STATE RECORDS NEW SOUTH WALES

General Retention and Disposal Authority - Public Health Services: Patient/Client Records (GDA 17)

Issued May 2004

Table of Contents

Part 1: The General Retention and Disposal Authority

1.1 Statement of authority

GDA No	GDA 17
Public office	This authority applies to any organisation, facility or service which is part of the New South Wales public health system.
Scope	This general retention and disposal authority covers records documenting the provision of health care to patients and clients of the public health system.
Authority	This general retention and disposal authority is issued under section 21(2)(c) of the State Records Act. It has been approved by the Board of the State Records Authority in accordance with section 21(3) of the State Records Act.

Authorised	David Roberts Director State Records Authority of New South Wales 19 May 2004

1.2 Scope of patient/client health care records

Patient and client health care records document an individual's health evaluation, diagnosis, treatment, care, progress and health outcome. These records should be created and maintained in accordance with:

- the principles outlined in NSW Department of Health Circular No 98/59 *Principles for the creation, management, storage and disposal of health care records*
- policies and procedures contained in the Department's *Patient Matters Manual* and *Health Records and Information Manual for Community Health Facilities*
- any guidelines or directives that may be issued by the Department from time to time.

Records relating to the provision of treatment and care to a patient/client include (but are not limited to) records relating to or of a patient's/client's:

- admission, including medical and nursing records
- history (medical and social of the patient or their family)
- examination results (physical or other)
- transfer, referral or assessment documentation
- correspondence between the patient or their representative and the health care service
- consultation reports (medical or other)
- principal diagnosis and any other significant diagnosis
- medication or drug orders and medication administered or prescribed (including oral, parenteral and incident reports)
- nursing care (including all versions or revisions of nursing care plans) and clinical pathways observations
- counselling, allied health, social work or other health care professional notes
- allergies or special conditions
- doctor's or physician's orders
- all observations and progress notes (including those recorded on separate sheets)
- problem lists (master or other)
- requests for and results or reports of all laboratory, diagnostic or investigative tests or procedures performed (including pathology, X-ray or other medical imaging examinations)
- consent or authority to carry out any treatment, procedure or release of information and certification that consent is informed (including removal or donation of tissue or organs, consent to special procedures etc. See also NSW Health Department Circular No 99/16 *Patient information and consent to medical treatment*)
- refusal of treatment or withdrawal of consent
- prenatal, obstetric, newborn and perinatal treatment, care and outcomes (includes newborn records and perinatal morbidity statistics)
- surgical procedure or operation (including pre-operative checklists, anaesthetic records and peri operative nurses reports including instrument and swab count records and post operative observations)
- all therapeutic treatments or procedures (including anti-coagulant, diabetic, dialysis, electric shock therapy (EST) and electro convulsive therapy (ECT))

- statements made for the Police and Coronial Inquest Reports
- discharge (includes final diagnosis, operative procedures, summary or letter of discharge and discharge at own risk or against advice)
- death (includes autopsy or post-mortem reports)

1.3 Quick reference to classes of records covered

Records		Reference
PATIENT/CLIENT TREATMENT AND CARE	Hospital care	1.1.0
	Community health care	1.2.0
	Oral (dental) health care	1.3.0
	Obstetric/maternal health care	1.4.0
	Psychiatric and mental health care	1.5.0
	Genetic or inherited disorders	1.6.0
	Assisted Reproductive Technology (ART)	1.7.0
	Sexual assault patients	1.8.0
	PANOC Specialist Services	1.9.0
	Radiotherapy treatment	1.10.0
	Electronic health records	1.11.0
	Patient records of significance	1.12.0
	Correspondence	1.13.0
	Legal matters and incident management	1.14.0
	Clinical audits	1.150
	Medical certificates	1.16.0
	Sterilisation (instruments)	1.17.0

	Surgical procedures (accountable items)	1.18.0
PATIENT/CLIENT REGISTRATION AND IDENTIFICATION	Registers and indexes	2.1.0
	Lists and schedules	2.2.0
	Diaries and appointment books or registers	2.3.0
	Censuses and returns	2.4.0
	Ward records	2.5.0
	Electronic patient administration systems	2.6.0
	Health Information Exchange (HIE)	2.7.0
PATIENT DIAGNOSIS – IMAGING SERVICES	Requests	3.1.0
	Diagnostic reports	3.2.0
	Recordings	3.3.0
	Registers	3.4.0
PATIENT DIAGNOSIS – PATHOLOGY AND LABORATORY SERVICES	Requests	4.1.0
	Diagnostic results and reports	4.2.0
	Specimens and samples	4.3.0
	Blood bank and blood collection services	4.4.0
	Semen supply	4.5.0
	Quality assurance	4.6.0
	Equipment maintenance	4.7.0
	Procedures and methods	4.8.0
PHARMACEUTICAL SUPPLY AND ADMINISTRATION	Dispensation and supply	5.1.0

NOTIFICATIONS	Births and deaths	6.1.0
	Health reporting	6.2.0
PATIENT/CLIENT FINANCE AND PROPERTY MANAGEMENT	Patient property	7.1.0
	Patient/client accounts and finances	7.2.0
	Program of Appliances for Disabled People (PADP)	7.3.0
RESEARCH MANAGEMENT	Research projects, trials or studies	8.1.0
RECORDS IMAGING	Records that have been imaged	9.1.0
PRE 1930 RECORDS		10.0.0

1.4 Retention periods and disposal actions

The following table contains the authorised retention periods and disposal actions applying to the classes of patient and client health care records maintained by public health services.

No	Classes of records	Disposal Action
1.0.0	**PATIENT/CLIENT TREATMENT AND CARE**[1] The provision of health assessment, diagnosis, management, treatment and care services and/or advice to individual patients/clients[2] For records created prior to 1930 **see 10.0.0** For records relating to: - Assisted Reproductive Technology (ART) **see 1.7.0** - genetic or inherited disorders **see 1.6.0** - obstetric/maternal health care **see 1.4.0** - PANOC Specialist Services patients **see 1.9.0** - psychiatric and mental health care **see 1.5.0** - radiotherapy treatment **see 1.10.0** - sexual assault patients **see 1.8.0** - clinical trial participants **see 8.0.0** For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning **see 9.0.0** Records of private hospitals, services, nursing homes, centres etc are not State records and should be retained and disposed of in accordance with any requirements of the Act, or any regulations made under the Act, under which the establishment is licensed.	

1.1.0	**Hospital Care** Records relating to the provision of treatment and care to individual acute care in-patients, out-patients and accident and emergency patients.	
1.1.1	Group A Hospitals[3] (viz Principal Referral Groups A and B, Paediatric Specialist and ungrouped Acute hospitals) **-** records of discharged or deceased in-patients	Retain: - minimum of 15 years after last attendance or official contact or access by or on behalf of the patient[4], or - until patient attains or would have attained the age of 25 years, whichever is the longer, then destroy
1.1.2	Groups B-F Hospitals[3] - records of discharged or deceased in-patients	Retain: - minimum of 10 years after last attendance or official contact or access by or on behalf of the patient, or - until patient attains or would have attained the age of 25 years, whichever is the longer, then destroy
1.1.3	Records of patients attending or presenting to Emergency or Out-Patient Departments not admitted as in-patients - all hospital groups. This includes records of patients who are dead on arrival (DOA) and records maintained as part of the Emergency Department Information System (EDIS).	Retain: - minimum of 7 years after last attendance (in respect of DOA's date of death) or official contact or access by or on behalf of the patient, or - until patient attains or would have attained the age of 25 years, whichever is the longer, then destroy
1.2.0	**Community Health Care** Records relating to clients of community health services or centres. This includes records of unregistered clients, clients who are only 'visitors', clients who are screened without follow up, potential clients or clients who are referred elsewhere. **See** **1.3.0** for records relating to oral (dental) health care	

