Mental Health Act 2016
Chief Psychiatrist Policy

Patient records

Contents

General

The *Mental Health Act 2016* (MHA 2016) requires that the Chief Psychiatrist **must** establish and maintain a system for keeping electronic records of advance health directives, enduring powers of attorney (for a personal matter), and appointment of nominated support persons.

The Consumer Integrated Mental Health and Addiction (CIMHA) application is a statewide consumer-centric clinical information system designed to support the provision of mental health alcohol and other drug services in Queensland and is the designated patient record for the purposes of the MHA 2016.

CIMHA **must** contain information stating the name of the person who made the directive or appointment, the date that it was made, and an electronic copy of the document.

The MHA2016 also requires the administrator of an authorised mental health service (AMHS) to keep a record containing specified information for involuntary patients and classified patients (voluntary) for the AMHS.

An accurate, comprehensive and up to date patient record management system supports staff and administrators in delivering high quality treatment and care and upholding the rights of involuntary patients.

Scope

This policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the MHA 2016 **must** comply with this policy.

Staff should work collaboratively and in partnership with individuals in their care to ensure their unique-age related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. This should include the timely involvement of appropriate local supports and a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the MHA 2016.

This policy is issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly
Chief Psychiatrist, Queensland Health
1 July 2024

Policy

1 Legislative requirements for record keeping

All records created or received by Queensland Health are governed by the *Public Records Act 2002*, which applies to all public authorities. Retention and disposal of Queensland Health records **must** comply with the relevant schedules issued under the *Public Records Act 2002*.

All patient information created or received by Queensland Health is subject to the confidentiality provisions of the *Hospital and Health Boards Act 2011*.

A relevant person (as defined in the MHA 2016) is also subject to duty of confidentiality provisions under the MHA 2016.

The *Private Health Facilities Act 1999* provides for the Chief Health Officer to make standards about patient records. Private facility AMHS administrators **must** ensure that all local recordkeeping arrangements align with the standard issued by the Chief Health Officer for information management.

1.1 Record management systems

Mental health records must be stored in patient recordkeeping systems (paper or electronic), according to local Hospital and Health Service requirements.

For the purposes of the MHA 2016, the CIMHA application is the designated patient record which enables information in relation to a person's assessment, treatment and care in an AMHS to be managed and viewed in one location. This information comprises data and documents, including forms, clinical notes, clinical reports, medico-legal documents and non-clinical information.

Limited information from CIMHA is available via 'The Viewer' and 'Health Provider Portal' (see definitions) for staff without access to CIMHA. Information available via 'The Viewer' and 'Health Provider Portal' includes:

- patient demographic and clinical information,
- status under the MHA 2016,
- advance health directives and documents relating to appointment of an enduring power of attorney,
- alerts, and
- certain clinical notes such as assessments and discharge summaries.

Key points

AMHS administrators must ensure that CIMHA data entry relevant to the assessment, treatment and care of patients under the MHA 2016 is accurate and up to date.

- All MHA 2016-related documents (e.g. reports, forms, advance health directives and documents relating to the appointment of a nominated support person, guardian or attorney) must be electronically entered or uploaded to CIMHA.
- For private sector AMHS, it is also necessary for a copy of these documents to be stored on the relevant patient's clinical record at the AMHS to ensure that they are readily accessible to staff and provided in the event of transfer to a public sector AMHS.

1.2 Medico-legal documents

Documents which are both medico-legal and clinical in nature must be saved in the CIMHA clinical notes module to allow access to timely clinical history and to support comprehensive risk management and treatment planning. Such documents include:

- a psychiatrist report to inform decisions about criminal responsibility and fitness for trial,
- an expert report received in evidence by the Mental Health Court, and
- an examination report provided to another court.

Expert reports may also be saved in the CIMHA clinical notes module if they have been filed with the Mental Health Court but not yet received in evidence, provided the Court has granted approval for this to occur. In these circumstances, the Office of the Chief Psychiatrist is responsible for advising the AMHS of the Court's approval, including any conditions made by the Court (e.g. information required to be redacted).

Other medico-legal documents and non-clinical information such as police reports, QP9 forms, witness statements and court materials must be scanned and saved in the Mental Health Act forms module.

