Queensland Health

Assignment of unique Unit Record Number

Department of Health Standard

QH-IMP-280-3:2014

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

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

Compliance with this standard is mandatory.

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

This standard outlines the requirements for the assignment of the unique URN.

3. Requirements

The standard applies to clinical records managed by the HHS and/or individual health facilities regardless of the technology or medium:

- **Physical record** (physical form such as paper, photographs, film)
- **Electronic record** (a record created or captured through electronic means such as a computer, scanner or born digital materials).
- **Hybrid record** (a combination of physical and electronic records).

In accordance with the Queensland Recordkeeping Metadata Standard and Guideline issued by Queensland State Archives, under s.25 of the *Public Records Act 2002* (Qld), a unique identifier must be allocated to a record at the time of registration.[1]

A URN is a unique permanent identifier assigned to a patient and used for the purpose of identifying the patient and their associated clinical record within a healthcare facility.

[1] Queensland State Archives, Queensland Recordkeeping Metadata Standard and Guideline, viewed April 2024

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 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 one URN correctly assigned and recorded.

3.1.4. A URN shall be the unique key to accurately identifying an individual patient within the Patient Administration System (PAS), providing the key patient demographics, location, and the associated clinical record.

3.1.5. A comprehensive search prior to allocating a new URN shall be conducted within the PAS incorporating the minimum datasets to perform a patient search (Refer to the Patient identification and clinical record matching fact sheet).

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 be issued permanently to one patient and shall not be deleted, re-used, or overwritten, even if a patient fails to attend a health service or has been notified as deceased within the PAS.

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 be investigated and where verified as the same patient, shall be merged so that only one URN and one clinical record exist for the patient.

3.2.3. Where there is a multi-campus wide PMI (including an affiliated satellite hospital), a URN shall be unique for each patient across the multi-campus or across the facility and its affiliated satellite hospital.

3.2.4. Within a health facility, verification of an existing URN and correctly matching a patient to their clinical record shall occur to ensure each patient has a single unique URN and to prevent instances of the same patient having multiple URNs.

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

3.2.6. Training shall cover at a minimum relevant polices and standards, procedures, work instructions identifying consequences and risks to patient health care arising from duplicate registration URNs and clinical records. (Refer to the Same facility potential duplicate fact sheet and Same facility active fact sheet).

3.3. A PMI shall be retained permanently.

3.3.1. A PMI shall be permanently retained in accordance with the *Public Records Act 2002* (Qld) and the Health Sector (Clinical Records) Retention and Disposal Schedule.

4. Human rights

Human rights are not engaged by this standard.

5. Legislation

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

- *Adoption Act 2009* (Qld)
- *Births, Deaths and Marriages Registration Act* 2003 (Qld)
- *Child Protection Act 1999* (Qld)
- *Coroners Act 2003* (Qld)
- *Electronic Transactions (Queensland) Act 2001*
- *Evidence Act 1977* (Qld)
- *Hospital and Health Boards Act 2011* (Qld)
- *Human Rights Act 2019* (Qld)
- *Information Privacy Act 2009* (Qld)
- *Judicial Review Act 1991* (Qld)
- *Mater Public Health Services Act 2008* (Qld)
- *Mental Health Act 2016* (Qld)
- *Public Records Act 2002* (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
- Australian Standard 2828.2:2019, Health records, Part 2: Digitized health records

- Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service (NSQHS) Standards, Clinical Governance Standard – Patient safety and quality systems
- Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service (NSQHS) Standards, Communicating for Safety Standard – Correct identification and procedure matching

Queensland Government Enterprise Architecture (QGEA)

- Records governance policy
- Records governance policy implementation guideline

Queensland Health

- Clinical Data Standardisation standard (QH-IMP-279-1:2014)
- Clinical documentation guide
- Clinical records management policy (QH-POL-280:2014)
- Data management policy (QH-POL-279:2014)
- Data management standard (QH-IMP-279-4:2023)
- Information Management Framework
- Patient identification and clinical record matching fact sheet
- Person and Provider Identification Data Set-Definitions
- Queensland Hospital Admitted Patient Data Collection (QHAPDC)
- Same facility active fact sheet
- Same facility potential duplicate fact sheet

Queensland State Archives

- Health Sector (Clinical Records) Retention and Disposal Schedule

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
Electronic 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 digitised health records. Any record created, communicated, and maintained by means of electronic equipment.	Australian Standard 2828.2:2019, Health records, Part 2: Digitized health records
Health service	(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 -	*Hospital and Health Boards Act 2011* (Qld)

Term	Definition	Source
	(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. (3) In addition, a health service includes a support service for a service mentioned in subsection (1).	
Hybrid record	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 digitised format to full electronic health record.	Australian Standard 2828.2:2019, Health records, Part 2: Digitized health records
Information	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. Information may also be a public record or an information asset if it meets certain criteria.	Queensland Government Glossary

Term	Definition	Source
Physical source record	A source record that is tangible and takes up physical space (e.g. paper, photographs, film).	Queensland Government Glossary
Record(s)	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; 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.	*Public Records Act 2002* (Qld)
Metadata (for recordkeeping)	Data that describes the content, context and structure of records. Metadata is structured or semi-structured, descriptive information about a record. It usually includes the title of the record, author, date created, changes to the record, and applicable disposal or sentencing information. Recordkeeping metadata enables a record to be managed. It assists in identifying and retrieving records and supporting long term record functionality, reliability, and effective preservation or disposal authentication.	Queensland Government Glossary
Registration	Saving or registering a record into your organisation's recordkeeping system (whether hardcopy or digital). This may mean registering the record into a recordkeeping system and assigning metadata to describe it and place it in context, allowing for the appropriate management of the record over time.	Queensland Government Glossary

Term	Definition	Source
Unit Record Number (URN) (also referred to as patient identifier)	The identifier of a person for exclusive use by a health service	Australian Standard 2828.1:2019, Health records, Part 1: Paper health records

Version control

Version	Date	Comments
1.0	04 Aug 2014	Approved
1.1	12 Jun 2015	Transferred information into new template and reviewed by Clinical Information Management.
2.0	13 Oct 2022	Transferred information into new template, content reviewed and updated. Amendments made to Requirements section, section 3.2.2, section 3.2.6, and PMI term in Definitions table. Approved by the Information Management Strategic Governance Committee. Approved by Deputy Director-General, eHealth Queensland and Chief Information Officer, Queensland Health.
2.1	01 May 2024	Content reviewed. Minor addition to Requirements section (point 3.2.3) to include satellite hospital wording. Legislation section updated for currency. Inclusion of Source within Definitions table.