1.2.1	Client health records Records documenting the provision of health care, assessment or screening services to registered or unregistered clients, including records relating to confidential referrals or temporary records of transfers or 'visitors'. This includes records of deceased clients, ie records relating to clients where the facility has been officially notified of the death of the client, and sensitive or registered records documenting or reporting instances of abuse, family disharmony, developmental disorders, pregnancy etc. **See** **1.8.0** and **1.9.0** for records relating to instances of sexual assault and PANOC Specialist Services patients/ clients	Retain: - minimum of 7 years after last attendance or official contact or access by or on behalf of the client, or - until client attains or would have attained the age of 25 years, whichever is the longer, then destroy
1.2.2	Immunisation records not maintained as part of the main client record and where there is no adverse or other reaction	Retain minimum of 7 years after date of immunisation or after last official contact or access on behalf of the client, then destroy
1.2.3	Immunisation records not maintained as part of the main client record and where there is an adverse or other reaction	Retain: - minimum of 7 years after last official contact or access by or on behalf of the client, or - until client attains or would have attained the age of 25 years, whichever is the longer, then destroy
1.2.4	Child/baby health care screening records documenting the screening and monitoring of the health of infants from birth to 4-5 years where there is no abnormality detected. This includes progress notes, centile charts, immunisation schedule etc.	Retain until child attains or would have attained the age of 6 years, then destroy
1.2.5	Child/baby health care screening records where there is an abnormality detected[5] or with possible legal implications. This includes sensitive or registered records documenting or reporting instances of abuse, family disharmony, developmental disorders etc. **See** **1.8.0** and **1.9.0** for records relating to instances of sexual assault and PANOC Specialist Services patients/ clients	Retain: - minimum of 7 years after last official contact or access by or on behalf of the client, or - until client attains or would have attained the age of 25 years, whichever is the longer, then destroy

1.2.6	School screening records documenting the screening and monitoring of the health of pre-primary, primary and secondary school students where there is no abnormality detected	Retain until student completes either primary or secondary school in which the screening was undertaken, then destroy
1.2.7	School screening records where there is an abnormality detected[5] or with possible legal implications. This includes sensitive or registered records documenting or reporting instances of abuse, family disharmony, developmental disorders, pregnancy etc. **See** **1.8.0** and **1.9.0** for records relating to instances of sexual assault and PANOC Specialist Services patients/ clients	Retain: - minimum of 7 years after last official contact or access by or on behalf of the patient, or - until client attains or would have attained the age of 25 years, whichever is the longer, then destroy
1.2.8	Criminal histories held on files of clients under the Magistrates Early Referral Into Treatment (MERIT) Program	Retain until the conclusion of the client's active involvement in the program, then destroy
1.3.0	**Oral (dental) health care**	
1.3.1	Records relating to the examination, assessment and treatment of patients/clients. This includes dental charts, x-rays etc for both adults and minors.	Retain: - minimum of 7 years after last attendance or official contact or access by or on behalf of the patient/client, or - until patient/client attains or would have attained the age of 25 years, whichever is the longer, then destroy
1.3.2	School dental risk assessment consent forms	Retain minimum of 2 years from date of consent, then destroy
1.4.0	**Obstetric/maternal health care**	
1.4.1	Records documenting birth episodes	These records are currently required to be retained indefinitely by the organisation responsible for their management
1.4.2	Social work records relating to instances of arrangements for adoptions	These records are currently required to be retained indefinitely by the organisation responsible for their management

1.5.0	**Psychiatric and mental health care** **See** **2.1.12** for registers required to be maintained under the *Mental Health Act 1990*	
1.5.1	Records of patients/clients of former Crown operated/5th Schedule psychiatric hospitals where the records were wholly or partly created prior to 1960	Required as State archives
1.5.2	Records of patients/clients receiving psychiatric treatment and care and/or treatment and care (including community health care) under the Mental Health Act. This includes records of deceased patients/ clients (ie records of patients receiving treatment and care under the Mental Health Act who die while in or receiving treatment from a facility or where the facility has been officially notified of death). Records relating to the treatment and care of patients not covered by the Mental Health Act who have mental disorders are to be retained in accordance with **1.1.0** or **1.2.0**	Retain: - minimum of 15 years after last attendance or official contact or access by or on behalf of the patient, or - until patient attains or would have attained the age of 25 years, whichever is the longer, then destroy
1.6.0	**Genetic or inherited disorders** **See** **4.2.5** for laboratory/pathology records relating to the diagnosis of genetic or inherited disorders	
1.6.1	Records documenting the diagnosis of a genetic or inherited disorder[6]	These records are currently required to be retained indefinitely by the organisation responsible for their management
1.6.2	Records relating to the management of patients with genetic or inherited disorders	To be retained and disposed of in accordance with the requirements for the type of patient/client records they comprise eg hospital or community health care
1.7.0	**Assisted Reproductive Technology (ART)** Records relating to ART procedures (including In Vitro Fertilisation (IVF), gamete intrafallopian transfer (GIFT) and artificial insemination).[7] This includes case records of each individual person or family unit, consent to ART procedures, donation and use of semen, ova, embryos and the withdrawal of consent for such procedures or processes.	

1.7.1	Records relating to ART patients/clients where a child is born or, if it is not known whether a child is born, where a pregnancy is achieved	Retain minimum of 75 years from date of birth (or estimated date of birth if not known), then destroy
1.7.2	Records relating to any other ART patients/clients	Retain minimum of 15 years after last attendance or last official contact with the service or after last access by or on behalf of the patient, then destroy
1.8.0	**Sexual assault patients**	
1.8.1	Records relating to instances of sexual assault	Retain minimum of: - 30 years after any legal action is completed and resolved (where known) or after last contact for legal access, or - 30 years after the individual attains or would have attained the age of 18, whichever is the longer, then destroy
1.9.0	**Physical Abuse and Neglect of Children (PANOC) Specialist Services**	
1.9.1	Client records of PANOC Specialist Services	Retain minimum of: - 30 years after any legal action is completed and resolved (where known) or after last contact for legal access, or - 30 years after the individual attains or would have attained the age of 18, whichever is the longer, then destroy
1.10.0	**Radiotherapy treatment records**	
1.10.1	Records documenting radiation dose delivery in respect to patients (admitted and non-admitted) who have undergone radiotherapy treatment. (These records are generally held in Radiotherapy Departments.)	Retain minimum of: - 10 years after patient would have attained the age of 70 or after last attendance, whichever is the longer, or - where the service has received notification of the date of death, 10 years after date of death, then destroy
1.11.0	**Electronic health records**	

1.11.1	Extract summary data created to facilitate the making of treatment decisions where the source records still exist and are retrievable for and at any particular point in time	Retain until no longer required for administrative purposes, then review, if no longer required, then destroy
1.11.2	Extract summary data created to facilitate the making of treatment decisions where the source records are not retrievable or no longer exist	To be retained and disposed of in accordance with the requirements for the type of patient/client records they comprise eg hospital or community health care
1.11.3	Original data where the electronic record is the only record	To be retained and disposed of in accordance with the requirements for the type of patient/client records they comprise eg hospital or community health care
1.12.0	**Collections or samples of patient records of significance** **See** Section 2.3 of Part 2 of this Authority for guidance on the identification of these records **See also** **10.0.0** for records created prior to 1930	
1.12.1	Collections or samples of patient records identified as being of continuing value for medical or social research purposes	Required as State archives
1.13.0	**Correspondence** Incoming and outgoing correspondence relating to the treatment and care of individual patients and/or clients, including referrals **See** **1.14.0** for records relating to the management and handling of complaints, incidents, investigations or litigation involving the health facility and its patient/ clients	

