

APPRAISAL LOG

Health Sector (Clinical Records) Retention and Disposal Schedule

Date: 27 July 2021

EXPLANATORY NOTES

APPLICABLE LEGISLATION/STANDARDS FOR THE HEALTH SECTOR IN QUEENSLAND

There are numerous regulatory and legislative requirements – as well as professional codes, standards, guidelines and policies – that apply to creating, keeping and managing public records for the Health Sector in Queensland. Below is a comprehensive listing of applicable legislation and standards that have been identified as relevant to public records that are managed under the Health Sector (Clinical Records) retention and disposal schedule:

LEGISLATION THAT APPLIES TO QUEENSLAND HEALTH:

- *Adoption Act 2009* (Qld)
- *Ambulance Service Act 1991* (Qld)
- *Births, Deaths and Marriages Registration Act 2003* (Qld)
- *Child Protection Act 1999* (Qld)
- *Civil Liability Act 2003* (Qld), schedule 2
- *Coal Mining and Safety and Health Act 1999* (Qld)
- *Coal Mining Safety and Health Regulation 2017*(Qld)
- *Coroners Act 2003* (Qld)
- *Electronic Transactions (Queensland) Act 2001* (Qld)
- *Explosives Act 1999* (Qld)
- *Evidence Act 1977* (Qld)
- *Food Act 2006* (Qld)
- *Forensic Disability Act 2011*(Qld)
- *Guardianship and Administration Act 2000* (Qld)
- *Health Act 1937* (Qld)
- *Health (Drugs and Poisons) Regulation 1996* (Qld)
- *Health Ombudsman Act 2013* (Qld)
- *Health Practitioner Regulation National Law Act 2009* (Qld)
- *Hospital and Health Boards Act 2011* (Qld)
- *Hospital Foundations Act 2018* (Qld)
- *Information Privacy Act 2009* (Qld)
- *Limitation of Actions Act 1974* (Qld)

- *Mater Public Health Services Act 2008 (Qld)*
- *Mental Health Act 2016 (Qld)*
- *Mining Safety and Health Legislation (Coal Workers' Pneumoconiosis and Other Matters) Amendment Regulation 2016 (Qld)*
- *Mining and Quarrying Safety and Health Act 1999 (Qld)*
- *Mining and Quarrying Safety and Health Regulation 2017(Qld)*
- *National Health Act 1953 (Cth)*
- *National Health (Pharmaceutical Benefits) Regulations 1960 (Cth)*
- *Pest Management Act 2001 (Qld)*
- *Pharmacy Business Ownership Act 2001(Qld)*
- *Private Facilities Health Act 1999 (Qld)*
- *Public Health Act 2005 (Qld)*
- *Public Health (Infection Control for Personal Appearance Services) Act 2003 (Qld)*
- *Public Records Act 2002 (Qld)*
- *Public Service Act 2008 (Qld)*
- *Queensland Institute of Medical Research Act 1945 (Qld)*
- *Queensland Mental Health Commission Act 2013 (Qld)*
- *Radiation Safety Act 1999 (Qld)*
- *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003 (Qld)*
- *Right to Information Act 2009 (Qld)*
- *Tobacco and Other Smoking Products Act 1998 (Qld)*
- *Termination of Pregnancy Act 2018 (Qld)*
- *Transplantation and Anatomy Act 1979 (Qld)*
- *Water Fluoridation Act 2008 (Qld)*
- *Workers' Compensation and Rehabilitation Act 2003 (Qld)*
- *Workers' Compensation and Rehabilitation Regulation 2014 (Qld)*

PUBLISHED MATERIALS FROM QUEENSLAND GOVERNMENT DEPARTMENTS AND PROFESSIONAL BODIES INCLUDING, BUT NOT LIMITED TO, STANDARDS, GUIDELINES, POLICIES AND CODES

- Department of Child Safety, Youth and Women:
 - Suspected Child Abuse and Neglect (SCAN) Team System Manual (2019)
 - Child Safety Practice Manual

- Department of Health (QLD)
 - Assignment of Unique Unit Record Number Standard (QH-IMP-280-3:2014)
 - Clinical Documentation Guideline
 - Clinical Records Management Policy (QH-POL-280:2014)
 - Coronavirus (COVID-19) data and application custodianship policy (QH-POL-477:2020)
 - Coronavirus (COVID-19) data and application custodianship guideline (QH-GDL-477:2020)
 - Documentation of date and time entry in the paper based health record Standard (QH-IMP-279-2:2013)
 - Guideline for Medical Imaging – Patient identification and procedure matching (QH-GDL-957:2015)
 - Guideline for the Provision of Diagnostic Imaging Reports (QH-GDL-017:2013)
 - Governance of Outpatient Services Policy (QH-POL-300:2010)
 - Health Innovation, Investment and Research Office, Health Service Directive, Research Ethics and Governance (QH-HSD-035:2016)
 - Health Innovation, Investment and Research Office, Standard of Practice (No. 80): Case Report Forms, Source Documents, Record Keeping and Archiving
 - Health Innovation, Investment and Research Office, Standard of Practice (No.130): Site Close Out and Archiving
 - Hospital and Health Service Human Research Ethics Committee guidelines
 - Maternity and Neonatal Clinical Guideline – Normal birth (2018)
 - Maternity and Neonatal Clinical Guideline – Standard care (2018)
 - Maternity and Neonatal Clinical Guideline – Stillbirth care (2018)
 - Mental Health Alcohol and Other Drugs Branch, Chief Psychiatrist Policy – Examination and assessment (2020)
 - Mental Health Alcohol and Other Drugs Branch, Chief Psychiatrist Policy – Judicial Orders: Examination Orders, Court Examination Orders and Other Judicial Orders (2020)
 - Mental Health Alcohol and Other Drugs Branch, Chief Psychiatrist Policy – Support to the Mental Health Review Tribunal (2020)
 - Office of Health and Medical Research, Researcher User Guide (2010)
 - Queensland Clinical Trials Coordination Unit (QCTCU) - COVID-19: Queensland Health Operational Guidance for sponsors, trial sites, ethics committees, research governance officer/s and researchers (April 2020)
 - Retention and Disposal of Clinical Records Standard (QH-IMP-280-1:2014)
 - Reporting a Reasonable/Reportable Suspicion of Child Abuse and Neglect (QH-GDL-948:2015)
 - Specialist Outpatient Data Collection (SODC) Manual 2018-2019 v2 (2018)
 - Specialist Outpatient Services Approved Letter Suite (QH-IMP-300-1-ATT1) (2016)
 - Specialist Outpatient Services Implementation Standard (SOSIS) (QH-IMP-300-1:2017)

- Department of Natural Resources, Mines and Energy
 - Standards for acquiring digital chest radiography images for medical surveillance of Queensland coal mine workers: Including technical quality grading guidelines for ILO classifications (September 2017)
 - Department of Natural Resources, Mines and Energy (2018) Recognised standard 14: Monitoring respirable dust in coal mines [Recommendation 19]
- Office of the State Coroner Queensland, Information for Health Professionals (2019)
- Queensland Government Customer and Digital Group (QGCDG)
 - Records governance policy
 - Records governance policy implementation guide
- Queensland Government, Mental Health Review Tribunal, Practice Direction Number 1 of 2017, Provision of Relevant material prior to hearing
- Queensland Parliament, Coal Workers' Pneumoconiosis Select Committee, Report No. 2, 55th Parliament: Coal Workers' Pneumoconiosis Select Committee: Inquiry into the re-identification of Coal Workers' Pneumoconiosis in Queensland (2017)

PUBLISHED MATERIALS FROM AUSTRALIAN GOVERNMENT DEPARTMENTS AND PROFESSIONAL BODIES INCLUDING, BUT NOT LIMITED TO, STANDARDS, GUIDELINES, POLICIES AND CODES

- Australian Commission on Safety and Quality in Health Care (ACSQHC):
 - National Safety and Quality Health Service (NSQHS) Standards (2017)
 - National Safety and Quality Health Service (NSQHS) Standards User guide for health services providing care for people with mental health issues (2018)
 - National Safety and Quality Health Service (NSQHS): Communicating for Safety Standard (2017)
 - National Safety and Quality Health Service (NSQHS) – Clinical Governance Standard (2017)
- Australian Government, Department of Health:
 - Therapeutic Goods Administration (TGA) Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) (2000)
 - Australian Health Ministers' Advisory Council National Health Genomics Policy Framework 2018- 2021 (2019)
 - Australian Health Ministers' Advisory Council Supplementary Information to the National Health Genomics Policy Framework 2018 – 2021 (2019)
 - Coronavirus Disease 2019 (COVID-19) - CDNA National Guidelines for Public Health Units (2020)
 - Diagnostic Imaging Accreditation Scheme - Practice Accreditation Standards (2016)
- AS 2828.1:2019 - Health records, Part 1: Paper health records
- AS 2828.2:2019 - Health records, Part 2: Digitized health records

- Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (2014)
- National Health and Medical Research Council
 - Australian Code for the Responsible Conduct of Research (2018)
 - Commonwealth Department of Health & Therapeutic Goods Administration (TGA) – COVID-19: Guidance on clinical trials for institutions, HRECs, researchers and sponsors
 - Ethical guidelines on the use of assisted reproductive technology in clinical practice and research (2017)
 - Ethical Guidelines for organ transplantation from deceased donors April 2016
- National Pathology Accreditation Advisory Council – Requirements for the retention of laboratory records and diagnostic material (Seventh Edition 2018)
- Parliament of Australia, Fifth Interim Report (Black Lung) (2016)
- Society of Hospital Pharmacists of Australia, Standards of Practice for Clinical Pharmacy Services (2016)
- Standards Australia, Information and documentation – Part 1: Concepts and principles (AS ISO 15489.1:2017)
- Standards Australia (2009) Workplace atmospheres – Method for sampling and gravimetric determination of respirable dust (AS 2985:2009) [Recommendation 19]

PUBLISHED MATERIALS FROM INTERNATIONAL PROFESSIONAL BODIES INCLUDING, BUT NOT LIMITED TO, STANDARDS, GUIDELINES, POLICIES AND CODES

- International Labour Organization (ILO)
 - Guidelines for the use of the ILO International Classification of Radiographs of Pneumoconiosis (Occupational Safety and Health Series 22) Revised edition 2011, p.17
 - International Labour Organization (ILO) (2011) International Classification of Radiographs of Pneumoconioses [Recommendations 53, 57 and pages 85, 171]
- Royal Australian and New Zealand College of Radiologists, Clinical Radiology Written Report Guidelines - Faculty of Clinical Radiology (2017)
- Records management – Physical storage (AS/NZS 1015:2011)
- Thoracic Society of Australia and New Zealand (developed in partnership with Qld Government) (2017) Standards for the delivery of spirometry for coal mine workers [Recommendation 39(d)]

CLINICAL RECORDS – GENERAL

Records displaying evidence of clinical care and health status to an individual or groups of patients/clients.

