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 employees, contractors and consultants within the Department of Health divisions and business units.

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 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). All information in digital formats should be maintained with necessary metadata to support the retrieval and access to the information
- **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 patient 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 15 August 2022 Queensland Recordkeeping Metadata Standard and Guideline (forgov.qld.gov.au)

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 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 clinical record exist for the patient.

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 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. 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)
- *Commission for Children and Young People and Child Guardian Act 2000* (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 Service Act 2008* (Qld)
- *Right to Information Act* 2009 (Qld)

5. 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

- Queensland Government Enterprise Architecture Records Governance Policy
- Queensland State Archives - Health Sector (Clinical Records) Retention and Disposal Schedule

Queensland Health

- Clinical Data Standardisation Standard QH-IMP-279-1:2014
- Clinical Documentation Guideline
- Clinical Records Management Policy QH-POL-280:2014
- Data Management Policy QH-POL-279:2014
- Information Management Framework
- Person and Provider Identification Data Set-Definitions
- Patient identification and clinical record matching Fact sheet
- Queensland Hospital Admitted Patient Data Collection (QHAPDC)
- Same facility potential duplicate Fact sheet
- Same facility active Fact sheet

6. Definitions

Term	Definition
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.
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.
Health record number	The unique identifier of a given patient for a health record within an organisation. 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.

Term	Definition
	2. The health record number is typically used to support filing and retrieval of healthcare records within the healthcare organisation's record system. It is used for patient and information identification as the unique identifier within the organisation.
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 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 b. a service dealing with public health, including a program or activity for, i. the prevention and control of disease or sickness. 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). NOTE: examples of a health service include Emergency Department, Hospital in the Home Service, Boarders
Hospital and Health Service (HHS)	A Hospital and Health Service established under Section 17 of the *Hospital and Health Boards Act 2011*.
Hybrid record	A health record comprising paper, digital 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
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.
ieMR	Replacing paper-based clinical charts, the integrated electronic Medical Record (ieMR) allows healthcare professionals to simultaneously access and update patient information.
PAS	Patient administration system designed to improve the automation of the administrative aspects, such as paperwork in healthcare organisations, like hospitals. Patient administration systems are a primary component of the IT infrastructure in a hospital system.

Term	Definition
Patient	A patient is any recipient of health care services that is performed by healthcare professionals.
Patient identifier	The identifier of a person for exclusive use by a healthcare system. Note: The term 'patient identifier' includes the unit record number (URN), medical record number (MRN), client record number, clinical record number and subject of care identifier.
PMI	Patient Master Index is a database which uniquely identifies all patients who have been admitted or receive treatment at a hospital and includes their demographic information. The PMI is retained permanently as per the Health Sector (Clinical Records) Retention and Disposal Schedule.
Patient information	Personal Information: has the same meaning as in s.12 of the Information Privacy Act 2009, namely, information or an opinion, including information or an opinion forming part of a database, whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.
Permanent records	Records with high or significant archival value that cannot be destroyed and must be retained indefinitely by either the agency or Queensland State Archives. These are records that have ongoing usefulness or significance to the state, based on their evidential, administrative, financial, legal, informational, and historical value.
Physical record	A physical form such as a paper-based record, photographs and/or film.
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 (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.
Recordkeeping metadata	Structured or semi-structured information which enables the creation, management and use of records through time and across domains. Recordkeeping metadata can identify, authenticate and contextualise records and the people, processes and systems that create, manage and use them.
Registration	Registration is a process that results in the creation of a record of registration, and the establishment of an associated identity. The record is usually allocated an identifier that is unique within the domain of the issuer.

Term	Definition
	The registration process may include identification of the client, wherein the validity of claimed attributes and evidence of identity is assessed. Depending on the domain, several attributes may be required to distinguish an identity uniquely e.g. the identifier set name: name, date and place of birth is commonly used to distinguish human identity within large domains. Registration may also involve the issuing of a credential to the applicant. Multiple enrolments may occur after a user has been registered. Although 'registration' and 'enrolment' are sometimes used as synonyms, a distinction is being drawn here between the two terms.
URN	Unit Record Number. A permanent identification number that is assigned to the patient and used to identify the patient and their associated information.

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.