1.13.1	Routine correspondence with individual patients/ clients, or others on behalf of patients/ clients, of a health care facility or service. Correspondence includes records of telephone contact and a record of any medical advice given is to be retained.[8]	Retain: - minimum of 7 years after last attendance or official contact or access by or on behalf of the patient, or - until patient attains or would have attained the age of 25 years, whichever is the longer, then destroy
1.13.2	Correspondence logs or registers	Retain minimum of 7 years after last entry, then destroy
1.13.3	Copies of requests or referrals for other services, eg diagnostic, where the medical record does not incorporate details or where the patient did not attend the service for which the referral was provided. This includes private patient referrals/requests.[9]	Retain minimum of 3 years after last action, then destroy
1.14.0	**Legal matters and incident management** Records relating to the management and handling of complaints, incidents, investigations or litigation involving the health facility and its patients/clients. Records include but are not necessarily restricted to correspondence between the health facility and solicitors or legal defence organisations regarding a patient of the facility, complaint files, incident reports [10] and associated records of investigations[11] into the incident or complaint.	
1.14.1	Records relating to issues, claims or case matters: • of major public interest or controversy, or • which are precedent setting in nature, or • which result in significant changes to the service's or facility's policy and/or procedures	Required as State archives
1.14.2	Records relating to other issues, claims or case matters involving legal action	Retain minimum of 15 years after legal action is completed and resolved (where known) or after last contact for legal access purposes, then destroy
1.14.3	Records relating to complaints and incidents not involving legal action	Retain for minimum of 7 years after last action, then destroy

1.14.4	Subpoenas and discovery orders relating to legal action involving the health service or facility. Records covered by this class are records of correspondence etc concerning the service's or facility's receipt of and compliance with a subpoena or discovery order. It does not apply to the records that are the subject of the subpoena or discovery order.	Retain minimum of 7 years after finalisation of legal proceedings (where known) or after last contact for legal access purposes, then destroy
1.14.5	Subpoenas and discovery orders relating to other litigation not directly involving the health service or facility. Records covered by this class are records of correspondence etc concerning the service's or facility's receipt of and compliance with a subpoena or discovery order where the service of facility is not a respondent or plaintiff to the litigation. It does not apply to the records that are the subject of the subpoena or discovery order.	Retain minimum of 2 years after finalisation of legal proceedings (where known) or after last contact for legal access purposes, then destroy
1.14.6	Register of patient injuries	Retain minimum of 30 years after last entry, then destroy
1.15.0	**Clinical audits**	
1.15.1	Records relating to the conduct of clinical audits for the purposes of evidence based quality management eg an audit of the outcome of pain management treatment	Retain minimum of 5 years after completion of the audit, then destroy
1.16.0	**Medical certificates**	
1.16.1	Copies of medical certificates issued to patients detailing dates of attendance and where appropriate reason for attendance[12]	Retain minimum of 7 years after date of issue, then destroy
1.17.0	**Sterilisation records** Records relating to the sterilisation of surgical instruments and equipment used in procedures	
1.17.1	Sterilisation print-outs[13]	Retain minimum of 15 years after date of printout, then destroy
1.17.2	Log books/sterilisation register used to keep a record of a steriliser's performance	Retain minimum of 15 years after last entry, then destroy
1.18.0	**Surgical procedures (accountable items)**	
1.18.1	Duplicates of records of accountable items (MR18) used in operating theatres eg instruments and swab counts. (The original is required to be placed on the patient's file.)	If used as a Register of surgically implanted devices see **2.1.11**, otherwise retain minimum of 1 year after date of completion, then destroy

2.0.0	**PATIENT/CLIENT REGISTRATION AND IDENTIFICATION** Management of the identification, registration, admission, transfer and discharge of new or readmitted patients/clients and the treatments or procedures performed on them[14] For records created prior to 1930 **see 10.0.0** For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning **see 9.0.0**	
2.1.0	**Registers and indexes** Summary and control records relating to patient admission, identification, diagnosis, treatment and discharge **See** **3.4.0** and **4.3.0** for registers of diagnostic services and **5.1.0** for drug registers Registers etc of private hospitals, services, nursing homes, centres etc are not State records and should be retained and disposed of in accordance with any requirements of the Act, or any regulations made under the Act, under which the establishment is licensed.	
2.1.1	Patient Master Index (PMI), Number register (eg card register) or equivalent[15] This includes records relating to the names and medical record numbers of clients or admitted patients of hospitals, health care facilities and services. In addition to the patient's name and medical record number, details recorded may also include date of birth, sex, address and other relevant details to assist patient identification. Where the PMI or its equivalent maintains a record of summary patient admission and discharge registration details not recorded elsewhere then it should be sentenced in accordance with entry **2.1.4**.	Retain until no longer required for administrative purposes[16], then destroy
2.1.2	Disease and operation index Recording for each disease, condition, operation or procedure code number the details of each in-patient having that diagnosis or having undergone that operation or procedure.[17]	Required as State archives

2.1.3	Physicians index A record for each medical practitioner with admitting rights of the details of each patient attended by the practitioner during the period covered by the index. In addition to the patient's name, medical record number and all disease, condition, operation and procedure codes relating to each patient attended, details recorded may also include age, sex, date of admission, length of stay, discharge status and destination.	Retain minimum of 15 years after date of last entry, then destroy
2.1.4	Admission and discharge registers In addition to the details of the patient's date of admission and discharge, details recorded may also include time of admission, patient's medical record number, address, sex, date of birth, next of kin, admitting diagnosis, discharge diagnosis and length of stay. Where the details recorded in the discharge register are duplicated in the admission register **see 2.1.13**	Required as State archives
2.1.5	Register of births[18] A record of each birth occurring in the service or facility. This includes Birth and Labour Ward registers, confinement books or their equivalent.	Required as State archives
2.1.6	Death register[19] A record of each death occurring in the hospital or facility, including deaths on arrival (DOA's). **See** **6.1.2** for death certificates	Required as State archives
2.1.7	Emergency Department register In addition to date of attendance and name of patient, details recorded may also include patient's medical record number, address, sex, date of birth, reason for attendance and outcome of any follow up arrangements.	Required as State archives
2.1.8	Surgical procedures, Operation or Theatre register[20] A record of each operation or surgical procedure carried out.	Required as State archives

2.1.9	Community health registers A record of details of individual client contact, demographics, presenting problem, transfers in and out etc. This includes Baby health registers.	Retain: - minimum of 15 years after date of last entry, or - until youngest child in the register attains the age of 25 years, whichever is the longer, then destroy
2.1.10	Ward register A record of dates of reception of individual patients into a ward. Information recorded should include date of reception and name of individual patient.	Retain minimum of 7 years after date of last entry, then destroy
2.1.11	Register of surgically implanted devices A record of details of any surgically implanted prostheses or devices.[21]	These records are currently required to be retained indefinitely by the organisation responsible for their management
2.1.12	Electro Convulsive Therapy (ECT)[22], Sedation[23] and Seclusion[23] registers and Rapid tranquillisation journals[24]	Retain minimum of 15 years after date of last entry, then destroy
2.1.13	Duplicate registration and index records This applies to records in hard copy or electronic format that duplicate details or information recorded in and accessible from a centrally maintained or alternate registration system.	Retain until no longer required for administrative or reference purposes[25], then destroy
2.2.0	**Lists and schedules**	
2.2.1	In-patient admission, transfer, discharge or death lists	Where the admission, discharge or death register does not exist sentence in accordance with **2.1.4** or **2.1.6**, otherwise retain minimum of 2 years after date of last entry or list, then destroy
2.2.2	Operation/theatre lists or schedules eg theatre bookings	Retain minimum of 2 years after list or schedule completed, then destroy
2.2.3	Clinical lists. This includes out-patient lists, attendance books etc **See** **2.3.1** for records of client contact not recorded elsewhere	Retain minimum of 1 year after date of last entry or list, then destroy
2.2.4	Waiting lists - quarterly waiting list surveys (Form A's)	Retain minimum of 1 year after date of survey, then destroy