For specific clinical records having different retention periods or special requirements other than those covered by this Section, see [CLINICAL RECORDS – EXCEPTIONS](#)

For non-clinical pharmacy records, including records of Schedule 8 controlled drugs and Schedule 4 restricted drugs that are not individual clinical records see PHARMACEUTICAL - [Health Sector \(Corporate Records\) retention and disposal schedule](#), sections 2622, 2623 and 2624.

Such records under the corporate schedule include records of Schedule 8 controlled drugs made in accordance with Chapter 2, Part 7, and Schedule 4 restricted drugs made in accordance with Chapter 3, Part 7 of the Health (Drugs and Poisons) Regulation 1996 (Qld).

Disposal Authorisation	Record class and retention period	Justifying the retention period
2654	<i>Clinical records - Adults</i> Records displaying evidence of clinical care and health status to an individual or groups of adult patients/clients attaining 18 years of age or over. Records may include, but are not limited to: - Admitted, non-admitted or emergency. - Assessment, observation, screening or monitoring, diagnosis, investigation, management and care planning, coordination, consultation, treatment, follow-up and referral, crisis and general counselling, allied health consultations, disease prevention, early intervention,	Date authorised: 27 July 2021 Why are these records created: The Clinical records - Adults records are created to provide evidence of the clinical care of an individual patient/client or a group of patients/clients. These records are referred to when providing continued care for the patient/client for an ongoing medical condition and may also be accessed to provide information about past clinical care that may impact on current treatment and care for the patient/client. A unique record number (URN) is allocated to a patient at a facility. It is a permanent identification number that is assigned to the patient and used to identify the patient and their associated information. If a patient attends another health facility, they will be allocated another URN at this facility. Why the records are retained for this retention period: The retention period allows sufficient time for records to be retained for referral by practitioners to comprehensive medical histories for medical conditions that may require sporadic or ongoing treatment. The retention period also covers the limitation of action rights of the patient/client outlined in the <i>Limitation of Actions Act 1974</i> (Qld). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	liaison and support, and advice provision. - Medication orders, medication chart, discharge medication records, pharmacy copies of prescription forms and records relating to pharmacy or medication orders written by the prescriber and the record of administration written by health professionals. - 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). - Diagnostic Imaging, Audio and Other Similar Material kept on the clinical file. Includes but is not limited to, request forms with pertinent diagnostic information and annotation diagrams, relevant video records and clinical photographs, radiologists working notes and microform master copies of clinical records and images. - Consent or authority to carry out any treatment, procedure or release of information. Also, refusal of treatment or withdrawal of consent.	Comparison with other schedules' retention period: ACT: Destroy 15 years after last action (see 019.169.002) NSW: Destroy 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 (see 1.1.0) NT: Destroy 15 years after last attendance or 15 years after last access on behalf of patient for whatever reason (provided that the patient has attained the age of 25 years) (Class 1.1.1) SA: Destroy 15 years after last contact (see 1.1.1) TAS: Destroy 15 years after last attendance or last access on behalf of patient (provided patient has attained the age of 30 years) and 15 years after resolution of the legal matter (see 2.1.1, 2.5.0) VIC: Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age (see 1.1.1) WA: Destroy 15 years after last attendance or date of last access (provided the patient has attained the age of 25 years) (see 1.1). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 1.1 Clinical Records – Adults: Retain for 10 years after last patient/client service provision or medico-legal action.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Copies of death notifications, autopsy and post-mortem reports See <u><i>Forensic and Scientific Services retention and disposal schedule for Coronial autopsies</i></u> Excludes clinical records covered in <u>CLINICAL RECORDS – EXCEPTIONS</u> of this Schedule. Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See <u><i>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</i></u> Disposal action – Temporary. Retain for 10 years after last patient/client service provision or legal action, whichever is the later.	

Disposal Authorisation	Record class and retention period	Justifying the retention period
2655	<i>Clinical records - Minors</i> Records displaying evidence of clinical care and health status to an individual patient/client who is a minor prior to attaining adulthood at 18 years of age. Records may include, but are not limited to: - Admitted, non-admitted or emergency. - Assessment, observation, screening or monitoring, diagnosis, investigation, management and care planning, coordination, consultation, treatment, follow-up and referral, crisis and general counselling, allied health consultations, disease prevention, early intervention, liaison and support, and advice provision. - Consent or authority to carry out any treatment, procedure or release of information. Also, refusal of treatment or withdrawal of consent. - Dental records displaying clinical care provided to children by the Child and Adolescent Oral Health Services formally known as School Dental Services.	Date authorised: 27 July 2021 Why are these records created: The Clinical records – Minors records are created to provide evidence of the clinical care of an individual patient/client or a group of patients/clients who are minors i.e. under the age of 18 at the time of treatment. These records are referred to when providing continued care for the patient/client for an ongoing medical condition and may also be accessed to provide information about past clinical care that may impact on current treatment and care for the patient/client. A unique record number (URN) is allocated once to a patient at a facility. It is a permanent identification number that is assigned to the patient and used to identify the patient and their associated information. If a patient attends another health facility, they will be allocated another URN at this facility. Once the individual patient reaches 28 years of age the record is then appraised and resentedenced in line with Clinical records – Adults. The URN allocated as a minor is retained. The exception is records of Children’s Health Queensland (CHQ) which would not roll over as they are a designated children’s hospital. Why the records are retained for this retention period: The retention period allows sufficient time for records to be retained for referral by practitioners to comprehensive medical histories for medical conditions that may require sporadic or ongoing treatment. To ensure that minors have the same opportunities and rights to consult their clinical records and take legal action as adult patients, the retention periods for these records are retained for 10 years after the patient has reached the age of 18 years old. This is in addition to retaining records for 10 years after last patient/service provision or legal action. The retention period covers the limitation of action rights of the patient/client once they reach adulthood at 18 years, then he or she will have until they are 21 years old to commence personal injury proceedings as outlined in the <i>Limitation of Actions Act 1974</i> (Qld). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	- Medication orders, medication chart, discharge medication records, pharmacy copies of prescription forms and records relating to pharmacy or medication orders written by the prescriber and the record of administration written by health professionals. - 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). - Diagnostic Imaging, Audio and Other Similar Material kept on the clinical file. Includes but is not limited to, request forms with pertinent diagnostic information and annotation diagrams, relevant video and clinical photographs, Child/neonate images, neonatal oximeter printouts and 3D images, radiologists working notes and microform master copies of clinical records and images. See Clinical Records – Deceased Minors for records of minors who have deceased before attaining 18 years of age	Comparison with other schedules' retention period: ACT: Destroy 15 years after the patient reaches the age of 18 years or 15 years after last action whichever is later (see 019.169.003) NSW: Destroy 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 (see 1.1.0) NT: Destroy 15 years after the patient reaches the age of 18 years or 15 years after last action whichever is later (see 019.169.003, 019.169.011) Records relating to instances of arrangements for adoption - retain as Territory Archives (see 019.169.012) Records relating to clients of the Child at Risk - destroy 75 years after date of birth of patient (see 019.169.019) SA: Destroy 15 years after last contact once child attains 18 years of age (see 1.1.2) TAS: No specific record class VIC: Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age (see 1.1.1 and 1.3.1) WA: Destroy 15 years after last attendance or date of last access (provided the patient has attained the age of 25 years) (see 1.1). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 1.2 Clinical Records – Minors: Retain for 10 years from patient/client attaining 18 years of age; AND 10 years after last service provision or medico-legal action.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	See OBSTETRIC RECORDS for records relating to stillbirth Excludes clinical records covered in CLINICAL RECORDS – EXCEPTIONS of this schedule. Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons. Disposal action – Temporary. Retain for when patient/client reaches 28 years of age AND 10 years after last patient/client service provision or legal action, whichever is the later.	

Disposal Authorisation	Record class and retention period	Justifying the retention period
2656	<i>Clinical records – Deceased Minors</i> Records displaying evidence of clinical care to an individual patient/client who was a minor and who has deceased prior to attaining adulthood at 18 years of age. Records may include, but are not limited to: - Admitted, non-admitted or emergency. - Assessment, observation, screening or monitoring, diagnosis, investigation, management and care planning, coordination, consultation, treatment, follow-up and referral, crisis and general counselling, allied health consultations, disease prevention, early intervention, liaison and support, and advice provision. - Child/neonate (28 days or less) deaths where the clinical record displays either no evidence of, or evidence of Artificial Insemination (AI) or In-Vitro Fertilisation (IVF) procedures. - Consent or authority to carry out any treatment, procedure or release of information. Also,	Date authorised: 27 July 2021 Why are these records created: The Clinical records – Deceased Minors records are created to provide evidence of the clinical care of an individual patient/client or a group of patients/clients who are minors – and yet to attain 18 years of age at the time of treatment. Because the patient/client has deceased prior to attaining 18 years of age, the retention of these records are principally required to meet any requests for access to records relating to a legal action. Why the records are retained for this retention period: Sections 5(2) and 29 of the <i>Limitation of Actions Act 1974</i> (Qld) provide that the limitation period for actions on behalf of children is three years from the date of attaining age 18 or date of death, whichever occurs first. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Destroy 15 years after the patient reaches the age of 18 years or 15 years after last action whichever is later (see 019.169.003, 019.169.021) NSW: Destroy 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 (see 1.1.0) NT: No specific record class SA: Destroy 15 years after last contact once child attains 18 years of age (see 1.1.2) TAS: No specific record class VIC: Destroy 12 years after the date of death of the patient or last access on behalf of the patient (see 2.2.4). WA: No specific record class Previous schedule reference:

Disposal Authorisation	Record class and retention period	Justifying the retention period
	refusal of treatment or withdrawal of consent. • Copies of death notifications, autopsy and post-mortem reports. • Dental records displaying clinical care provided to children by the Child and Adolescent Oral Health Services formally known as School Dental Services. • Medication orders, medication chart, discharge medication records, pharmacy copies of prescription forms and records relating to pharmacy or medication orders written by the prescriber and the record of administration written by health professionals. • 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). • Diagnostic Imaging, Audio and Other Similar Material that may be kept on the clinical file. Includes but is not limited to, request forms with pertinent diagnostic information and annotation diagrams, relevant video and clinical photographs,	Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 1.3 Clinical Records – Deceased Minors: Retain for 10 years from date of patient's/client's death; AND 10 years after last medico-legal action.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Child/neonate images, neonatal oximeter printouts and 3D images, radiologists working notes and microform master copies of clinical records and images See OBSTETRIC RECORDS for records relating to stillbirth See Clinical records – Minors for records relating to individuals yet to attain 18 years of age See Forensic and Scientific Services retention and disposal schedule for Coronial autopsies Excludes clinical records covered in CLINICAL RECORDS – EXCEPTIONS of this Schedule Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.	

