Brisbane, QLD 4001.

3.3.2 Where the birth parents decide not to proceed with adoption, access to and information release of the child's information shall be managed in accordance with any other request for information under legislative requirements.

3.3.3 All requests for access to the clinical records in the adopted name of adopted children shall be managed in accordance with any other request for information under legislative requirements (see section 3.5 – adopted child clinical record).

3.4 Clinical records for children in foster care transitioning to adoption

3.4.1 Staff shall maintain a clinical record in the birth name of all children, even when placed in foster care while transitioning to adoption.

3.4.2 Clinical records shall be updated to include the postal address and contact details of the foster carer.

3.4.3 Staff shall ensure that birth parents are not provided with any information that identifies the foster carer. Any clinical record information released to the birth parents prior to adoption being finalised shall be checked to ensure it does not identify the foster carer.

3.4.4 All written communication with foster carers shall be filed in the correspondence section of the child's clinical record.

3.5 Adopted child clinical record

3.5.1 Hospital and Health Services staff shall create a new clinical record under the adopted name of an adopted child when they are subsequently admitted to the same and/or any other hospital for treatment and/or care. A new Unit Record Number or Medical Record Number shall be created.

3.5.2 Hospital and Health Services shall ensure the clinical record created under the child's adopted name is not linked to any information that is held in the birth name of that child.

4. Related legislation and documents

Relevant legislation and associated documentation includes, but is not limited to, the following:

Legislation

- *Public Records Act 2002*
- *Adoption Act 2009*
- *Births, Deaths and Marriages Registration Act 2003*
- *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*
- *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

- Clinical Records Management Policy
- Assignment of Unique Unit Record Number Standard
- Health Sector (Clinical Records) Retention and Disposal Schedule Standard
- Managing the Clinical Records of Children Available for Adoption Guideline
- Retention and Disposal of Clinical Records Standard

Related policy or documents

- 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
  - Documentation of Date and Time Entry in the paper based Health Record Guideline
  - Records Management for Administrative and Functional Records Policy
- United Nations Convention on the Rights of the Child
- Australian Standard ISO 15489-2002 Records Management
- 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

5. Definitions

Term	Definition	Source
Adoption order	A final adoption order or interim order.	*Adoption Act 2009*
Adoptive parent	A person who has adopted someone else under the relevant adoption laws A person who has adopted someone else under a final adoption order.	*Adoption Act 2009*
Approved foster carer	A person who holds a certificate of approval as an approved foster carer.	*Child Protection Act 1999*
Birth name	The name a child is given by his or her parents at birth.	
Birth parent	A person who was a parent of the adopted person at any time before the adoption, including- (i) a biological parent of the adopted person; and (ii) someone who was a parent of the adopted person under a previous adoption.	*Adoption Act 2009*
Child	A child is an individual under 18 years.	*Child Protection Act 1999*
Clinical record	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.	Australian Standard AS2828.1 Health Records
Electronic clinical record	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.	Australian Standard AS2828.2 Health Records
Electronic Document Records Management Systems (eDRMS)	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	Queensland State Archives Glossary of

Term	Definition	Source
	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.	Archival and Recordkeeping Terms
Final adoption order	A final adoption order under part 9.	*Adoption Act 2009*
Interim order	An interim order under part 9.	*Adoption Act 2009*
Parent	The child's mother or father; and anyone else, other than the chief executive (child safety) or a corresponding officer of another jurisdiction, with the right to have the child's daily care, and the right and responsibility to make decisions about the child's daily care, under- (i) a law of the State other than this Act; or (ii) a law of the Commonwealth or another State; or (iii) a court order other than an order under this Act.	*Adoption Act 2009*
Recordkeeping	The act of making, keeping and preserving evidence of government business in the form of recorded information.	Queensland State Archives Glossary of Archival and Recordkeeping Terms
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: 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.	*Public Records Act 2002*

Version Control

Version	Date	Comments
3.1	01 Jul. 2013	Approved.
3.2	12 Jun. 2015	Transferred to new template and reviewed by Clinical Information Management.