2.2.5	Waiting lists - clerical audit reports	Retain minimum of 3 years after audit, then destroy
2.2.6	Recommendation for admission forms where the patient did not attend and no medical record was created	Retain minimum of 3 years after creation, then destroy
2.3.0	**Diaries and appointment books or registers**	
2.3.1	Personal/work diaries or appointment books/registers recording details of appointments and client contact or attendance not recorded elsewhere	Retain minimum of 7 years after date of last entry, then destroy
2.3.2	Personal/work diaries or appointment books used to record basic information or details such as dates and times of meetings and appointments	Retain until no longer required for administrative or reference purposes, then destroy
2.4.0	**Censuses and returns** **See** **6.2.0** for records relating to the reporting of notifiable diseases etc	
2.4.1	Records reporting numbers of patients admitted or transferred eg bed returns or daily in-patient census	Retain minimum of 1 year after date of creation or until completion of audit, if sooner, then destroy
2.4.2	Originals of data collection forms, returns etc held by the Department of Health. This includes data related to sexual assault, brain injury, admitted patient statistics, midwife data collection etc.	Retain until no longer required for administrative or reference purposes, then destroy
2.4.3	Copies of data collection records/returns held by public health organisations	Retain minimum of 1 year after date of submission, then destroy
2.5.0	**Ward records** **See** **5.1.3** for drug registers maintained on the ward	
2.5.1	Records relating to the management, treatment and care of patients on the ward not incorporated into the main (unit) patient record eg ward reports, report books and related records	Retain minimum of 7 years after date of last entry or action, then destroy
2.6.0	**Electronic patient administration systems**[26]	To be retained and disposed of in accordance with the requirements for the type of records they comprise.
2.6.1	Systems (eg Cerner/I Soft PAS systems) that consist of and manage patient personal (PMI), admission, transfer, separation (ATS) and disease index (DI) details	
2.7.0	**Health Information Exchange (HIE)**	

2.7.1	Extracted electronic data from existing source systems which is aggregated for reporting, analysis and service planning purposes	Retain until no longer required for administrative or reference purposes, then review, if no longer required, then destroy
3.0.0	**PATIENT DIAGNOSIS - IMAGING SERVICES** Imaging procedures and tests performed for the purposes of patient/client diagnosis. Includes diagnostic radiology, tomography, nuclear medicine, ultrasound, magnetic resonance imaging and related diagnostic digital imaging procedures For records created prior to 1930 **see 10.0.0** For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning **see 9.0.0**	
3.1.0	**Requests**[27] Medical officer's requests for diagnostic imaging procedures	
3.1.1	Diagnostic service copy of requests for imaging procedures	Retain minimum of 3 years after receipt of the request[28], then destroy
3.2.0	**Diagnostic reports**[29] Records and reports documenting findings based on an analysis, evaluation or interpretation of recordings or procedures	
3.2.1	Patient record copy **See** **1.0.0** for patient health care records	To be retained and disposed of in accordance with the type of patient record they comprise
3.2.2	Diagnostic service copy (that is originals or copies of diagnostic reports or findings maintained by the diagnostic service)	Retain minimum of 3 years after date of report, then destroy
3.3.0	**Recordings**[30] Recordings produced for or created as a result of diagnostic processes	
3.3.1	Diagnostic visual, image or pictorial recordings. This includes x-rays, videotapes, films, photographs or equivalent image recordings.	Release to patient upon request [31] or retain: - minimum of 7 years after last attendance for diagnostic procedure, or - until patient attains or would have attained the age of 25 years, whichever is the longer, then recycle or destroy[32]

3.3.2	Diagnostic graphical recordings, that is recordings or tracings of a graphical nature created via diagnostic measuring processes eg electroencephalograms, electrocardiograms, electromyograms or cardiotocograms, where there is an abnormality detected	Retain: - minimum of 7 years after last attendance for diagnostic procedure, or - until patient attains or would have attained the age of 25 years, whichever is the longer, then recycle or destroy
3.3.3	Diagnostic graphical recordings where there is no abnormality detected	Subject to results being noted in the patient's record, retain until no longer required for administrative purposes, then destroy
3.4.0	**Registers**	
3.4.1	Registers or associated control records maintained for the purposes of identifying or locating diagnostic recordings and reports	Retain until no longer required for administrative purposes[33], then destroy
4.0.0	**PATIENT DIAGNOSIS - PATHOLOGY AND LABORATORY SERVICES** Records of procedures and tests performed on body specimens for the purposes of patient/client diagnosis [34] For records created prior to 1930 **see 10.0.0** For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning **see 9.0.0**	
4.1.0	**Requests**[35] Medical officer's requests for a diagnostic test or procedure	
4.1.1	Diagnostic service copy of requests for tests or procedures	Retain minimum of 3 years after receipt of the request [36], then destroy
4.2.0	**Diagnostic results and reports**[37] Records documenting diagnostic results, including copies or originals of diagnostic reports maintained by the pathology or laboratory service. This includes records relating to the analysis, evaluation or interpretation of the results of pathology or laboratory processes generated by an instrument or operator and the records of test result validity.	

4.2.1	Anatomical pathology, cytology (exfoliate and non exfoliate) and autopsy or post-mortem reports/records, registers, diagrams and copies of any representative images prepared	Retain minimum of 20 years from date of report, then destroy
4.2.2	Histopathology and bone marrow reports/records	Retain minimum of 20 years from date of report, then destroy
4.2.3	Blood alcohol reports/records. This includes medical practitioner declarations.	Retain minimum of 3 years from date of report or declaration, then destroy[38]
4.2.4	Haematology, clinical chemistry/chemical pathology, microbiology and immunology records	Retain minimum of 3 years from date of report, then destroy
4.2.5	Genetics reports/records. This includes karyotypes and digital images. **See also** **1.6.0** for records documenting the diagnosis of genetic or inherited disorders	These records are currently required to be retained indefinitely by the organisation responsible for their management
4.2.6	Neonatal screening (Guthrie) cards	Retain: - until child attains or would have attained the age of 25 years, or - minimum of 7 years after last action, whichever is the longer, then destroy
4.2.7	Reports documenting diagnostic findings, including autopsy/post-mortem reports) - patient record copy **See** **1.0.0** for patient health care records	To be retained and disposed of in accordance with the type of patient record they comprise.
4.3.0	**Specimens and samples**[39]	
4.3.1	Bodily specimens, samples or materials examined in a diagnostic pathology procedure. This includes slides, films, blocks, cultures and related material.	To be retained in accordance with current NPAAC minimum standards for the retention of diagnostic material
4.3.2	Registers or equivalent records of specimens collected and received. This includes laboratory information management systems.	Retain until no longer required for administrative purposes[40], then destroy
4.3.3	Extract summary data from the register used to undertake management activities (eg printouts of reports to facilitate the tracking or monitoring of testing completion) and where no data or actions are noted on that extract data	Retain until no longer required for administrative purposes, then destroy