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Disposal action – Temporary. Retain for 10 years from patient/client date of death AND 10 years after legal action, whichever is the later.	

CLINICAL RECORDS – EXCEPTIONS

Specific clinical records having different retention periods or other special requirements other than those covered in [CLINICAL RECORDS – GENERAL](#) of this Schedule.

Disposal Authorisation	Record class and retention period	Justifying the retention period
COAL WORKERS' PNEUMOCONIOSIS (BLACK LUNG DISEASE)		
2657	<i>Coal Workers' Pneumoconiosis (Black Lung Disease)</i> Records displaying evidence of clinical care for the treatment of an individual patient/client requiring long-term monitoring of Coal Workers' Pneumoconiosis (Black Lung Disease) caused by the inhalation of fine coal dust particles. Records may include, but are not limited to: • Medical examinations and health assessments. • All medical imaging irrespective of format or storage medium. • Diagnostic measuring processes (e.g. audiology, spirometry, electroencephalograms, electrocardiograms,	Date authorised: 27 July 2021 Why are these records created: The Coal Workers' Pneumoconiosis (Black Lung Disease) records are created to document health assessments for coal workers. Why the records are retained for this retention period: QSA specifically requested Queensland Health to include a record class for Coal Workers' Pneumoconiosis (Black Lung Disease). The importance of long-term Workplace Health & Safety health monitoring (i.e. Black Lung disease) has been identified in Report No. 2, 55th Parliament: Coal Workers' Pneumoconiosis Select Committee which was published in May 2017 as part of a parliamentary inquiry. The recommendations have been endorsed by the Queensland Government along with amendments to the <i>Coal Mining Safety and Health Regulation 2017</i> (Qld) and the <i>Mining and Quarrying Safety and Health Regulation 2017</i>(Qld). Longitudinal screening programs are crucial for monitoring the health of coal workers to identify individuals with early-stage disease and prevent progression from mild disease to progressive lung fibrosis. The proposed retention period provides sufficient time for the patient/client to exercise their limitation of action rights as outlined in the <i>Limitation of Actions Act 1974</i> (Qld) and for ongoing claims. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	electromyograms or cardiotocograms). See <i>PUBLIC AND ENVIRONMENTAL HEALTH</i> in the Health Sector (Corporate Records) retention and disposal schedule for records relating to public and environmental health notifications and orders Disposal action – Temporary. Retain for 85 years from patient's/client's date of birth AND 10 years after last patient/client service provision or legal action, whichever is the later.	Comparison with other schedules' retention period: • <i>GRDS Disposal Authorisation 1220</i> Health monitoring–radiation – 75 years from date of birth or 30 years after last assessment, whichever is later. • <i>GRDS Disposal Authorisation 1221</i> Health monitoring–asbestos – 40 years after business action completed. • <i>GRDS Disposal Authorisation 1222</i> Health monitoring–hazardous chemicals – 30 years after business action completed. Confirmed by jurisdictional mapping of other states and territories, with confirmation from the Victorian State Archives, that there is no specific retention and disposal record class in their schedule for clinical records of patients/clients with the Black Lung Disease. Other comments/factors for consideration: • This is a new record class. • Includes all mediums: diagnostic images, paper-based and electronic clinical records. • Report No. 2, 55th Parliament: Coal Workers' Pneumoconiosis Select Committee, Inquiry into the re-identification of Coal Workers' Pneumoconiosis (CWP) in Queensland: ○ Coal Workers' Health Scheme health assessment form includes all respiratory components, including radiology report using the International Labour Organisation (ILO) format, spiogram tracings and results, comprehensive respiratory history and respiratory symptom questionnaire (Recommendation 39). ○ All underground coal mine workers should be required to undertake assessment every three years (Recommendation 45). ○ All other coal workers should be required to undertake a health assessment at least every six years (Recommendation 46). ○ Cases of CWP identified or diagnosed by medical professionals are to be compulsorily reported to the Chief Health Officer, Queensland, as a notifiable disease under the <i>Public Health Act 2005</i> (Recommendation 59). ○ The <i>Workers' Compensation and Rehabilitation Act 2003</i> (Qld) and <i>Workers' Compensation and Rehabilitation Regulation 2014</i> (Qld) should be amended as necessary to provide for statutory clarification that a worker with CWP who experiences disease progression can apply to reopen their workers' compensation

Disposal Authorisation	Record class and retention period	Justifying the retention period
		claim to access further benefits under the workers' compensation scheme (Recommendation 62). ○ The Coal Workers' Health Scheme should be extended to provide for continuing health assessments of retired and former coal workers, on a voluntary basis, under the scheme. These assessments should include the same elements and criteria as routine assessments under the scheme, and be provided for in addition to the 'retirement examinations' provided for by the current scheme (Recommendation 63) • <i>Coal Mining Safety and Health Regulation 2017 (Qld):</i> ○ s46A – Content of health assessments ▪ Results of 1 or more previous respiratory function examinations of the person are to be available and an examination of the person's respiratory function including a comparative assessment of the person's respiratory function levels and occupational dust exposure limits for coal mines. ○ s50 – Records about health assessments and retirement examinations ▪ A nominated medical adviser must, on behalf of the chief executive, keep the following records for each health assessment or retirement examination carried out by the nominated medical adviser. ○ s53 – Records of monitoring for workers' exposure to hazards ▪ The site senior executive for a coal mine must ensure a record about monitoring carried out under section 49 for coal mine workers at the mine is kept for 30 years after the record is made; or the lesser period agreed with the chief executive. • The proposed retention period for these significant diagnostic records will ensure that an ongoing medical history of health monitoring records are available for review to identify potential changes in the health or physical condition of workers in this industry over time. Previous schedule references: N/A

Disposal Authorisation	Record class and retention period	Justifying the retention period
CLINICAL RESEARCH RECORDS <i>Records of ethical investigation or study of patients/clients or subjects to improve and maintain the health of individuals and the wider community, and to prevent, diagnose and treat disease. Encompasses the work of both research practitioners as well as the business of Human Research Ethics Committees set up within public health units to monitor and advise on ethical behaviour within the pursuit of research.</i> <i>Clinical records created before, during and after relating to clinical research (including clinical trials) where:</i> - Queensland Health has been the investigator and/or the institution in accordance with the Therapeutic Goods Administration in section 4.9 and 5.5.11 of the Integrated Addendum to ICH E6(R1): Guideline for Good Clinical Practice ICH E6(R2) and the Australian Code for the Responsible Conduct of Research 2018. - Health Innovation, Investment and Research Office Standard of Practice (No. 80): Case Report Forms, Source Documents, Record Keeping and Archiving. - Health Innovation, Investment and Research Office Standard of Practice (No.130): Site Close Out and Archiving. - The sponsor has notified Queensland Health in writing that the records are no longer required in accordance with section 5.5.11 of the Therapeutic Goods Administration Integrated Addendum to ICH E6(R1): Guideline for Good Clinical Practice ICH E6(R2). <i>See GRDS COMMON ACTIVITIES – Committees for records created and maintained by Committees formed to oversee the conduct of research activities (e.g. Research Ethics Committees)</i> <i>See RESEARCH in the Health Sector (Corporate Records) retention and disposal schedule for records relating to ethics, treatment and analysis of diseases and medical research funding</i>		
2658	<i>Clinical Research Records - Adults</i> Clinical research records (including clinical trials) where the patients/clients or subjects were adults. Records may include, but are not limited to: - Clinical questionnaire and surveys. - Laboratory results. - Other diagnostics or investigative reports.	Date authorised: 27 July 2021 Why are these records created: The Clinical Research Records – Adults records are created to document clinical research, including clinical trials, involving Queensland Health and patients/clients or subjects that were adults at the time of the research or trial. Records can include laboratory results, reports, questionnaires and surveys obtained from consenting patients/clients or subjects for the specific purpose of research or clinical trial. Why the records are retained for this retention period: The Therapeutic Goods Administration (TGA) requires clinical records to be retained for at least 15 years following completion of a clinical trial. The Therapeutic Goods Administration does not differentiate between a clinical research record of an adult or a minor. As some participants will also be patients/clients of Queensland Health, the records also need to be retained for the same period as other clinical records. The retention period of 15 years from completion of clinical research/trial or after date of publication or termination of the study, also aligns with the National

Disposal Authorisation	Record class and retention period	Justifying the retention period
	• Patient/client or subject's consent for participation. • Patient/client or subject's authorisation for use of his/her information from the study See RESEARCH in the Health Sector (Corporate Records) retention and disposal schedule for records relating to ethics, treatment and analysis of diseases and medical research funding Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons. Disposal action – Temporary.	Health and Medical Research Council guidelines. The retention period allows sufficient time for the patient/client or subject to exercise their limitation of action rights as outlined in the <i>Limitation of Actions Act 1974</i> (Qld). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Destroy 15 years after last action or date of publication of the research whichever is the later (see 019.091.002) NSW: Destroy 15 years after date of publication or termination of the study, then destroy (see 8.0.0, 8.1.0) NT: No specific record class SA: Destroy 15 years after research project completed (see 6.7.1, 6.17.1) TAS Destroy 15 years after last attendance or last access on behalf of patient (provided patient has attained the age of 30 years) (see 2.1.1). Other comments/factors for consideration: • Pharmaceutical companies have ownership of the information generated by a clinical trial unless stipulated otherwise in a contract. Queensland Health owns/is responsible for the patient/client records relating to the clinical care of the patient/client. • Pharmaceutical company sponsors will be responsible for adhering, at a minimum, to these record retention requirements for clinical research records involving Queensland Health Research. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.1.1 Clinical Research Records – Adults: Retain for 15 years from completion of clinical research/trial; AND 10 years after last patient/client service provision or medico-legal action.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Retain for 15 years from completion of clinical research/trial or after date of publication or termination of the study AND 10 years after last patient/client service provision or legal action, whichever is the later.	
2659	<i>Clinical Research Records - Minors</i> Clinical research records (including clinical trials) where the patients/clients or subjects were minors. Records may include, but are not limited to: • Clinical questionnaire and surveys. • Laboratory results. • Other diagnostics or investigative reports. • Patient/client or subject's consent for participation. • Patient/client or subject's authorisation for use of his/her information from the study. See RESEARCH in the Health Sector (Corporate Records) retention and disposal	Date authorised: 27 July 2021 Why are these records created: The Clinical Research Records – Minors records are created to document clinical research, including clinical trials, involving Queensland Health and patients/clients or subjects that were minors who had not yet attained 18 years of age at the time of the research or trial. Records can include laboratory results, reports, questionnaires and surveys obtained from consenting patients/clients or subjects for the specific purpose of research or clinical trial. Why the records are retained for this retention period: The Clinical Research Records – Minors records are retained for 15 years from patient/client attaining 18 years of age after the completion of clinical research/trial or after date of publication or termination of the study to align with the guidelines of the National Health and Medical Research Council on the retention of these types of records. The retention period also covers the limitation of action rights of the patient/client once they reach adulthood at 18 years, then they will have until they are 21 years old to commence personal injury proceedings as outlined in the <i>Limitation of Actions Act 1974</i> (Qld). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. QSA permanent appraisal characteristics: Not applicable

