1. **Statement**
This standard describes the steps for the assignment of a unique Unit Record Number (URN) to a patient for the purpose of uniquely identifying them from other patients.

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**
This standard 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).

The Public Records Act 2002 and Queensland Government Enterprise Architecture Information Standard Recordkeeping (IS40) require clinical records to be uniquely identified. The Queensland Hospital Admitted Patient Data Collection requires a unique URN to be allocated to each patient.

A URN is a permanent identifier that is assigned to the patient and used to uniquely identify the patient and their associated clinical record. This standard describes the requirements for the assignment of unique URN.

3.1 **A URN shall identify one and only one patient.**

3.1.1 A URN shall be allocated to a patient who receives a health service or where the intention is that they will receive a health service.

3.1.2 A unique URN shall be issued once for each patient and maintained through the source Patient Master Index (PMI). A URN that is not maintained as unique in the source PMI may have an impact on patient safety.

3.1.3 A patient shall have a URN correctly assigned and recorded.

3.1.4 A URN shall be the unique key to locating an individual clinical record in a clinical information system as it provides a link between the demographics of a patient and the clinical record.

3.2 **A URN shall be assigned once and shall not be deleted or re-used to identify any other patient.**

3.2.1 A URN shall not be deleted or re-used even if the patient fails to attend for a health service.

3.2.2 A patient registered in the source PMI, in error (for example duplicate registration where a patient has an existing URN and clinical record), shall require that registration (URN) to be merged with their existing URN, as best practice. The merged URN shall not be deleted or re-used.

3.2.3 Where there is a multi-campus wide PMI a URN shall be unique for each patient across the multi-campus.
3.2.4. Within a facility, verification of an existing URN and correctly matching a patient to their clinical record shall occur to ensure that each patient has a single unique URN to prevent instances of the same patient having multiple URN’s.

3.2.5. Staff responsible for registering a patient within a Patient Administration System shall be trained in all aspects of accurate identification of a patient and URN assignment to ensure that each patient has only one URN for the facility.

3.2.6. Training shall cover at a minimum relevant policies and standards, consequences and risks to patient health care arising from duplicate registration, URN’s and clinical records.

3.3 A PMI shall be retained permanently.

3.3.1. In accordance with the Public Records Act 2002, Queensland Government Enterprise Architecture Information Standard Retention and Disposal of Public Records (IS31), and the clinical records retention and disposal schedule, records in the PMI shall be retained permanently.

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
- Child Protection Act 1999
- 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
- Recordkeeping Information Standard IS40
- Retention and Disposal of Public Records Information Standard IS31

Supporting documents
- Clinical Records Management Policy
- 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

Related policy or documents
- Australian Standard 2828.1-2012 Health Records – Paper-based health records
5. Definitions

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<th>Term</th>
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<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 (QSA Glossary)</td>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<td>Clinical Information System</td>
<td>A system dedicated to collecting, storing, manipulating, and making available clinical information that applies at the point of care. (Source: Adapted from Canada Health Infoway Glossary).</td>
<td>Australian Standard AS2828.2 Health Records</td>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<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>QSA Glossary</td>
</tr>
<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>
</tr>
<tr>
<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.</td>
<td>QSA Glossary</td>
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Chief Health Information Officer
Clinical Information Management
Effective date: 01 July 2015

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<tr>
<td>or</td>
<td>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 transmission of records between recordkeeping systems, and the transfer of custody or ownership of records.</td>
<td>Management Protocol</td>
</tr>
<tr>
<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>
</tr>
<tr>
<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>QSA Glossary</td>
</tr>
<tr>
<td>Facility</td>
<td>Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment, as represented by a code.</td>
<td>Healthcare provider–facility type QHHLTH 040263 Version No.8 Queensland Health Data Dictionary</td>
</tr>
<tr>
<td>Health record number</td>
<td>The unique identifier of a given patient for a health record within an organization. Notes: 1. The term ‘health record number’ includes the medical record number, healthcare record number, UR number (deprecated), clinical record number, client record number and local record number. 2. The health record number is typically used to support filing and retrieval of healthcare records within the healthcare organization’s record system. It is used for patient and information identification as the unique identifier within the organization.</td>
<td>Australian Standard 2828.2(Int)-2012 Health Records – Digitized (scanned) health record system requirements</td>
</tr>
<tr>
<td>Health Service</td>
<td>1. A health service is a service for maintaining, improving, restoring or managing people’s health and wellbeing. 2. Without limiting subsection (1), a health service includes- a. a service mentioned in subsection (1) that is provided to a person at a hospital, residential care facility, community health facility or other place; and b. a service dealing with public health, including a program or activity for- i. the prevention and control of disease or sickness; or ii. the prevention of injury; or iii. the protection and promotion of health. Examples of health service mentioned in paragraph</td>
<td>Hospital and Health Boards Act 2011</td>
</tr>
<tr>
<td>Term</td>
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<tr>
<td>(b)</td>
<td>a cancer screening program</td>
<td></td>
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<td>(3)</td>
<td>In addition, a health service includes a support service for a service mentioned in subsection (1). NOTE: examples of a health service include Emergency Department, Hospital in the Home Service, Boarders</td>
<td>Australian Standard AS2828.2 Health Records</td>
</tr>
<tr>
<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>QSA Glossary</td>
</tr>
<tr>
<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>QSA Glossary</td>
</tr>
<tr>
<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>QSA Glossary</td>
</tr>
</tbody>
</table>
| Legal action                 | Means an action relating to a legal process that has commenced or is reasonably anticipated including, for example:  
  • a proceeding in the courts instituted by one party against another  
  • a demand or claim (demand for compensation made on an entity by a third party)  
  • applications under Right to Information Act 2009 (Qld) or Information Privacy Act 2009 (Qld) (excluding administrative access)  
  • a subpoena and other third party requests for records including, but not limited to:  
    o summons  
    o search warrant  
    o notice of non-party disclosure  
    o notice to produce  
    o other requests made under, for example:  
      ▪ Evidence Act 1977 (Qld) [s.134A]  
      ▪ Personal Injuries Proceedings Act 2002 (Qld) [s.9 and Personal Injuries Proceedings Regulation 2014 (Qld) [s.5]  
      ▪ Motor Accident Insurance Act 1994 (Qld) [s.37 and Motor Accident Insurance Regulation 2004 (Qld) [s.19]  
      ▪ Workers’ Compensation and Rehabilitation Act 2003 (Qld) [s.519]  
      ▪ Police Powers and Responsibilities Act 2000 (Qld) [s.547]  
      ▪ Industrial Relations(Tribunals) Rules 2001 (Qld) [Part 2, Division 2, Subdivision 7 and Part 3, Division 5]  
      ▪ Queensland Civil and Administrative Tribunal Act 2009 (Qld) [s.97]  
      ▪ Coroner’s Act 2003 (Qld) [s.37]  
  Note: Where doubt exists as to whether an action is covered by the term ‘legal action’, legal advice should be sought.                                                                                                                                                                                                                                                  | Legal and Governance Branch, Department of Health |