4.3.4	Extract summary data from the register used to undertake management activities and where data or actions are noted on the extract data and not recorded on the main register (that is the extract data in effect becomes a unique record containing information not recorded elsewhere)	Retain minimum of 1 year after action is completed, then destroy
4.3.5	Retained human tissue records[41] Records associated with the management of and consents to the retention of human tissue. This includes records of statutory declarations, registers, consent forms and clinical information about the deceased etc.	Retain minimum of 20 years after tissue disposed of, then destroy
4.4.0	**Blood bank and blood collection services**[42] (autologous and homologous)	
4.4.1	Diagnostic results and reports[43]	Retain: - minimum of 10 years after last action, or - until donor attains or would have attained the age of 30 years, whichever is the longer, then destroy
4.4.2	Laboratory records of blood donations and administration of blood and blood products[43]	Retain: - minimum of 20 years after last action, or - until donor attains or would have attained the age of 30 years, whichever is the longer, then destroy
4.4.3	Registers of blood products Recorded details of fresh and pooled blood products.[44]	Retain minimum of 20 years after date of last entry, then destroy
4.4.4	Statements by persons intending to donate blood. This includes records of consents, questionnaires and associated donor records.[45]	Retain: - minimum of 20 years after last action, or - until donor attains or would have attained the age of 30 years, whichever is the longer, then destroy
4.5.0	**Semen supply**[46] **See** **1.7.0** for retention periods for donor records relating to Assisted Reproductive Technology	

4.5.1	Records relating to the business of semen supply. This includes records of: • full name and date of birth of donor • donor's written consent • the results of tests and identification of all details • the name of the medical practitioner to whom semen supplied	Retain: - minimum of 10 years after last action, or - until donor attains or would have attained the age of 30 years, whichever is the longer, then destroy
4.6.0	**Quality assurance**	
4.6.1	Records relating to the certification, implementation and audit of processes and services. This includes quality control and quality assurance records.	Retain minimum of 3 years from date of review, then destroy
4.7.0	**Equipment maintenance**	
4.7.1	Records relating to the maintenance and servicing of equipment used for diagnostic purposes	Retain minimum of 3 years after the equipment has been replaced or disposed of, then destroy
4.8.0	**Procedures and methods**	
4.8.1	Records relating to the services' approved methodologies and standard procedures for the conduct of tests and procedures	Retain minimum of 3 years after methods/procedures superseded, then destroy
5.0.0	**PHARMACEUTICAL SUPPLY AND ADMINISTRATION**[47] Management of the supply, administration, dispensing and use of pharmaceuticals, encompassing drugs, poisons and other substances. For records created prior to 1930 **see 10.0.0** For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning **see 9.0.0**	
5.1.0	**Dispensation and supply**[48]	
5.1.1	Records relating to the supply and dispensation of pharmaceuticals. This includes requisitions, prescriptions, records of medication chart orders, records of supply other than on prescription and receipts/records of delivery.	Retain minimum of 2 years after date of supply, then destroy

5.1.2	Medication charts[49] and incident reports **See** **1.0.0** for patient health care records	To be retained and disposed of in accordance with the type of patient record they comprise
5.1.3	Registers. This includes Registers of drugs of addiction (H31, H32) held in the Pharmacy Department, Ward or other department.	Retain minimum of 7 years[50] after date of last entry, then destroy
5.1.4	Stock and inventory control records. This includes requisitions and orders for pharmaceutical products or substances and receipts/records of delivery.	Retain minimum of 2 years after date of last entry or action, then destroy
5.1.5	Section 100 (highly specialised) drugs.[51] This includes prescriptions and declaration forms signed by the prescriber.	Retain minimum of 7 years after date of receipt, then destroy
5.1.6	Special Access Scheme (SAS) drugs consent forms for non-admitted patients[52]	Retain: - minimum of 7 years after last action, or - until child attains or would have attained the age of 25 years, whichever is the longer, then or destroy
5.1.7	Therapeutic Drugs Administration (TGA) application forms, eg form no. 2949 (0105), where only copies are held by the public health organisation	Retain minimum of 7 years after last action, then destroy
5.1.8	Records relating to applications to prescribe drugs of addiction for persons. This includes Methadone or Buprenorphine Program records, medical reports, authorities, treatment proposals, correspondence etc. [53]	Retain minimum of 7 years after date of last entry, then destroy
5.1.9	Records relating to reports of lost or stolen drugs or lost or stolen drug registers	Retain minimum of 10 years after action completed, then destroy
6.0.0	**NOTIFICATIONS** Notification and reporting to prescribed bodies regarding patient medical conditions, instances or episodes in accordance with statutory or other requirements For records created prior to 1930 **see 10.0.0** For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning **see 9.0.0**	
6.1.0	**Births and deaths**	

6.1.1	Copies of birth registration forms[54] **See** **1.0.0** for patient health care records	To be retained and disposed of in accordance with the type of patient record they comprise
6.1.2	Copies of death certificates retained separately from the main patient record[55]	Retain minimum of 1 year after date of notification, then destroy
6.2.0	**Health reporting**	
6.2.1	Records of notification maintained by hospitals, community health services etc fulfilling obligations to report notifiable diseases etc under the *Public Health Act 1991*[56]	Retain: - minimum of 15 years after last attendance, date of death or still birth or after last official contact or access by or on behalf of the patient, or - until patient attains or would have attained the age of 25 years, whichever is the longer, then destroy
6.2.2	Records relating to the initial report of an incidence of a notifiable disease maintained by Public Health Units	Retain minimum of 7 years after receipt of the notification, then destroy
6.2.3	Duplicate records of notifications received by Public Health Units subsequent to the initial notification	Retain until no longer required for administrative or reference purposes, then destroy
7.0.0	**PATIENT/CLIENT FINANCE AND PROPERTY MANAGEMENT** Management of patient/client finances and property during their admission to a facility or service For records created prior to 1930 **see 10.0.0** For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning **see 9.0.0**	
7.1.0	**Patient property** Records relating to the management of patient property	
7.1.1	Patient Property and Wearing Apparel books	Retain minimum of 6 years after date of last entry, then destroy
7.1.2	Patient Money and Valuables register	Retain minimum of 6 years after date of last entry, then destroy

7.1.3	Patient Money and Valuables register where a copy page from the register is maintained in the patient file and the copy page is used to record the movement and disposal of property and money to the patient etc[57]	Retain minimum of 1 year after date of last entry, then destroy
7.1.4	Patient/client authorities to make payment or transfer property	Retain minimum of 6 years after date of last entry, then destroy
7.2.0	**Patient/client accounts and finances** Records relating to the management of patient finances including accounts, benefits and claims	
7.2.1	Assigned Benefits Claim books	Retain minimum of 1 year after last completed entry, then destroy
7.2.2	Hospital Private Patient Claim and Assignment form (HC21) and Patient Election forms	Retain minimum of 6 years after action completed, then destroy
7.2.3	Register of Patient Admission and Account forms	Retain minimum of 6 years after date of last entry, then destroy
7.3.0	**Program of Appliances for Disabled People (PADP)**[58]	
7.3.1	Applications for PADP aids, appliances and services	Retain minimum of 3 years after last with or use of service, then destroy
7.3.2	Records relating to the provision and maintenance of PADP services	Retain minimum of 5 years after action completed, then destroy
8.0.0	**RESEARCH MANAGEMENT** Management of the conduct of clinical and non-clinical research, trials or studies etc[59] **Note:** This does not apply to records created and maintained by Committees formed to oversight the conduct of research activities (eg Research Ethics Committees) For records created prior to 1930 **see 10.0.0** For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning **see 9.0.0**	
8.1.0	**Research projects, trials or studies**	
8.1.1	Records relating to the conduct of clinical research. This includes records or documentation relating to the recruitment and consent of research participants, the collection and analysis of data, preliminary findings, surveys and results.	Retain minimum of 15 years after date of publication or termination of the study, then destroy[60]