Disposal Authorisation	Record class and retention period	Justifying the retention period
	schedule for records relating to ethics, treatment and analysis of diseases and medical research funding Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons. Disposal action – Temporary.	Comparison with other schedules' retention period: ACT: Destroy 15 years after last action or date of publication of the research whichever is the later (see 019.091.002) NSW: Destroy 15 years after date of publication or termination of the study, then destroy (see 8.0.0, 8.1.0) NT: No specific record class SA: Destroy 15 years after research project completed (see 6.7.1, 6.17.1) TAS: Destroy 15 years after last attendance or last access on behalf of patient (provided patient has attained the age of 30 years) (see 2.1.1) WA: No specific record class. Other comments/factors for consideration: • The Therapeutic Goods Administration requires records to be retained by the trial sponsor for at least 15 years following the completion of a clinical trial. The Therapeutic Goods Administration does not differentiate between a clinical research record of an adult or a minor. • Pharmaceutical companies have ownership of the information generated by a clinical trial unless stipulated otherwise in a contract. Queensland Health owns/is responsible for the patient/client records relating to the clinical care of the patient/client. • Pharmaceutical company sponsors will be responsible for adhering, at a minimum, to these record retention requirements for clinical research records involving Queensland Health Research. • Revised and updated the record class description for further clarification on the retention and destruction of Clinical Research Records – Minors. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.1.2 Clinical Research Records – Minors: Retain for 15 years from patient/client attaining 18 years of age; AND 10 years after last medico-legal action.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Retain until patient/client attains 18 years of age AND Retain for 15 years from completion of clinical research/trial or after date of publication or termination of the study AND 10 years after last patient/client service provision or legal action, whichever is the later.	
DIAGNOSTIC IMAGING, AUDIO AND OTHER SIMILAR MATERIAL		
2660	<i>Diagnostic Imaging, Audio and Other Similar Material</i> The production of images, audio and other similar material records displaying evidence of clinical care for the treatment of an individual patient/client. Records may include, but are not limited to: • All medical imaging irrespective of format or storage medium. • Duplicate reports (not sent to requesting clinician).	Date authorised: 27 July 2021 Why are these records created: This record class comprises of images, audio and other similar material records displaying evidence of clinical care to patient/clients. The records may include: • All medical imaging irrespective of format or storage medium. • Duplicate reports (not sent to requesting clinician). • Production of grading, measurements and readings of organs and/or tissues. Why the records are retained for this retention period: The proposed retention period ensures that a suitable medical history of diagnostic audio, images and other similar material is available for review over time by practitioners providing treatment and care to patients/clients. The retention period allows sufficient time for the patient/client to exercise their limitation of action rights as outlined in the <i>Limitation of Actions Act 1974</i> (Qld).

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Production of grading, measurements and readings of organs and/or tissues. See CLINICAL RECORDS – GENERAL for examples of other diagnostic imaging, audio and other similar material kept on the clinical record See OBSTETRIC RECORDS for diagnostic imaging, audio and other similar material related to obstetrics See Routine clinical worksheets for Sonographer worksheets Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.	Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. QSA permanent appraisal characteristics: Not applicable Comparison with other schedules' retention period: ACT: Destroy 7 years after the patient reaches the age of 18 years or 7 years after last action whichever is later (See 019.169.033, 019.169.034) NSW: Destroy 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 (see 3.3.1, 3.3.2) NT: Destroy 7 years after last attendance or 7 years after last access on behalf of the patient for whatever reason (provided that the patient attained or would have attained the age of 25 years) (see 2.1, 2.1.1) SA: Destroy 8 years after last film taken (Adults) or 8 years after child attains 18 years of age (Minors) (see 1.17.2) TAS: No specific record class WA: Destroy 7 years after date of last attendance for diagnostic imaging (see 13.2) VIC: Destroy 5 years after creation (3.2.2). Other comments/factors for consideration: Revised and updated the record class description for further clarification and increased the retention period from 5 years to 7 years. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.3.1 Films and other visual material – Retain for 5 years after image or recording was made.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Disposal action – Temporary. Retain for 7 years after image or recording was made.	
GENETIC HEALTH RECORDS		
2661	<i>Genetic Health Records</i> Records resulting from genetics consultations by clinical geneticists. Records may include, but are not limited to: • Family history of cancer. • Inherited cardiac condition. • Genetic counselling and screening the diagnosis of genetic diseases and birth defects including antenatal and newborn screening. • Congenital metabolic, genetic or inherited disorder testing by laboratories, including investigations conducted by metabolic laboratories. Excludes records related to the abuse of vulnerable persons. See GRDS Proactive Protection of	Date authorised: 27 July 2021 Why are these records created: Genetic Health Records comprise of records created by Genetic Health Queensland (GHQ) for the retention of genetic, inherited disorder and neoplasm health records for patients/clients. GHQ provides diagnoses for patients/clients, counselling and management advice to individuals and family members who have or are at risk of having a genetic or inherited condition. The clinical records contain clinical information of the patient/client and their family history of genetic or suspected inherited genetic conditions including preconception and prenatal counselling and diagnostic service to minors and adult patients/clients; and counselling families following the death of an affected relative. These clinical records are created specifically for the attendance at specialist genetics clinics, or treatment by a unit under the care of a clinical geneticist and include: • Results from genetic (DNA) testing by laboratories, including investigations conducted by metabolic laboratories. • Routine genetic screening, including antenatal and newborn screening, as well as metabolic screening. • Genetics consultations by clinical geneticists, including genetic counselling and the diagnosis of genetic diseases and birth defects. • Screening and risk factor assessment for genetic conditions. • Consent that is obtained for all the relevant records including death certificates for family members, providing an invaluable resource when providing genetic assessment and counselling to other family members including future generations. • Written consent to share the information with other family members.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	<u>Vulnerable Persons – relevant records</u> Disposal action – Temporary. Retain for 120 years after last patient/client service provision.	Why the records are retained for this retention period: These records need to be retained for 120 years to allow for ongoing reference by family members and their subsequent descendants for the next 3-4 generations (approximately 120 years based on a generation being 25-30 years). Research interests include dysmorphology, paediatric genetics, cardiac genetics, renal genetics and cancer genetics with major research collaborations looking at translating genomics into clinical care. These records are created, maintained and stored separately from the main health facility clinical records and are shared across several regional sites in Queensland. GHQ undertakes record-keeping practices in line with Queensland Health policies in accordance with legislative, agreed organisational and clinical requirements. There can be a delay between when the presymptomatic genetic testing is done and when the clinical information is sought by family members exceeding the standard requirements for disposal of medical records for Clinical Records – General. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Retain permanently (see 019.169.001) NSW: Retain permanently (see 1.6.0, 1.6.1, 1.6.2) NT: No specific record class SA: Destroy 100 years after action completed (Applies to both Adults and Minors) (see 1.12.1) TAS: No specific record class VIC: No specific record class WA: Record must be retained for 100 (one hundred) years (see 11.8). Other comments/factors for consideration: • This is a new class.

Disposal Authorisation	Record class and retention period	Justifying the retention period
		- During the jurisdictional mapping of other states and territories, it was identified that Queensland does not have a specific record class for genetic, inherited disorder and neoplasm health records of patients - Persons seeking presymptomatic genetic testing can only be offered testing if the gene fault (mutation) causing the genetic disease in the family is known (e.g. breast cancer with BRCA testing or whole exome/genome testing of tumours). - GHQ are frequently contacted by interstate and overseas genetic services seeking health information for their relatives of Queensland patients. - GHQ services provided include the Queensland Familial Cancer Registry, Queensland Cardiac Genetics Clinic and Queensland Renal Genetics Clinic. Previous schedule references: Nil
HANDOVER WORKSHEETS		
2662	<i>Handover worksheets</i> Handover worksheets and notes made to facilitate the handover and change of shifts. Records may include, but are not limited to: Records relating to the changeover of nursing shift and the documentation of any events required by the next shift (e.g. records created as part of patient/client monitoring and/or shift activities it includes shift handover sheets and day/night reports).	Date authorised: 27 July 2021 Why are these records created: Handover worksheets cover ephemeral material of a facilitative nature comprising detailed and frequent observations of patients/clients. These worksheets are not the principal clinical record of the patient/client. Why the records are retained for this retention period: These records are transitory in nature and created as a means of recording observations about the patient/client during a work shift. The information is recorded in the clinical record of the patient/client which is retained as the principal record of the care and treatment of the patient/client. The proposed retention period allows sufficient time to ensure that accurate information is transferred to the patient/client clinical record from the handover worksheets. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Disposal action – Temporary. Retain until the accuracy of the outcomes/results have been transferred to the patient/client clinical record and have been verified.	Comparison with other schedules' retention period: ACT: No specific record class NSW: No specific record class NT: No specific record class SA: Destroy when information summarised or edited, and placed on the clinical or client-related record (applies to both adults & minors). If the information is not summarised or edited – as for item 1.1.1 (Adults) or item 1.1.2 (Minors) (see 1.18.1) TAS: Destroy when information has been transcribed, summarised or edited (see 1.1.0) VIC: No specific record class WA: Destroy when information is transcribed, summarised or edited (see 10.1). Other comments/factors for consideration: Included to ensure these records are managed confidentially when reference ceases. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.2.2 Handover worksheets - Retain until the end of the corresponding shift.
INAPPROPRIATE REFERRALS		
2663	<i>Inappropriate Referrals</i> Referrals for no further action where the patient/client is not treated because the patient/client is either deemed unsuitable or did not attend. The patient/client has no clinical record created within the health facility. Records may include, but are not limited to: Records of assessment that does not result in	Date Authorised: 27 July 2021 Why are these records created: Referrals received that do not meet referral criteria and/or Clinical Prioritisation Criteria (CPC) (where available) or are not suitable for treatment within a medical specialty and where no clinical record was created and the patient/client has no history with the health facility. This aligns with the Specialist Outpatient Services Implementation Standard (SOSIS) 2017. If the patient/client has a clinical record, a record of the receipt of referral and non-acceptance of the referral must be maintained in the patient's medical record and/or outpatient services information system. The inappropriate referral may contain a record of clinical assessment, investigation results, treatment and/or care received for the condition(s) for which the referral was made.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	treatment or care but include records of triage activities (e.g. admission forms, general correspondence, letters, clinical notes, referral forms and investigation/pathology reports). See CLINICAL RECORDS – GENERAL for records <i>displaying evidence of clinical care and health status to an individual or groups of patients/clients.</i> Disposal action – Temporary. Retain for 2 years after last action.	Why the records are retained for this retention period: Inappropriate referrals are to be retained for 2 years after last action (e.g. awaiting further information, reviewed, classified as non-referral and outcome recorded in a register or outpatient services information system). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. QSA permanent appraisal characteristics: Not applicable Comparison with other schedules' retention period: ACT: Destroy 7 years after the patient reaches the age of 18 or 7 years after last action whichever is later (see 019.169.020, 019.169.021) NSW: Retain minimum of 2 years after action completed, then destroy (2.2.1) NT: No specific record class SA: No specific record class TAS: No specific record class VIC: Destroy 2 years after last action (1.1.3) WA: Destroy 12 months after date of receipt of document (5.11). Other comments/factors for consideration: • This is a new class. • Clinical Excellence Queensland have provided the Clinical Prioritisation Criteria. A patient/client may be unsuitable for a health service where the: • Referral does not comply or meet with the clinical prioritisation criteria • Referral validity timeframe has expired for a single course of treatment (i.e. 3 or 12 months) • Referral is illegible or does not contain sufficient information to accurately categorise the level of clinical urgency