- Access to these documents is restricted to staff with relevant CIMHA access. Access to these documents, as with all patient records, is based on necessity and relevance for staff role and function and must be defensible. Prior to viewing saved medico-legal documents, staff must consider whether this is necessary and appropriate for carrying out their functions under the MHA 2016.
- If staff without relevant CIMHA access attempt to open these documents an error message will be displayed advising the user they are not currently authorised to view that specific form. Staff who receive this message who believe they require

access to these documents should contact their local Mental Health Information Manager.

This functionality removes the requirement for a separate administrator paper record to be retained. The necessity to retain an administrator paper record for historical information which is not scanned and saved in CIMHA will remain pending the development of functionality to manage this information.

Key points

Public facility AMHS Administrators **must** ensure that clinical documentation relevant to the assessment, treatment and care of patients under the MHA 2016 is recorded in CIMHA clinical notes.

This documentation may also be located in other patient record-keeping systems (paper or electronic), according to local Hospital and Health Service requirements.

Original paper records **must** be retained until the accuracy and clarity of the digitised (scanned) image has been verified and quality checks have been conducted on the digitised image according to local arrangements.

AMHS Administrators are responsible for ensuring processes are in place to manage the integrity of scanned information so that it remains accessible as required.

1.3 Legally privileged documents

There may be instances where legal advice is obtained in relation to a consumer's treatment and care. Legal advice is subject to legal professional privilege, is confidential and **must not** be recorded in CIMHA. Services should refer to local Hospital and Health Service policy in relation to storage, retention and disposal of legally privileged documents.

Where the advice is directly relevant and/or important for the person's treating team to be aware of in providing treatment and care, the service should consult with the legal officer about inclusion of relevant aspects of the advice in CIMHA.

1.4 Retention and disposal

The retention and disposal of Queensland Health records is determined by their class under the *Public Records Act 2002* and the relevant retention and disposal schedule.

- Different retention and disposal schedules apply for clinical, medico-legal and administrative records.
- Digitised records **must** be retained for the full retention period required by the relevant schedule.

1.5 Access to CIMHA

The level of access to CIMHA **must** be in accordance with staff roles and functions, and the relevant information security classifications and levels.

AMHS administrators **must** ensure that all relevant staff are trained and competent in the use of CIMHA.

The Office of the Chief Psychiatrist undertakes regular data quality activities in conjunction with AMHSs as part of compliance mechanisms to ensure the accuracy and consistency of data in CIMHA.

Further information

Definitions and abbreviations

Term	Definition
AMHS	Authorised mental health service – a health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the MHA 2016 for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health and Addiction application is a statewide consumer-centric clinical information system which is the designated patient record for the purposes of the MHA 2016.
Health Provider Portal	Eligible health practitioners can access a secure web-based portal which providers healthcare information from Queensland's public health services. Eligible health practitioners that can access the Health Provider Portal can include general practitioners (GPs), other medical specialists, nurses, midwives, paramedics and pharmacists.
MHA 2016	*Mental Health Act 2016*
The Viewer	A web-based application available on desktop computers and mobile devices, The Viewer collates administrative and clinical data from multiple Queensland Health systems, ensuring healthcare professionals can access patients' information quickly, without having to log in to different systems.
Relevant AMHS Administrator	The relevant AMHS Administrator is: • the Administrator of the AMHS currently providing clinical services to the person, or • if the person is not currently receiving mental health services (i.e. no open service episode), the Administrator of the AMHS for the location where the person resides.

Referenced policies and resources

Mental Health Act 2016 forms and resources

Mental Health Act 2016

Legislation

Public Records Act 2002

Hospital and Health Boards Act 2011

Private Health Facilities Act 1999

Referenced documents and sources

Private Health Facilities (standard) Notice 2016

Queensland State Archives Glossary of Archival Recordkeeping Terms

Queensland State Archives (QSA) Digitisation Disposal Policy

Health Sector (Clinical Records) Retention and Disposal Schedule (27 July 2021)

General Retention and Disposal Schedule

General Retention and Disposal Schedule for Digital Source Records

Clinical Records Management Policy: QH-POL-280:2014

Audit and Recordkeeping Standard: QH-IMP-484-9:2021

Document status summary	
Date of effect:	1 July 2024
Supersedes version that took effect on:	14 July 2023
To be reviewed by:	1 July 2027
Assessment of compatibility with the *Human Rights Act 2019* completed on:	1 December 2021