8.1.2	Records relating to the conduct of non clinical research or research not involving humans. This includes records or documentation relating to the recruitment and consent of research participants, the collection and analysis of data, preliminary findings, surveys and results.	Retain minimum of 5 years after date of publication or completion of the research or termination of the study, then destroy
8.1.3	Records of requests to access records for approved clinical research purposes where the research proceeds [61]	Retain minimum of 15 years after the expected research completion date or date of termination of the study, then destroy
8.1.4	Records of requests to access records for approved non clinical research purposes where the research proceeds	Retain minimum of 5 years after the expected research completion date or date of termination of the study, then destroy
8.1.5	Records of requests relating to projects where the research does not proceed	Retain minimum of 3 years after last action, then destroy
9.0.0	**RECORDS IMAGING** Duplication of records by means of imaging technologies for storage, access, reference or related management purposes	
9.1.0	**Records that have been imaged** This refers to records identified in the previous sections which have been subject to processes resulting in the creation of authentic, complete and accessible image copies in digital or microform format and which are not required as State archives.[62]	
9.1.1	Originals of records that have been imaged and that are not required as State archives **See** section 2.4 of Part 2 of this Authority for additional conditions relating to the destruction of originals.	Retain until all requirements for the retention of the originals have been fulfilled[63], then destroy
9.1.2	Master copies of imaged records	Retain in accordance with the retention period and disposal action that applied to the original record
9.1.3	Reference, working or superseded copies of imaged records	Retain until no longer required for reference purposes, then destroy
9.1.4	Affidavits and documentation relating to records authenticity	Retain until the master copy of the records to which they relate is destroyed or superseded, then destroy

10.0.0	**PRE 1930 RECORDS**	
10.1.0	Patient/client records created prior to 1930. This refers to records identified in the previous sections created wholly or in part prior to 1930. **See** section 2.3 of Part 2 of the Authority for further guidance concerning proposals for the transfer of these records	Required as State archives

[1] See Part 1, section 1.2 above for the scope of records relating to or of a patient's/client's treatment and care.

[2] Health care records are to incorporate original observations. Transcribing is not an endorsed practice and should be avoided. Summary records are to be managed in accordance with the purpose for which they were created.

[3] The term 'teaching' previously used to categorise hospitals has been replaced with the groups as listed in the NSW Health Department document *NSW Peer Hospital Groups 2001/02*. Hospitals listed under 1.1.1 are groups A1a, A1b, A2 and A3. Hospitals listed under 1.1.2 (Groups B to F) cover all hospitals, nursing homes, rehabilitation facilities, hospices, Multi Purpose Services etc that are **not** Group A Principal Referral, Paediatric Specialist or ungrouped Acute hospitals. If any further groups are added beyond F they will fall into this category and should retain records in accordance with the minimum retention periods identified for this category.

[4] 'Access by or on behalf of the patient' refers to any use made of the record or access to the records for any purpose directly concerning the patient, such as attendance by the patient, provision of a report to another health care worker or agency, access under subpoena, inspection by the patient or their legal representative. Access for research, quality assurance, audit or educational purposes or by next of kin checking medical history does not constitute 'access by or on behalf of the patient'.

[5] If an abnormality is detected then the record should be incorporated into the main Community Health client record system.

[6] Where possible these records should be filed, maintained and stored separately from the main (unit) patient record. Diagnostic results held in other departments should be returned to the genetics department. Where records are maintained as part of the individual's patient record the records must be maintained for the minimum retention period specified in this section.

[7] Where possible these records should be filed, maintained and stored separately from the main (unit) patient record. Where records are maintained as part of the individual's main (unit) patient record the records must be maintained for the minimum retention period specified in this section. For further information concerning recordkeeping requirements for the accreditation of Reproductive Medicine Units refer to NSW Department of Health Circular no. 97/49 and the National Health and Medical Research Council (NHMRC) *Ethical Guidelines on Assisted Reproductive Technology*.

[8] Where possible these records should be filed and maintained as part of the main (unit) patient/client record and retained accordingly. If there is no record of the patient, note receipt of the correspondence in the correspondence log book or register and return to sender.

[9] Where possible a copy of the request/referral form is to be filed and maintained as part of the main (unit) patient/client record and retained accordingly. This retention period encompasses Health Insurance Commission requirements to retain private patient referrals/requests for at least 18 months.

[10] A copy of any incident report or notification is to be filed and maintained as part of the main (unit) patient/client record and retained accordingly. Correspondence and associated records relating to the handling of these matters should be filed and maintained separately from the individual patient record.

[11] Records of an investigation into or analysis of the cause of an incident (Root Cause Analysis) are to be appropriately managed and retained in accordance with the retention periods identified in this section.

[12] Where possible a copy of any medical certificate issued is to filed and maintained as part of the main (unit) patient/client records and retained accordingly.

[13] A photocopy of the print-out should be made and kept with the original as fading may occur.

[14] Records relating to the registration, identification, admission, discharge, transfer etc of patients/clients maintained in electronic formats must be maintained in a readily accessible format for as long as they are required to be retained in accordance with the identified minimum retention period for the class of record they constitute.

[15] Services are required to create and maintain these records. The PMI or Number register is the key to locating an individual's patient record in the medical records filing system as it provides a link between the name of the patient and the facility's medical record number.

[16] The index or register will need to be retained for as long as it is required for the purpose of locating individual patient records and, where the index or its equivalent records the details of the disposal of individual records, for an appropriate period thereafter to account for the disposal of individual patient records. Depending on other types of records maintained, the PMI may be required to be retained indefinitely.

[17] Services are required to create and maintain these records. In addition to the patient's name, medical record number and disease/condition and operation/procedure codes relevant to each episode of care, details recorded may also include age,

sex, date of admission, length of stay, discharge status and destination, responsible doctor or unit (name or code identifier), ward.

[18] Services are required to create and maintain these records. Information recorded should include date and time of birth, mother's name, sex of child and names of medical and nursing staff in attendance. Details recorded may also include mother's medical record number, age and address.

[19] Services are required to maintain this register in accordance with NSW Department of Health Circular no. 98/114 *Register of Deaths*.

[20] Services are required to maintain this register in accordance with NSW Department of Health Circular no. 94/122 *Register of surgical operations*.

[21] Services are required to create and maintain these records for the purposes of product recall. If details of surgically implanted devices are retained in a form other than a register it is to be ensured that such details are retained and recoverable in accordance with the requirements of this section.

[22] A Register of Electro Convulsive Therapy is required to be maintained under s.196 of the *Mental Health Act 1990* and in accordance with the form prescribed by the *Mental Health Regulation 2000*.

[23] Services are required to maintain this register in accordance with NSW Department of Health Circular no. 94/127 *Policies on seclusion practices, the use of restraints and the use of IV sedation in psychiatric in-patient facilities*.

[24] Services are required to maintain this register in accordance with NSW Department of Health Circular no. 93/8 *Policies and procedures on the use of psychotropic drugs in mental health services*.

[25] Where records are created and used for the purposes of data entry the determination of appropriate retention periods must allow adequate time for data verification and audit requirements.

[26] Records maintained within these systems are to be sentenced in accordance with entries **2.1.1** to **2.2.6**. Organisations should have in place strategies for managing the deletion of records from the system when they are no longer required and for the ongoing maintenance of access to patient registration details that are required to be retained permanently as State archives.

[27] Details of requests for diagnostic procedures or tests should be recorded and maintained as part of the main (unit) patient record, eg as part of the progress notes or a copy of the request is attached to the file, and retained accordingly.

[28] This retention period encompasses Health Insurance Commission requirements to retain private patient referrals/ requests for at least 18 months.

[29] The original or a copy of any diagnostic report should also be maintained as part of the main (unit) patient record and retained accordingly.

[30] Recordings produced by diagnostic services should be retained in the originating department or area, for example radiographic films or diagnostically equivalent recordings should be retained in the Radiography/Radiology Department. If recordings are digitally stored the retention periods specified in this section are the minimum retention requirements for the records.