Disposal Authorisation	Record class and retention period	Justifying the retention period
		- Referral is for a service that the health facility does not have the capability to provide and may be redirected to another appropriate health facility or an alternative care pathway - Patient/client lives outside of the HHS catchment area - Patient/client is ineligible for Medicare Previous schedule references: N/A
MENTAL HEALTH RECORDS Revised and updated the record class for further clarification on the retention and destruction of Mental Health Records. Mental health records displaying evidence of an individual patient/client's clinical care at a mental health facility including the assessment, examination, treatment and care planned to be provided, and that is provided, to the patient/client under the <i>Mental Health Act 2016</i> (Qld). In addition, mental health records also include records displaying evidence of an individual patient/client's clinical care at a mental health facility under the repealed <i>Mental Health Act 2000</i> (Qld) or <i>Mental Health Act 1974</i> (Qld). See CLINICAL RECORDS – GENERAL for mental health clinical records not described below See Mental Health Registers for a central register of mental health patients See MENTAL HEALTH in the Health Sector (Corporate Records) retention and disposal schedule for non-clinical records related to mental health treatment and services See Disability Services retention and disposal schedule for records relating to forensic disability facilities Excludes records related to the abuse of vulnerable persons. See GRDS Proactive Protection of Vulnerable Persons – relevant records		
2664	<i>Mental Health Facility Clinical Records – Mental Health Act 2016 (Qld) Forensic Order and</i>	Date authorised: 27 July 2021 Why are these records created: The Forensic Order and Treatment Support Order records display evidence of clinical care at a mental health facility of an individual patient/client. Under the <i>Mental Health Act 2016</i>, the health record of the patient/client must provide details of the treatment and care planned to be provided as well as details of the treatment and care that is provided to the patient/client.

<i>Treatment Support Order Patients</i> A Forensic Order (mental health) or Forensic Order (disability) is made when the Mental Health Court decides a person was of unsound mind at the time of an alleged prescribed offence or is unfit for trial under Chapter 5 Part 4 of the <i>Mental Health Act 2016</i> (Qld). A Treatment Support Order is made by the Mental Health Court under s.143 of the <i>Mental Health Act 2016</i> (Qld) or the Mental Health Review Tribunal under s.450 of the <i>Mental Health Act 2016</i> (Qld) where a less restrictive order than a forensic order is required. These orders are subject to periodic review by the Mental Health Review Tribunal. Records may include, but are not limited to: Records made in accordance with the <i>Mental Health Act 2016</i> (Qld) or a repealed Mental Health Act (<i>Mental Health Act 2000</i> (Qld) or <i>Mental Health Act 1974</i> (Qld))	A Forensic Order (mental health) or Forensic Order (disability) is made when the Mental Health Court decides a person was of unsound mind at the time of an alleged prescribed offence or is unfit for trial under Chapter 5 Part 4 of the <i>Mental Health Act 2016</i> (Qld). A treatment support order may be made by the Mental Health Court (the Court), if the Court decides a person was of unsound mind at the time of an alleged offence or is unfit for trial. Treatment support orders are made by the Court to protect the safety of the community in circumstances where a forensic order is not warranted. A treatment support order authorises involuntary treatment and, if necessary, detention in an authorised mental health service. The Tribunal must review treatment support orders every six months. When the Mental Health Review Tribunal (the Tribunal) reviews a forensic order, the Tribunal may revoke the forensic order and make a treatment support order. The making of a treatment support order by the Tribunal acts as a 'step down' from a forensic order as part of a person's recovery. The relevant person, someone on the person's behalf, or the Chief Psychiatrist can apply for a review at any time. Why the records are retained for this retention period: The retention period for these clinical records is intended to cover the life span of the patient/client and to ensure that there is sufficient time for the patient/client to exercise their limitation of action rights as outlined in the <i>Limitation of Actions Act 1974</i> (Qld) and <i>Forensic Disability Act 2011</i> (Qld). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Destroy 15 years after last action (adult) or destroy 15 years after the patient reaches the age of 18 years or 15 years after last action (minor) whichever is later (see 019.169.013, 019.169.014) NSW: Required as State archives (created prior to 1960 see 1.5.1) Destroy 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 (see 1.5.2) NT: Destroy 15 years after last attendance or 15 years after last access on behalf of patient for Whatever reason (provided that the patient has attained the age of 25 years) (see 1.1.1) SA: Destroy 33 years after last contact (see 1.6)
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Disposal Authorisation	Record class and retention period	Justifying the retention period
	and displaying evidence of clinical care at a mental health facility of an individual patient/client subject to a Forensic Order or Treatment Support Order. See also the <i>Forensic Disability Act 2011</i> (Qld) for the purposes of provision for the involuntary detention, and the care and support and protection, of forensic disability clients. See Clinical Records-General for mental health clinical records not described in 2664 and 2665 Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.	TAS: Destroy 15 years after date of last contact (see 7.2) VIC: Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age (see 2.2.1, 2.3.1, 4.4.0, 4.5.0, 4.7.0, 5.1.2, 5.2.2) WA: Destroy 7 years after death for all psychiatric patient records. (see Section 1, Part 3.7 Psychiatric Patient Records). Other comments/factors for consideration: There has been a change in the disposal trigger for this record class. Increase from 85 years to 100 years endorsed by the Office of the Chief Psychiatrist. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.4.2 Mental Health Facility Clinical Records – Mental Health Act 1974 – Forensic Patients - Retain for 85 years from patient's/client's date of birth; AND 10 years after last patient/client service provision or medico-legal action

