Information management standard (version 5)

STANDARD

- Every patient must have a medical record which:
  - facilitates effective patient care management prior to, during and after their stay in the health facility;
  - provides for effective communication between health care providers; and
  - enables evaluation of the patient's progress and health outcome.

- Patient clinical records must be retained and stored for specified minimum periods.

- Permanent registers of patient activity must be maintained for medico-legal/legislative requirements.

- All stored personal information must be protected from unauthorised access, alteration or loss through the use of appropriate security measures.

This standard is not satisfied unless:

- Information management systems meet the needs of patient care delivery and the organisation.

- Medical Records:
  - The health facility's medical records comply with Australian Standard 2828.1 - 2012 (Health records - Paper-based health records) and/or AS 2828.2(Int)-2012 Health records - Digitized (scanned) health record system requirements.
  - Each patient, including each infant born or treated at the health facility, has a complete medical record which includes the following:
    i. information required for the provision of reports to the Chief Health Officer under section 144 of *the Private Health Facilities Act 1999*;
    ii. progress notes which include the patient's medical history, the nature of the principal condition of the patient and the nature of any other condition, including adverse events, treated during the patient's stay in the health facility;
    iii. the nature of any surgical/diagnostic procedure performed on the patient during an episode of care;
    iv. a daily record of all medical and nursing care given in relation to the patient's medical, physical, psychological and social needs and responses;
    v. detail of all medication; and
    vi. record of informed consent for the performance of any surgical and/or potentially harmful diagnostic procedures and/or treatment regime.

- Retention and Storage:
  - The minimum period for the retention and storage of medical records is:
    i. for clinical records – 10 years after the last clinical attendance or last medico-legal action, whichever is later;
    ii. for minors' clinical records and obstetric records – 10 years from the child attaining adulthood (18 years);
    iii. for patients with a condition affecting their decision-making capacity (e.g. intellectually disabled relating to traumatic brain injury, dementia, or severe mental illness) – 10 years from the date the patient's decision-making capacity is no longer limited, or 80 years from the date of birth of the patient.
  - All records of Assisted Reproductive Technology procedures are retained according to National Health and Medical Research Council guidelines.
  - If the licence of a health facility is to be transferred, the existing licensee ensures that all patient records are made available and transferred to the incoming licensee.

- Prior to a facility ceasing to operate as a health facility, the licensee submits details of the safe keeping of the records to the Chief Health Officer for approval.

- Registers:
  - The following registers are available where relevant:
    i. Admission and Discharge register:
      a) the patient's full name and usual residential address;
      b) the patient's gender and date of birth;
      c) the patient's unit record number;
      d) the date of the patient's admission;
      e) the name of the patient's attending medical practitioner;
      f) the patient's diagnosis on discharge; and
      g) the date of separation for the patient's episode of care.
    ii. Birth register:
      a) the mother's full name;
      b) the mother's unit record number;
      c) the name of the mother's attending medical practitioner;
      d) the date and time of delivery of each infant;
      e) the gender of each infant;
      f) whether or not the infant was born alive;
      g) the method of delivery; and
      h) the name of the midwife and medical practitioner in attendance for the delivery.
    iii. Operating theatre and/or procedure register:
      a) the patient's full name, gender, date of birth and unit record number;
      b) the date and time the operation or procedure was performed;
      c) the serial number of the operation or procedure;
      d) the nature of the procedure;
      e) the name of the surgeon, surgeons assistant, anaesthetists and scrub nurse;
      f) the nature and identification number of any prosthesis used during any procedure; and
      g) any complications that may have occurred during a procedure.
    iv. Mental health register:
      a) information required under the relevant Mental Health legislation.

- Security:
  - Security of records complies with:
    - AS ISO/IEC 27001:2015 Information technology – Security techniques – Information security management systems – Requirements.
    - AS ISO/IEC 27002:2015 Information technology – Security techniques – Code of practice for information security controls.

References:

- *Mental Health Act 2016.*
- *Mental Health Regulation 2017.*
- AS 2828.1 :2012 Health records – Paper-based health records.
- The National Health and Medical Research Council (NHMRC) 2007, Ethical Guidelines on the use of Assisted Reproductive Technology in clinical practice and research.