[31] If a patient requests a diagnostic recording and the recording is not required for possible future treatment or other requirements, for example litigation, the recording can be released subsequent to the patient signing for its release.

[32] If it is known that the recordings could possibly be required for legal action or compensation claims, the recordings should retained for appropriate time periods, that is at least until the legal action has been completed. If it is known that an adverse event has occurred the visual recording associated with that event should be retained until the matter has been resolved or for the minimum retention period as specified, whichever is the longer.

[33] The records should be retained for as long as they might conceivably be required for the purposes of locating a recording or, where the records contain the details of the disposal of individual recordings, accounting for the disposal of the recording.

[34] Retention periods for these records reflect current minimum standards considered acceptable for good laboratory practice in relation to the retention of laboratory records and diagnostic material established by the National Pathology Accreditation Advisory Council (NPAAC) *Retention of Laboratory Records and Diagnostic Material*, 3rd edition, 2002. Laboratories involved in biochemical, molecular genetics or newborn screening should refer to current NPAAC standards for details of specific requirements applying to them.

[35] Details of requests for diagnostic procedures or tests should be recorded and maintained as part of the main (unit) patient record, eg as part of the progress notes or a copy of the request is attached to the file, and retained accordingly.

[36] This retention period encompasses Health Insurance Commission requirements to retain private patient referrals/ requests for at least 18 months.

[37] The original or a copy of any diagnostic report, including autopsy/post-mortem reports, should also be maintained as part of the main (unit) patient record and retained accordingly.

[38] Regard should be had to potential retention requirements for legal purposes. **See 1.14.0**

[39] Bodily specimens and samples do not constitute 'recorded information' for the purposes of the State Records Act.

[40] Retention periods should be in accordance with the minimum retention required for the type/s of specimens recorded in the register, **see 4.3.1**, and, where these records contain the details of the disposal of individual specimens, the records should be retained for as long as they might conceivably be required for the purposes of accounting for the disposal of the specimen.

[41] Where any tissue, organ or body part is retained for purposes (eg teaching or research) other than for which originally taken or examined (eg for the purposes of treatment, diagnosis, autopsy or post-mortem) then the provisions of the *Human Tissue and Anatomy Legislation Amendment Act 2003* apply.

[42] These records should be created and maintained in accordance with the requirements of the *Human Tissue Act 1983*, *Human Tissue and Anatomy Legislation Amendment Act 2003*, *Human Tissue Regulation 2000* and the Therapeutic Goods

Administration (TGA) *Australian Code of Good Manufacturing Practice (GMP) for Therapeutic Goods: Blood and Blood Products*. The retention periods identified for these records reflect current minimum standards established by the GMP code and NPAAC.

[43] See *Human Tissue Regulation 2000* Schedule 3 for full details of recordkeeping requirements

[44] Details recorded should include date of receipt, identification number of donation or batch/s, including the quantity in each batch, date of transfusion, date of issue to ward and blood group of product if applicable.

[45] See *Human Tissue Regulation 2000* Schedule 3 for full details of recordkeeping requirements

[46] See *Human Tissue Regulation 2000* Schedule 4 for full details of recordkeeping requirements

[47] The *Poisons and Therapeutic Goods Act 1966* and the *Poisons and Therapeutic Goods Regulation 2002* require certain records to be created and maintained by those responsible for the control, storage and supply of certain substances and drugs of addiction. These records should be maintained by the relevant area, department or ward of the service, for example pharmacy records should be maintained in the Pharmacy Department, ward records in the ward. The minimum retention periods for these records reflect current minimum retention requirements in accordance with the Regulation. The *National Health Act 1953* (C'wealth) also regulates the retention of prescription and order forms.

[48] Requisitions, prescriptions, orders etc for drugs of addiction, pentazocine or drugs listed in the *Poisons and Therapeutic Goods Regulation 2002* Appendix B are to be maintained separately to other pharmaceutical supply records. Refer also to NSW Department of Health circular no. 97/10 *Guidelines for the handling of medication in community based health services and residential facilities in NSW* and 01/64 *Policy on the handling of medication in NSW public hospitals*.

[49] Drug or medication charts comprising the medication orders written by medical staff and records of administration written by nursing or medical staff should be filed and maintained as part of the main (unit) patient record and retained accordingly.

[50] Services should note that this is longer than the 2 year period required by the *Regulation*.

[51] **See** NSW Department of Health circular no. 2000/83 *Section 100 highly specialised drugs program guidelines*

[52] Consent forms for admitted patients are to be placed on the main (unit) patient record and retained and disposed of in accordance with the type of patient record they comprise. **See 1.0.0** for patient health care records

[53] These records are held by the NSW Health Pharmaceutical Services Branch.

[54] A copy of the birth registration form is given to the parents and where possible a copy is to be filed and maintained as part of the main (unit) patient record.

[55] Where possible a copy of the death certificate is to be filed and maintained as part of the main (unit) patient record and retained accordingly.

[56] Notification requirements are outlined in NSW Department of Health Circular no. 2001/9 *Notification of diseases under the Public Health Act 1991*. Documents maintained as part of the patient record are to be retained and disposed of in accordance with the type of patient record they comprise. For the retention and disposal of cancer notification forms and registers, including the PAP Test Register, maintained by the NSW Department of Health see Disposal Authority DA25, entry 7.2.0 re data collections.

[57] Services or facilities must have in place a system to be able to undertake an inventory of items held at any time.

[58] Regard should be had to the expected life span of the equipment before destruction of records proceeds.

[59] Retention periods are based on recommendations for the retention of research data in Section 2.3 of the *Joint National Health and Medical Research Council (NHMRC)/Australian Vice-Chancellor's Committee (AVCC) Statement and Guidelines on Research Practice* (May 1977). See also the International Committee for Harmonisation (IHC) *Guidelines for Good Clinical Practice*, sections 4.9.4 and 4.9.5 and the NHMRC *National Statement on Ethical Conduct in Research Involving Humans* (1999).

[60] NHMRC guidelines recommend that where materials of a biological origin are being used in a clinical trial or research project records should be retained for appropriate periods of time to monitor effects and trace all participants in the event that late or long term effects emerge. Where the data is crucial to the substantiation of research findings and cannot readily be duplicated elsewhere, longer retention periods may also be appropriate.

[61] Where possible requests to access records for research purposes should be maintained as part of the patient record and retained accordingly.

[62] Originals of records required as State archives that have been imaged are not to be destroyed.

[63] The determination of appropriate retention periods for the originals of records that have been imaged must allow adequate time for data verification and audit requirements. Originals of records that have been imaged or duplicated in a way that does not comply with the requirements of the *Evidence Act 1995* will need to be retained and disposed of in accordance with the requirements for the type of records they comprise.

Part 2: Understanding and Using the Authority

2.1 Overview

Purpose

The purpose of issuing the *General Retention and Disposal Authority – Public Health Services: Patient/Client records* is to permit public health services and facilities to destroy certain health care records of patients and clients, after appropriate minimum retention periods have been met, and to identify which patient/client records are required as State archives.

Previous disposal authorisations superseded

This disposal authority supersedes previous disposal authorisation in the following authority:

General Disposal Authority	**Parts superseded**
Public Health Services: Patient/Client Records (GDA5) 1999	Whole

Changes to retention periods to note:

Assisted Reproductive Technology	**see 1.7.0**
Diagnostic recordings, including x-rays, graphical recordings etc	**see 1.3.1** and **3.3.0**
Diagnostic results and reports maintained by pathology or laboratory services	**see 4.2.0**
Drugs registers	**see 5.1.3**

What records does this authority cover?