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Disposal action – Temporary. Retain for 100 years from patient's/client's date of birth AND 10 years after last patient/client service provision or legal action, whichever is the later.	
2665	<i>Mental Health Facility Clinical Records – Mental Health Act 2000 (Qld) Special Notification Forensic Patients</i> A person who was or was liable to be, detained in an authorised mental health service under a Forensic Order as a Special Notification Forensic Patient under the repealed <i>Mental Health Act 2000</i> (Qld). Records may include, but are not limited to: Records made in accordance with the repealed <i>Mental Health Act 2000</i> (Qld) displaying evidence of clinical care at a mental health facility of an individual patient/client	Date authorised: 27 July 2021 Why are these records created: The Special Notification Forensic Patients (SNFP) records display evidence of clinical care at a mental health facility of an individual patient/client. Under the repealed <i>Mental Health Act 2000</i> (Qld), the health record of the patient/client must provide details of the treatment and care planned to be provided as well as details of the treatment and care that is provided to the patient/client. These patient/clients have committed violent offences and SNFP patient/clients' status are recorded in the Mental Health Information System. The Mental Health Facility Clinical Records – <i>Mental Health Act 2000</i> (Qld) Special Notification Forensic class remains relevant to be included in the Schedule for the previously identified SNFP who have not yet attained the 85 years from patient's/client's date of birth. Why the records are retained for this retention period: The proposed retention period for these clinical records is intended to cover the life span of the patient/client and to ensure that there is sufficient time for the patient/client to exercise their limitation of action rights as outlined in the <i>Limitation of Actions Act 1974</i> (Qld). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	with a 'Special Notification Forensic Patient' status. Note: The category 'Special Notification Forensic Patient' has been repealed under the <i>Mental Health Act 2016 (Qld)</i> See CLINICAL RECORDS – GENERAL for mental health clinical records not described in 2664 and 2665 Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons. Disposal action – Temporary. Retain for 100 years from patient's/client's date of birth AND	QSA permanent appraisal characteristics: Not applicable Comparison with other schedules' retention period: ACT: Destroy 15 years after last action (adult) or destroy 15 years after the patient reaches the age of 18 years or 15 years after last action (minor) whichever is later (see 019.169.013, 019.169.014) NSW: Required as State archives (created prior to 1960 see 1.5.1) Destroy 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 (see 1.5.2) NT: Destroy 15 years after last attendance or 15 years after last access on behalf of patient for Whatever reason (provided that the patient has attained the age of 25 years) (see 1.1.1) SA: Destroy 33 years after last contact (see 1.6) TAS: Destroy 15 years after date of last contact (see 7.2) VIC: Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age ((see 2.2.1, 2.3.1, 4.4.0, 4.5.0, 4.7.0, 5.1.2, 5.2.2) WA: Destroy 7 years after death for all psychiatric patient records. (see Section 1, Part 3.7 Psychiatric Patient Records) Other comments/factors for consideration: There has been a change in the disposal trigger for this record class. Increase from 85 years to 100 years endorsed by the Office of the Chief Psychiatrist. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.4.1 Mental Health Facility Clinical Records – Persons of Special Notification (PSN) – Retain for 85 years from patient's/client's date of birth AND 10 years after last patient/client service provision or medico-legal action.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	10 years after last patient/client service provision or legal action, whichever is the later.	
NOTIFIABLE DISEASE TREATMENT RECORDS		
2666	<i>Notifiable Disease Treatment Records</i> Records displaying evidence of clinical care for the treatment of an individual patient/client for notifiable conditions maintained by health facilities fulfilling obligations to report notifiable diseases under public health legislation. Refer to current legislation for the list of all notifiable conditions. Notifiable conditions include, but are not limited to: • Human immunodeficiency virus (HIV). • Leprosy. • Q Fever. • Severe Acute Respiratory Syndrome (SARS). • Syphilis. • Tuberculosis.	Date authorised: 27 July 2021 Why are these records created: These records display evidence of clinical care for the treatment of an individual patient/client for notifiable conditions and are created to document the initial reporting, diagnosis and treatment of instances of notifiable diseases at health care facilities. Why the records are retained for this retention period: The Queensland Health Communicable Diseases Branch has identified a list of conditions in this disposal authorisation where records of initial reporting/diagnosis of the condition at a health care facility need to be retained for future reference and research purposes. For a definitive list of all notifiable conditions, refer to current public health legislation. These diseases were selected by the Queensland Health Communicable Diseases and Infection Management reference group from the list of notifiable diseases contained in Schedule 2 of the <i>Public Health Regulation 2018</i> as requiring a longer retention period than other clinical records. This is due to the effect previous treatments have on the choice of subsequent treatments (e.g. the development of resistances to drugs, etc) and the need for the records to be available for the life span of the patient/client. A longer retention period for these records is recommended to ensure sufficient access to clinical information about the initial diagnosis and treatment of these conditions for the patient/client and for the broader community who may be at risk of contracting these serious illnesses. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	See CLINICAL RECORDS – GENERAL for records of Hepatitis B and Hepatitis C Disposal action – Temporary. Retain for 85 years from patient's/client's date of birth AND 10 years after last patient/client service provision or legal action, whichever is the later.	QSA permanent appraisal characteristics: Not applicable Comparison with other schedules' retention period: ACT: Destroy 15 years after last action (adult) or destroy after the patient reaches the age of 25 years (minor) (see 019.088.003, 019.008.004) NSW Treatment and care - Destroy 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 (see 1.1.1) Records of notification maintained by hospitals - Destroy 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 (see 6.2.1) NT: Destroy 10 years after date of death or if deceased status unknown then when patient would have attained the age of 80 years provided it is 15 years since last attendance or 15 years since last access on behalf of patient for whatever reason (see 1.7, Class 1.7.1 Tuberculosis) SA: No specific record class but records relating to medical conditions required by legislation to be reported to the Department of Health and Ageing or similar body Destroy 10 years after action completed if maintained separately (see. 2.6.1) TAS: Multiple record classes - - Statutory Health Reports 9.2.0 – sentence according to 2.1.1, 2.1.2, 2.1.3, 2.2.1 or 2.2.2): ○ 2.1.1 - Destroy 15 years after last attendance or last access on behalf of Patient (provided patient has attained the age of 30 years). ○ 2.1.2 - Destroy 10 years after date of death or last access on behalf of deceased. ○ 2.1.3 - Destroy 7 years after attendance. ○ 2.2.1 - Destroy 10 years after last attendance or last access on behalf of patient (provided patient has attained age of 25 years). ○ 2.2.2 - Destroy 10 years after date of death or last access on behalf of deceased. VIC: Destroy 6 months after date of notification (reporting of notifiable diseases) (see 4.2.1) WA: Individual patient record: ○ Destroy 15 years after last attendance or date of last access (provided the patient has attained the age of 25 years) (see 1.1, 1.2, 1.3, 2.1 or 2.2) OR

Disposal Authorisation	Record class and retention period	Justifying the retention period
		○ Destroy 10 years after date of death or date of last access (provided the patient has attained the age of 25 years) Agency notification files ○ Destroy 7 years after date of notification, provided there is no reasonable expectation of legal implication at time of disposal. Other comments/factors for consideration: • The Queensland Health Communicable Diseases Branch has identified and provided an amended list of notifiable diseases in this disposal authorisation. The following notifiable diseases have been removed and are to be sentenced under Clinical Records - General: ○ Hepatitis B ○ Hepatitis C Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.5 Notifiable Disease Treatment Records – Retain for 85 years from patient's/client's date of birth AND 10 years after last patient/client service provision or medico-legal action.
OBSTETRIC RECORDS Obstetrics records without or with evidence of artificial insemination and in-vitro fertilisation relating to attendance and/or admittance to the following: antenatal clinics, postnatal clinics, delivery, obstetric or birthing wards/units, or any other primary care, inpatient, outpatient and/or emergency care related to obstetrics.		
2667	<i>Obstetric Records without evidence of Artificial Insemination (AI) / In-Vitro Fertilisation (IVF)</i> Records displaying evidence of obstetric care to an individual patient/client where there is no evidence of artificial insemination (AI) or in-vitro fertilisation (IVF) procedures.	Date authorised: 27 July 2021 Why are these records created: As defined by the Statewide Maternity & Neonatal Clinical Network (SMNCN), obstetrics is a branch of medical science that deals with pregnancy, childbirth, and the postpartum period involving the provision of maternity care. An obstetric record is the clinical record of the pregnancy and/or delivery of the mother which will contain comprehensive information about the treatment and care of the patient/client throughout the pregnancy and delivery. This disposal authorisation covers records that display evidence of obstetric care throughout the pregnancy and records of the attendance or admittance of an individual patient/client for obstetric care, including delivery where there is no evidence of artificial insemination (AI) or in-vitro fertilisation (IVF) procedures.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Records may include, but are not limited to: • Clinical record of the mother. • Clinical record of the child /stillborn where there is no evidence of artificial insemination (AI) or in-vitro fertilisation (IVF) procedures. • Health facility's copy of the statutory notification of the Perinatal Data Collection Form (MR63D) to be filed in the individual patient/client record. • Diagnostic Imaging, Audio and Other Similar Material kept on the obstetric file. Includes but is not limited to Child/stillborn images, neonatal oximeter printouts and 3D images See Obstetric Records with evidence of Artificial Insemination (AI)/In-Vitro Fertilisation (IVF) for records with evidence of artificial insemination (AI) or in-vitro fertilisation (IVF) procedures Excludes any record listed above that relates to	This disposal authorisation also covers records relevant to obstetric care diagnostic imaging and associated written reports created about these records. Why the records are retained for this retention period: The retention period is based on the recommendation of the Statewide Maternity & Neonatal Clinical Network (SMNCN) that the mother's clinical record be retained until the child born reaches 28 years of age and 10 years after last patient/client service provision or legal action. This is to allow for ongoing reference by the patient and for the child/stillborn, adoption and research information. The SMNCN has also recommended that the clinical records of the child/stillborn remain as being retained for a minimum of 28 years after last delivery. The SMNCN advised events during pregnancy and birth have lifetime implications for the health and wellbeing of children. There is a need to maintain records for future access by the child. Important aspects of the pregnancy and birth history are not recorded in the child's record and need to be retained for the period aligning to that of the child records. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Retain permanently (see 019.169.010, 019.169.012) NSW: Retain a minimum of 50 years after date of birthing episode, or 15 years after last action completed (1.4.1) Records documenting arrangements for adoptions that proceed – Retain in agency (1.4.2) NT: Destroy 25 years after last delivery or 15 years after last access whichever is the latest (see 1.5.1) SA: Destroy 33 years after last obstetric care contact (which includes antenatal, delivery and post-natal care (see 1.21.1) TAS: Destroy 15 years after last attendance or last access on behalf of patient (provided patient has attained the age of 30 years) (2.1.0, 2.2.0) VIC: Destroy 15 years after date of last attendance or access by or on behalf of the patient provided the child has reached 30 years of age (see 2.2.5)

Disposal Authorisation	Record class and retention period	Justifying the retention period
	incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons. Disposal action – Temporary. Retain 28 years after last delivery AND 10 years after legal action, whichever is the later.	WA: Uncomplicated delivery - destroy 15 years after the mother's last attendance or after the date of last access (provided the mother has attained the age of 25 years) (Section 1, Part 3.8) Complicated delivery – destroy 15 years after the date of last attendance of the newborn/patient or after the date of last access (provided the newborn has attained the age of 25 years) (Section 1, Part 3.8). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.6.1 Obstetric Records without evidence of Artificial Insemination/In-vitro Fertilisation (IVF) – Retain for 10 years from the child attaining 18 years of age AND 10 years after last patient/client service provision or medico-legal action.
2668	<i>Obstetric Records with evidence of Artificial Insemination (AI) / In-Vitro Fertilisation (IVF)</i> Records displaying evidence of obstetric care to an individual patient/client where there is evidence of artificial insemination (AI) or in-vitro fertilisation (IVF) procedures which include consent to artificial insemination (AI), in-	Date authorised: 27 July 2021 Why are these records created: As defined by the Statewide Maternity & Neonatal Clinical Network (SMNCN), obstetrics is a branch of medical science that deals with pregnancy, childbirth, and the postpartum period involving the provision of maternity care. An obstetric record is the clinical record of the pregnancy and/or delivery of the mother which will contain comprehensive information about the treatment and care of the patient/client throughout the pregnancy and delivery. This disposal authorisation covers records that display evidence of obstetric care throughout the pregnancy and records of the attendance or admittance of a patient/client for obstetric care, including delivery where there is evidence of artificial insemination (AI) or in-vitro fertilisation (IVF) procedures. Information pertaining to artificial insemination (AI) or in-vitro fertilisation (IVF) procedures can be found within

Disposal Authorisation	Record class and retention period	Justifying the retention period
	vitro fertilisation (IVF) or/and use of semen, ova or embryos and the withdrawal of consent for such procedures. Records may include, but are not limited to: • Clinical record of the mother. • Clinical record of the child/neonatal death /stillborn where there is evidence of artificial insemination (AI) or in-vitro fertilisation (IVF) procedures. • Clinical records of each other individual or family unit involved in the artificial insemination or in-vitro fertilisation procedures. • Records relating to consent to treatment, use of semen, ova or embryos and withdrawal of consent. • Health facility's copy of the statutory notification of the Perinatal Data Collection Form (MR63D) is to be filed in the individual patient/client record. • Diagnostic Imaging, Audio and Other Similar Material that may be kept on the obstetric file. Includes but	a patient clinical file if the patient shares this information with the treating clinician, or if the AI/IVF clinician shares correspondence with the treating clinician. This disposal authorisation also includes records relevant to obstetric care diagnostic imaging and associated written reports created about these records where there is evidence of artificial insemination (AI) or in-vitro fertilisation (IVF). Why the records are retained for this retention period: The proposed retention period is based on the recommendation of the Statewide Maternity & Neonatal Clinical Network (SMNCN) that the mother's clinical record be retained for when the child born reaches 28 years of age and 10 years after last patient/client service provision or legal action to allow for ongoing reference by the patient and the child/neonatal death/stillborn for adoption and research information. The SMNCN has recommended that the clinical records of the child/stillborn remain as being retained for a minimum of 28 years after last delivery. The SMNCN advised events during pregnancy and birth have lifetime implications for the health and wellbeing of children. There is a need to maintain records for future access by the child. Important aspects of the pregnancy and birth history are not recorded in the child's record and need to be retained for the period aligning to that of the child records. Assistive reproductive technologies and pre-treatment screening have improved since 1996, when the permanent retention period was determined. Permanent retention offers no additional advantage to the parent, child or healthcare provider. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. QSA permanent appraisal characteristics: Not applicable Comparison with other schedules' retention period: Please see the following jurisdictions for the retention of clinical records for Obstetric Records with evidence of Artificial Insemination (AI) / In-Vitro Fertilisation (IVF): ACT: Destroy 75 years after date of birth of the child or date of insemination if the date of birth is unknown (see 019.169.015)

