Queensland Health

Clinical records management

Department of Health Policy

QH-POL-280:2014

1. Statement

The Department of Health is committed to ensuring that complete and accurate clinical records are created, managed, stored and disposed of in accordance with legislative and agreed (established) organisational, clinical and ethical requirements.

2. Purpose

The intent of this policy is to:

- foster an organisational culture that recognises the strategic importance and the enduring value of clinical records as critical assets of the organisation, essential to support the provision of quality health care and meet business, legislative and accountability requirements.
- encourage standardised clinical recordkeeping practices that promote the sharing of knowledge and support evidence-based decision making to deliver high quality health services.
- commit to the provision of appropriate levels of security regarding health information ensuring that it will be securely managed, and privacy and confidentiality will be maintained.
- comply with the *Public Records Act 2002 (Qld),* in addition to other policies, standards or guidelines made by the State Archivist about the making, keeping and disposing of clinical records.

3. Scope

This policy applies to all employees, contractors and consultants within the Department of Health divisions and business units.

The Department of Health is committed to safeguarding the privacy and confidentiality of its clients and staff and is subject to privacy and confidentiality legislation which sets the standards for how personal and confidential information is handled.

This policy applies to clinical records regardless of 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)

This policy does not include corporate records (administrative and non-clinical functions).

This policy does not include the My Health Record (national electronic health record) as it is an Australian Government initiative. It is not intended that the My Health Record will replace clinical

records maintained by a facility, as its purpose is to provide individuals with an online tool to manage and view a summary of their health records.

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

4. Principles

- **Managed** - Complete and accurate clinical records are made, managed and preserved for as long as they are required for business, legislative, accountability and cultural purposes. Clinical records are not to be managed through an electronic Document and Records Management System (eDRMS) or through Office 365 (including Microsoft SharePoint and Teams).
- **Governed** – Clinical recordkeeping responsibilities are assigned to and implemented by appropriately trained and skilled staff. The clinical records management systems and practices are regularly monitored, audited and evaluated for accountability, compliance and continuous improvement.
- **Secure** – Security provisions are implemented to maintain clinical record integrity and authenticity by preventing unauthorised access, damage, alteration or misuse, loss, and disclosure. All breaches should be actioned.
- **Trustworthy** – Physical, electronic and hybrid clinical records are managed to enable reliable and timely retrieval of records that retain integrity over time.
- **Accurate and complete** – Information is relevant, accurate, up to date and complete. Clinical records are clear, objective and thorough and created at, or as close as possible to the time of the encounter. Clinical records clearly show the author and the date created.
- **Disposal** – Clinical records must only be disposed of in accordance with the retention and disposal schedules approved by the Queensland State Archivist. Endorsement must be obtained from the facility's Chief Executive Officer or authorised delegate. Active disposal freezes must be complied with.

5. Legislation

- *Adoption Act 2009 (Qld)*
- *Births, Deaths and Marriages Registration Act 2003 (Qld)*
- *Child Protection Act 1999 (Qld)*
- *Coroners Act 2003 (Qld)*
- *Criminal Code Act 1899 (Qld)*
- *Electronic Transactions (Queensland) Act 2001*
- *Evidence Act 1977 (Qld)*
- *Hospital and Health Boards Act 2011 (Qld)*
- *Information Privacy Act 2009 (Qld)*
- *Judicial Review Act 1991 (Qld)*
- *Mental Health Act 2016 (Qld)*

- *Public Health Act 2005 (Qld)*
- *Public Records Act 2002 (Qld)*
- *Public Sector Ethics Act 1994 (Qld)*
- *Public Service Act 2008 (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
- Queensland Government Customer and Digital Group (QGCDG)
  - Information access and use policy (IS33)
  - Information security assurance and classification guideline
  - Information security classification framework (QGISCF)
  - Information security policy (IS18:2018)
  - Records governance policy
  - Records governance policy implementation guide
- Queensland Health
  - Assignment of unique unit record number Standard
  - Code of Conduct for the Queensland public service
  - Display of date and time in electronic systems Standard
  - Documentation of date and time in the paper based health record Standard
  - Information security Policy
  - Information security Standard
  - Management and access to documents and records Fact sheet
  - Managing the clinical records of children available for adoption Guideline
  - Managing the clinical records of children available for adoption Standard
  - Retention and disposal of clinical records Standard
- Queensland State Archives – Health Sector (Clinical Records) Retention and Disposal Schedule (QDAN683)

7. Definitions

Term	Definition
Born digital	Materials that originate in digital form (digitally native), not created on paper nor any other analogue 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.
Corporate records	Records that provide evidence of administrative and non-clinical functions of the Department (e.g. executive correspondence, finance, human resource, legal, research, scientific, cancer screening etc.).
Disposal freeze	An authority issued by the Queensland State Archivist, by Court issue or an agency's CEO (or delegate) that requires a temporary cessation of the destruction of public records relating to a specific topic or event. Once issued, a disposal freeze overrides any other authority to dispose records.
Electronic Document and Records Management System (eDRMS)	The electronic Document and Records Management System (eDRMS) is an automated system used to manage documents and records in a secure manner throughout the information management life-cycle, from creation to disposal. Its purpose is to support the creation, revision and management of digital documents, improve an organisation's workflow, improve tracking, reporting and searching capability of correspondence and provide evidence of business activities.
Electronic Health Record (EHR)	Health record with data structured and represented in a manner suited to computer calculations and presentation. Use of this term implies the ability to compute the content of the record. It is often described as presenting a lifetime record of health and care. It may include digitised information, as well as born digital records and other database entries.
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.
Hybrid record	Health record comprising paper, digitized and electronic formats, created and accessed using both manual and electronic processes. A hybrid health record often arises as a transitional

Term	Definition
	health record during migration from digitised format to a full EHR.
Office 365 SharePoint	Is a web-based collaboration and content management system that provides Queensland Health employees with an online communications portal to access, review, edit and share information and electronic documents. SharePoint allows people to collaborate and share ideas without the limitation of location. *Note: Office 365 (including Microsoft SharePoint and Teams) is not an authorised clinical recordkeeping application. Any clinical records held in Office 365 (including Microsoft SharePoint and Teams) must be captured and recorded in an authorised clinical recordkeeping application.*
Office 365 Teams	Is a chat, files, meeting and notes-based collaboration tool that allows the integration of many disparate services (such as Power BI, Forms and SharePoint) into any easy to navigate and customisable environment. *Note: Office 365 (including Microsoft SharePoint and Teams) is not an authorised clinical recordkeeping application. Any clinical records held in Office 365 (including Microsoft SharePoint and Teams) must be captured and recorded in an authorised clinical recordkeeping application.*
Physical record	A source record that is tangible and takes up physical space (e.g. paper or microfilm).
Recordkeeping	The act of making, keeping and preserving evidence of government business in the form of recorded information.
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 aid of anything else, or d) a map, plan, drawing or photograph.

Version Control

Version	Date	Comments
1.0	9 May 2014	Department of Health policy approved
2.0	9 November 2020	This updated policy has undergone consultation and had the content reviewed with updates made to the Purpose, Scope, Principles and Definitions sections.