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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  
• Police Reports  
• Workers Compensation Claims  
• Insurance Requests  
• Coronial Inquests  
• Ministerial Requests | Queensland Health                                                                                                                                  |
| Multi-campus               | A multi-campus health service/hospital has two or more locations providing treatment and/or care to patients  
Note: The term campus is a physically distinct site owned or occupied by a health service/hospital where treatment and/or care is regularly provided to patients. | Victorian Perinatal Data Collection (VPDC) manual, version 3.0  
State of Victoria, Department of Health, 2013 |
| Patient                    | One or more persons scheduled to receive, receiving, or having received a health service.  
NOTE: The term ‘patient’ is used throughout this standard to represent a subject of care assigned a URN. The term ‘patient’ is a synonym of the standard concept ‘Health Care Client’. Other synonyms include ‘client’, ‘consumer’, ‘individual’ and ‘subject of care’. | Australian Standard 2828.1-2012 Health Records – Paper-based health records |
| Patient Master Index (PMI) | A database which uniquely identifies all patients who have been admitted or receive treatment at the hospital, and includes their demographic information. | Queensland Health                     |
| Patient Identifier         | The identifier of a person for exclusive use by a healthcare system.  
Note: The term ‘patient identifier’ includes the unit record number (UR no), medical record number (MRN), client record number, clinical record number and subject of care identifier. | Australian Standard 2828.1-2012 Health Records – Paper-based health records |
| 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. | Queensland Health  
QSA Glossary            |
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<td>QDAN (Queensland Disposal Authority Number)</td>
<td>The unique number allocated to each Retention and Disposal Schedule approved by Queensland State Archives.</td>
<td>QSA Glossary</td>
</tr>
<tr>
<td>Recordkeeping</td>
<td>The act of making, keeping and preserving evidence of government business in the form of recorded information.</td>
<td>QSA Glossary</td>
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</tbody>
</table>
| 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* Schedule 2 Dictionary |
| Recordkeeping systems                      | The interaction of the technology, people, principles, methods, processes and information systems which captures, manages and provides access to records through time.                                                                                                                       | Adapted by Queensland State Archives from ISO15489, Part 1, Clause 3.17. |
| Registration                              | The act of giving a record a unique identity in a recordkeeping system.  
AS ISO 15489, Part 1, Clause 3.18  
The primary purpose of registration is to provide evidence that a record has been created or captured in a records system, and an additional benefit is that it facilitates retrieval. It involves recording brief descriptive information or metadata about the record and assigning the record an identifier, unique within the system.  
AS ISO 15489, Part 1, Clause 9.4  
The process used by archives in capturing data on agencies, series and items.  
Queensland State Archives                                                                                                             | QSA Glossary                                |
| 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:  
(a) 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.  
(b) General retention and disposal schedule, which is based on functions common to many public authorities and authorises the retention and disposal of 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). | QSA Glossary                                |
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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>QSA Glossary</td>
</tr>
<tr>
<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>QSA Glossary</td>
</tr>
<tr>
<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>QSA Glossary</td>
</tr>
<tr>
<td>Unit Record Number (URN)</td>
<td>A permanent identification number that is assigned to the patient and used to identify the patient and their associated information. NOTE: represented as alphanumeric or numeric characters</td>
<td>Health information management: Edna K.Huffman 1994</td>
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### Version Control

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<td>1.0</td>
<td>04 Aug. 2014</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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