Disposal Authorisation	Record class and retention period	Justifying the retention period
	is not limited to Child/stillborn images, neonatal oximeter printouts and 3D images See Obstetric Records without evidence of Artificial Insemination (AI)/In-Vitro Fertilisation (IVF) for records with no evidence of artificial insemination (AI) or in-vitro fertilisation (IVF) procedures Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for 100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons. Disposal action – Temporary. Retain 28 years after last delivery AND	NSW: Retain prescribed information in accordance with legislative requirements, all other records retain for minimum of 15 years after last access by or on behalf of the patient, then destroy (1.7.1) NT: Destroy 25 years after last delivery or 15 years after last access whichever is the latest (see 1.5.1) SA: Retain permanently (see 1.26.1) TAS: Destroy 75 years after action completed (see 3.1.1) VIC: Retain permanently – Records of Assisted Reproductive Technology patients where a child is born or pregnancy achieved using <u>donated</u> gametes or embryos (see. 2.4.1) Destroy 75 years after date of last attendance, or access by or on behalf of the patient – Records of Assisted Reproductive Technology patients where a child is born from <u>non-donated</u> gametes or embryos (see 2.4.2) Destroy 15 years after date of last attendance, or access by or on behalf of the patient – Records of Assisted Reproductive Technology patients where a child is not born (see 2.4.3) WA: Retain permanently (see. 5.2). Other comments/factors for consideration: The proposed retention period of 28 years has been reduced from the previous permanent retention period for this disposal authorisation. Revised and updated the record class description for further clarification on the retention and destruction of Obstetric Records with evidence of Artificial Insemination (AI) / In-Vitro Fertilisation (IVF). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.6.2 Obstetric Records with evidence of Artificial Insemination/In-vitro Fertilisation (IVF) – Retain permanently.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	10 years after legal action, whichever is the later.	
2669	<i>Artificial Insemination (AI) / In-Vitro Fertilisation (IVF) Donor Records</i> Records relating to information about individual donors involved in Artificial Insemination (AI) or In-Vitro Fertilisation (IVF) procedures. Records may include, but are not limited to records relating to semen supply, including: • Full name and date of birth of donor. • Name of each individual person or family unit. • Donor's written consent. • Results of tests. • Name of the medical practitioner to whom semen was supplied. • Use of semen, ova or embryos. • Withdrawal of consent for such procedures or processes.	Date authorised: 27 July 2021 Why are these records created: Artificial Insemination (AI)/ In-Vitro Fertilisation (IVF) donor records are created to document individual donors involved in AI / IVF procedures. Artificial Insemination (AI)/ In-Vitro Fertilisation (IVF) donor records relate to information about individual donors involved in AI / IVF procedures. These donor records relate to the clinical record of both the mother and the child/neonate. Why the records are retained for this retention period: Due to the need for records establishing the biological parents of the child/neonate, and on the recommendation of the National Health and Medical Research Council (NHMRC) Ethical guidelines on the use of assisted reproductive technology in clinical practice and research (2017), the Artificial Insemination (AI) / In-Vitro Fertilisation (IVF) Donor Records need to be retained permanently. 9.2.2 - Information about all parties involved in a donor conception program or surrogacy arrangement must be kept indefinitely (or at least for the expected lifetime of any persons born). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. QSA permanent appraisal characteristics: These records provide evidence of the following characteristics from the Queensland State Archives Appraisal Statement and should be retained as archival records for future research: • 3 – enduring rights & entitlements • 4 – significant impact on individuals • 5 – substantial contribution to community memory

Disposal Authorisation	Record class and retention period	Justifying the retention period
	See Obstetric Records for information relating to obstetrics Disposal action – Permanent. Transfer to QSA after business action completed.	Comparison with other schedules' retention period: ACT: Destroy 10 years after last action or after donor reaches the age of 30 years whichever is longer (019.169.048) NSW: Retain prescribed information in accordance with legislative requirements, all other records retain for minimum of 15 years after last access by or on behalf of the patient, then destroy (1.7.1) NT: No specific record class for AI/ IVF donor records SA: Retain permanently (see 2.8.2) TAS: Destroy 75 years after action completed (see 3.1.1) VIC: Retain permanently (see 2.4.4) WA: Retain permanently (see 5.1). Other comments/factors for consideration: This class comprises records relating to information about individual donors involved in Artificial Insemination (AI) / In-Vitro Fertilisation (IVF) procedures. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.6.3 Artificial Insemination/In-vitro Fertilisation (IVF) Donor Records – Retain permanently.
2670	<i>Unborn Child at Risk Notifications</i> The Department of Children, Youth Justice and Multicultural Affairs will issue an Unborn Child High Risk Alert (HRA) to Queensland Health maternity services where they believe that a pregnant woman, who they want to provide support to, will present to give birth. This record class comprises of notifications where the	Date authorised: 27 July 2021 Why are these records created: The Department of Children, Youth Justice and Multicultural Affairs will issue an Unborn Child High Risk Alert (HRA) to Queensland Health maternity services where they believe that a pregnant woman, who they want to provide support to, will present to give birth. The notifications (such as the Child Safety HRA Form 1 – Unborn Child High Risk Alert Form) received by Queensland Health facilities advise that an unborn child may be at risk of harm. It is the practice of The Department of Children, Youth Justice and Multicultural Affairs to send these forms to a number of health facilities in the area where the patient/client is expected to present for delivery and retains a record of the unborn child at risk notifications that they issue.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	patient/client does not present at that health facility for delivery. Records may include, but are not limited to: • Child Safety HRA Form 1 – Unborn Child High Risk Alert Form: Request for immediate notification when pregnant woman presents for delivery. • Child Safety HRA Form 2 – notification that a pregnant woman has presented for delivery. • Child Safety HRA Form 3 – is sent to maternity services by the Child Safety Services when a HRA Form 1 Unborn Child High Risk Alert is no longer required. See Obstetric Records when a patient/client delivers at a health facility. Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of	Why the records are retained for this retention period: This disposal authorisation comprises unborn child at risk notifications where the patient/client does not present at that health facility for delivery. The retention period is appropriate as this disposal authorisation only covers notifications received by health facilities where the mother does not present for delivery. Unborn child at risk notifications received by the health facility where the mother presents for delivery are retained under Obstetric Records of this Schedule. The Unborn Child High Risk Alert Forms do not meet the definition of a “Clinical Record” but are required to be managed as a clinical record due to policy and/or legislative obligations placed upon them. Health facilities where the mother presents manage the form in the clinical record. Health facilities where the mother does not present manage these forms separately. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: No specific record class for Unborn Child High Risk Notifications NSW: No specific record class for Unborn Child High Risk Notifications NT: No specific record class for Unborn Child High Risk Notifications SA: No specific record class for Unborn Child High Risk Notifications TAS: Destroy 1 year after action completed (see 9.2.2) VIC: No specific record class for Unborn Child High Risk Notifications WA: No specific record class for Unborn Child High Risk Notifications. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.6.4 Unborn Child at Risk Notifications – Retain for 3 months after expected presentation date.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	vulnerable persons. These records must be retained for 100 years after creation of the record. See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</u> Disposal action – Temporary. Retain for 3 months after expected presentation date.	
ORGAN AND TISSUE DONOR RECORDS		
2671	<i>Organ and Tissue Donor Records</i> Organ and tissue donor records displaying evidence of clinical care to an individual patient/client who has donated organs/tissues. Records displaying evidence of clinical care to an individual patient/client who has donated human organs and tissues, while the patient/client is living or after their death. The focus is to identify transplants utilising biomaterials from another person or species	Date authorised: 27 July 2021 Why are these records created: Organ and Tissue Donor Records include all clinical records of patients/clients (both adults and minors) who have donated organs/tissues either while they were alive or after their death. This class also includes records displaying evidence of clinical care prior to and after the organ/tissue donation. Why the records are retained for this retention period: The Transplant Clinical Advisory Committee of Queensland Health have advised that 50 years after the last patient/client contact is a sufficient retention period to cover the clinical need for these records. The Transplant Clinical Advisory Committee have identified a clinical need to retain these records for longer than General Clinical records. Clinical history of the donor both prior to and after organ/tissue donation may be relevant to the patient/client receiving the donated organ/tissue.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	against autologous procedures. Records may include, but are not limited to: • Clinical records of donors who are adults or minors. • Clinical records of donors made prior to and after the organ/tissue donation. • Clinical records of donors where the organ or tissue donation occurs. • Written consents to donate organs made by the patient/client, their parent or their senior available next of kin in accordance with s.10, s.11, s.12 and s.22 of the <i>Transplantation and Anatomy Act 1979</i> (Qld): ○ Living consent should reflect consent made by the patient/client/parent or legal decision maker. ○ Deceased consent should reflect the senior available next of kin. See Artificial Insemination (AI) / In-Vitro Fertilisation (IVF)	Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: Please see the following jurisdictions for the retention of clinical records for Organ and Tissue Donor Records: ACT: No specific record class for Organ and Tissue Donor Records NSW: No specific record class for Organ and Tissue Donor Records NT: No specific record class for Organ and Tissue Donor Records SA: Destroy 50 years after last contact (applies to both Adults & Minors) (see 1.22.1, 1.22.2) TAS: No specific record class for Organ and Tissue Donor Records VIC: No specific record class for Organ and Tissue Donor Records WA: Destroy 75 years after date of death (see 5.9). Other comments/factors for consideration: DonateLife Queensland and Queensland Tissue Banks have agreed to maintain the retention period of 50 years for organ and tissue donor records displaying evidence of clinical care to an individual patient/client who has donated organs/tissues. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.7 Organ and Tissue Donors Records – Retain for 50 years from last patient/client service provision or medico-legal action.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	<u>Donor Records</u> for donor records related to Artificial Insemination (AI)/ In-Vitro Fertilisation (IVF). Disposal action – Temporary. Retain for 50 years from last patient/client service provision or legal action, whichever is the later.	
ROUTINE CLINICAL WORKSHEETS		
2672	<i>Routine clinical worksheets</i> Routine clinical worksheets where the outcome/results are transferred to the patient's/client's clinical records. Records may include, but are not limited to: Records relating to frequent or continuous observation or monitoring (e.g. daily fluid balance sheets, frequent observations, worksheets, journals, daily ward diary). Disposal action – Temporary. Retain until the accuracy of the outcome/results have been transferred to the	Date authorised: 27 July 2021 Why are these records created: Routine clinical worksheets comprise of records relating to frequent or continuous observation or monitoring (i.e. daily fluid balance sheets) where the outcome/results are transferred to the patient's/client's clinical record. Why the records are retained for this retention period: Routine clinical worksheets are transitory in nature and created as a means of recording observations about the patient/client during a work shift. • Information is recorded in the clinical record of the patient/client which is retained as the principal record of the care and treatment of the patient/client. • The proposed retention period allows sufficient time to ensure that accurate information is transferred to the patient/client clinical record from the routine clinical worksheets. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	patient's/client's clinical record and have been verified.	Comparison with other schedules' retention period: Please see the following jurisdictions for the retention of clinical records for Routine clinical worksheets: • ACT: No specific record class for routine clinical worksheets • NSW: No specific record class for routine clinical worksheets • NT: No specific record class for routine clinical worksheets • SA: 1.18.1 - Destroy when information summarised or edited, and placed on the clinical or client-related 2.3.4 - Records relating to the change-over of nursing staff and the documentation of any events required by the next shift – destroy 6 months after action completed • TAS: Destroy when information has been transcribed, summarised or edited (see 1.1.0) • VIC: No specific record class for routine clinical worksheets • WA: Destroy when information is transcribed, summarised or edited (see 10.1,10.2). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 2.2.1 Routine clinical worksheets – Retain until the accuracy of the outcome/results, transferred to the patient's/client's clinical record, have been verified.