This Authority authorises the disposal of:

- records relating to the treatment and care of individual patients and clients within the NSW public health system, including records of allied health care services and research participants
- patient administration registers, systems and databases used to record summary information about patients and clients
- records relating to diagnostic imaging and pathology and laboratory services
- records relating to the supply and administration of pharmaceuticals, encompassing drugs, poisons and other substances
- records of notifications to prescribed bodies concerning patient medical conditions
- records relating to the management of patient and client finance and property during the period of their admission to a facility or service

Date range of records covered

Patient/client records listed in this authority created wholly or in part prior to 1930 are required as State archives (see also **2.3** below). For records created wholly after 1930 the minimum retention periods and disposal actions identified in this authority apply to the various classes of records listed.

What records are not covered

This Authority does not cover records relating to the management and administration of public health organisations. Services should consult the following for disposal authorisation.

For records relating to the function or activity of:	Use the following General Retention and Disposal Authority
General administration (ie not health sector specific)	General Retention and Disposal Authority – Administrative records
Personnel	General Retention and Disposal Authority – Personnel records
Financial management	General Retention and Disposal Authority – Financial and Accounting records

How long is this authority in force?

This authority will remain in force until it is superseded by a new authority or it is withdrawn from use by State Records.

Providing feedback

To suggest amendments or alterations to this Authority please fill out the suggestion form or contact us via email disposal@records.nsw.gov.au or phone (02) 8247 8636.

Further assistance

To obtain assistance in the interpretation or implementation of this Authority, or any of our general retention and disposal authorities, contact us via email disposal@records.nsw.gov.au or phone (02) 8247 8636.

2.2 Guidelines for implementation

Introduction

Comprehensive information about implementation of disposal authorities is found in State Records' guideline on sentencing records, guideline on destruction of records and procedures for transferring records to State Records custody.

Minimum retention periods

The Authority specifies minimum retention periods for all records not required as State archives. A Service must not destroy or otherwise dispose of records before the minimum retention period has expired. Services may retain records for longer periods of time, subject to organisational need, without further reference to State Records. Reasons for longer retention can include legal requirements, administrative need, on-going research use or government directives.

Retention of electronic records

Electronic records must be protected and readily accessible for the specified minimum retention period. See *Future Proof: Ensuring the accessibility of equipment/technology dependent records* for information relating to managing the accessibility of electronic and other technology dependent records.

Destroying records

When the authorised minimum retention period has been reached, appropriate arrangements for the destruction of records can be made. Destruction of records in accordance with the Authority may be undertaken without further reference to State Records, unless otherwise advised. Persons using the Authority should apply it with caution, bearing in mind that the authorisations for disposal are given in terms of the State Records Act only. It is the responsibility of the public office to ensure that all legal and other requirements for retention of records have been met before disposing of any of its records. A public office must not destroy any records where the public office is aware of possible legal action, investigation or inquiry where the records may be required as evidence.

Transferring records required as State archives

Records identified in the Authority as being required as State archives should be prepared for transfer to State Record's custody and/or control only when they are no longer required for ongoing business use.

Transfer of ownership must be authorised

Regardless of whether a record has been authorised for destruction or is required as a State archive, a public office must not transfer ownership of a State record to any person or organisation without the explicit authorisation of State Records.

2.3 Records required as State archives

Introduction

Records which are to be retained as State archives are identified with the disposal action *Required as State archives*.

Pre 1930 records

Patient/client records listed in this authority created wholly or in part prior to 1930 are required as State archives (for example a file started in 1913 and ending shortly after 1930). Prior to proposing to transfer pre 1930 records as State archives services should contact State Records to discuss the condition, types, content and quantities of records involved. Some records may be subject to further appraisal if State Records does not consider their retention as State archives is warranted.

Identifying significant and unique records

The provisions relating to significant or unique collections of patient records (see 1.12.0) are included for special exceptions that may arise from time to time. Individual services may identify exemplary or significant collections of records amongst their holdings that warrant ongoing retention as State archives. This may be because the service has taken a leading role in the development and delivery of new or specialised treatments or because the records:

- illustrate or provide comparative insight into the provision of services to particular community groups
- illustrate or provide comparative insight into aspects of treatment, care and the delivery of services over time
- document significant achievements in research or break throughs in research or relate to research of major national or international significance, interest or controversy
- document significant outbreaks of disease that represented major public health risks and their

impact

- document critical points of change or developments in the treatment or management of a particular type of condition, illness or disease
- relate to the diagnosis, management, treatment of or research into particularly rare diseases or conditions and would significantly enhance and contribute to the existing body of knowledge of these diseases or conditions

This may encompass records relating to a particular time period or to the treatment of a particular illness or condition or records of a specific service, facility or research project.

Services that think that they hold records of significance should contact State Records.

2.4 Records that have been imaged

This authority authorises the destruction of the originals of health care records that have been imaged provided that the following conditions have been met:

- the records are not identified in the authority as State archives
- all requirements for retaining the originals have been assessed and fulfilled
- copies are made which are authentic, complete and accessible for the authorised minimum retention period

See *Future Proof: Ensuring the accessibility of equipment/technology dependent records* for information relating to managing the accessibility of technology dependent records and *Digital Imaging and Recordkeeping* for guidance concerning the use of imaging technologies.

Part 3: Acknowledgements and sources

Introduction

The *General Retention and Disposal Authority – Public Health Services: Patient/Client Records* has been developed as a result of extensive research and consultation. Drafts of the Authority were circulated widely for comment and feedback was received from many health sector organisations. Written sources used include legislation, publications and web sites.

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Dr Milton Lewis, Senior Research Fellow, School of Public Health, University of Sydney

National Health and Medical Research Council

NSW Chief Radiation Therapist Group

NSW College of Nursing

NSW Operating Theatre Association

Red Cross Blood Transfusion Services

Royal Australasian College of Radiologists

School of Health Information Management, Faculty of Health Science, University of Sydney

School of Health Services Management, University of NSW

South Western Pathology Services

Sources: Legislation (available at www.legislation.nsw.gov.au)

Health Administration Act 1982

Health Services Act 1997

Human Tissue Act 1983

Human Tissue and Anatomy Legislation Amendment Act 2003

Human Tissue Regulation 2000

Mental Health Act 1990

Mental Health Regulation 2000

Poisons and Therapeutic Goods Act 1966

Poisons and Therapeutic Goods Regulation 2002

Public Health Act 1991

Sources: Publications

International Committee for Harmonisation (IHC) *Guidelines for Good Clinical Practice* 1996

National Health and Medical Research Council *Joint National Health and Medical Research Council*

(NHMRC)/Australian Vice-Chancellor's Committee (AVCC) Statement and Guidelines on Research Practice May1977

National Health and Medical Research Council *Ethical Guidelines on Assisted Reproductive Technology* 1996

National Health and Medical Research Council *Human Research Ethics Handbook* 2002

National Health and Medical Research Council *National Statement on Ethical Conduct in Research Involving Humans* 1999

National Pathology Accreditation Advisory Council (NPAAC) *Retention of Laboratory Records and Diagnostic Material*, 3rd edition, 2002

NSW Department of Health *Circulars*

NSW Department of Health *Health Records and Information Manual for Community Health Facilities*

NSW Department of Health *Patient Matters Manual*

Therapeutic Goods Administration *Australian Code of Good Manufacturing Practice (GMP) for Therapeutic Goods: Blood and Blood Products* 1995

Therapeutic Goods Administration *Guidelines for Good Clinical Research Practice in Australia* 1991

Part 4: Index

Index

The following index is provided to enable easy reference to the *General Retention and Disposal Authority – Public Health Organisations: Patient/Client Records*.

References

The index provides the reference number for either a specific entry or a section. Where the reference is to a section the index term may appear in several entries within that section.

The index also includes cross references where appropriate.

A

B

D

E

F

G

H

L

M

N

Q

R

S

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