REGISTERS AND INDICES

Patient/client registers and indices including paper-based and electronic registers. Where a single register is used to document multiple activities, retain for the longest minimum retention period for each individual register.

Registers and indices comprise of details including paper-based and electronic registers within a computerised patient/client administration system. The function of clinical administration can be defined as the unique administrative processes that support and coordinate patient/client or patient/client care services in a health facility.

If registers are combined, the longest minimum retention period for the register applies.

Disposal Authorisation	Record class and retention period	Justifying the retention period
2673	<i>Admission and Discharge Registers</i> Register listing in date order each patient/client admitted and discharged from a health facility. Records may include, but are not limited to: - Registers comprising details of admission and discharge of patients/clients from health facilities such as the admission and discharge dates, name, unit record number, date of birth or age and sex of the patient/client. - Registers may also include, admission and discharge times, address, next of kin, admitting diagnosis, discharge outcome (e.g. home, transferred, deceased, etc.), length of stay, health insurance details, guardian (if applicable), referring practitioner, concession eligibility, and summary note of the authority for admission and treatment (if applicable).	Date authorised: 27 July 2021 Why are these records created: In the absence of the patient/client clinical records, the admission and discharge registers document in summary form records of each patient/client admitted and discharged from Queensland Health facilities. Why the records are retained for this retention period: In the absence of the patient's clinical records, the admission and discharge registers would form the only public records documenting medical events in a person's life and their interaction with Queensland Health. The admissions and discharges to maternity hospitals would hold particular family history research value (including potentially identifying the birth of children who were then put up for adoption or where there may have been a stillbirth or miscarriage). Other potential research uses of these registers include identifying clusters of particular types of admissions in a specific region over time. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. QSA permanent appraisal characteristics: These records provide evidence of the following characteristics from the Queensland State Archives Appraisal Statement and should be retained as archival records for future research: 3 – enduring rights & entitlements 4 – significant impact on individuals 5 – substantial contribution to community memory Comparison with other schedules' retention period: Please see the following jurisdictions for the retention of clinical records for Admission and Discharge Registers: ACT: Retain permanently (see 019.026.004)

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Disposal action – Permanent. Transfer to QSA after business action completed.	NSW: Retain permanently (see 2.1.4) NT: No specific record class for Admission and Discharge Registers SA: Retain permanently (see 2.3.1, 2.8.1) TAS: Retain permanently (see 4.5.1, 4.6.1) VIC: Destroy 75 years after last action (see 1.2.1) WA: Retain permanently (see 9.5, 9.6). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.1 Admission and Discharge Registers.
2674	<i>Birth (Labour Ward) Registers</i> Register listing in date order of each birth occurring at a health facility providing a summary detail of medical procedure, episode or disease that is not captured elsewhere. This includes birth and labour ward registers, confinement books or their equivalent and may exist as a paper-based or electronically within a computerised patient/client administration system. Records may include, but are not limited to: Registers comprising details of births, which occur at health facilities, such as date and time of birth, mother's name, sex of baby, status of baby at	Date authorised: 27 July 2021 Why are these records created: Birth (Labour Ward) Registers comprise registers that document births that occur at Queensland Health facilities. These registers are not the birth registers maintained by the Department of Justice and Attorney-General in accordance with s.5 of the <i>Births, Deaths and Marriages Registration Act 2003</i> (Qld). Why the records are retained for this retention period: The registers comprise details of the date and time of birth, mother's name, sex of the baby and the names of the medical and nursing staff in attendance. Other details that may be included in the registers are the mother's record number, age, address, method of delivery and the baby's status at birth (e.g. live or stillborn). As these registers document in summary form each birth that occurred at Queensland Health facilities, they have research value in supplementing the Register General's records and warrant long term retention. The Queensland Health birth registers need to be retained for 120 years to allow for ongoing reference by the patient/client and their subsequent descendants for the next 3-4 generations (approximately 120 years based on a generation being 25-30 years) Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	birth (e.g. live, stillborn) and names of medical and nursing staff in attendance. Registers may also include mother's unit record number, age, address and type of birth. Disposal action – Temporary. Retain for 120 years after last action.	Comparison with other schedules' retention period: ACT: Retain permanently (see 019.026.005) NSW: Retain permanently (see 2.1.5) NT: No specific record class SA: Retain permanently (see 2.8.2) TAS: Retain permanently (see 4.8.1) VIC: Retain permanently (see 4.1.2) WA: Retain permanently (see 9.8). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule (QDAN 683 v1 – 3.2) – Retain for 120 years after last action.
2675	<i>Death Registers</i> Register comprising details of deaths of patients/clients that occur at health facilities. Records may include, but are not limited to: - Date and time of death, name and unit record number of patient/client. - Sex, date of birth or age, cause of death and name of medical officer. - Deaths on arrival. - Notification of deaths that have occurred in a health facility to the Registry of	Date authorised: 27 July 2021 Why are these records created: Death registers comprise registers that document deaths that occur at Queensland Health facilities. Why the records are retained for this retention period: The registers comprise details of the date and time of death, name and record number of the patient/client. Other details that may be included in the registers are the sex, date of birth or age, cause of death and the name of the medical officer. These death registers are not the death register maintained by the Department of Justice and Attorney-General in accordance with s.26, 33 and 44 of the <i>Births, Deaths and Marriages Registration Act 2003</i> (Qld). The Death Registers are compiled by copying information from the death certificates and as such, contain no further information than that recorded by the Department of Justice and Attorney-General. Queensland Health has a short-term business need to consult their death registers and have advised that generally all reference has ceased within 10 years. Queensland Health would be able

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Births, Deaths and Marriages. Disposal action – Temporary. Retain for 10 years after last action.	to consult the Department of Justice and Attorney-General for information beyond 10 years if required. The 10 year retention period is also consistent with the Clinical records – Adults and Clinical records – Deceased Minors. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Retain permanently (see 019.026.006) NSW: Retain permanently (see 2.1.2) NT: No specific record class for Death Registers SA: No specific record class for Death Registers TAS: Retain permanently (see 4.9.1) VIC: Retain permanently (see 4.1.4) WA: Retain permanently (see 9.9). Other comments/factors for consideration: Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.3 Death Registers – Retain for 10 years after last action
2676	<i>Diagnostic Images, Audio and Other Similar Material Registers</i> Register comprising details including location of diagnostic images, audio and other	Date authorised: 27 July 2021 Why are these records created: Diagnostic Images, Audio and Other Similar Material Registers document details including location of diagnostic images, audio and other similar materials used for tracking purposes and not showing the final disposal of the diagnostic images that occur at Queensland Health facilities.

similar materials used for tracking purposes. Records may include, but are not limited to: • registers of radiographic images or diagnostically equivalent recording of medical images/material relating to the production of: • Audiology, spirometry, grading, imaging, measurements and readings of organs and/or tissues, using radiological or other diagnostic medical procedures. • Diagnostic radiology, nuclear medicine, ultrasound, Computed Tomography and Magnetic Resonance Imaging and clinical photography records. Disposal action – Temporary. Retain until all diagnostic imaging, audio and other similar materials described in the register have been disposed of in accordance with Diagnostic Imaging, Audio and Other Similar Material of this Schedule.	Why the records are retained for this retention period: These registers do not form master control records and do not document disposal. Diagnostic Images, Audio and Other Similar Material Registers document the location of diagnostic films and other visual material and are used for tracking purposes. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Destroy 7 years after last action (see 019.026.019) NSW: Retain until no longer required for administrative purposes, then destroy (see 3.4.1) NT: No specific record class for Diagnostic Images, Audio and Other Similar Material Registers SA: No specific record class for Diagnostic Images, Audio and Other Similar Material Registers TAS: No specific record class for Diagnostic Images, Audio and Other Similar Material Registers VIC: No specific record class for Diagnostic Images, Audio and Other Similar Material Registers WA: Destroy when all film and visual materials registered have been destroyed (see 13.3). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.6 Film and Other Visual Material Registers – Retain until all the film and visual materials described in the register have been disposed of in accordance with Reference Number 2.3.1 of this Schedule.
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Disposal Authorisation	Record class and retention period	Justifying the retention period
2677	<i>Disease and Operation Indices</i> Indices listing each disease, condition, operation or procedure code numbers with the selected items for each patient/client having diagnoses or having undergone that operation or procedure that is not captured elsewhere. Records may include, but are not limited to: • Register/indexes listing in date and time order, each operation or procedure carried out in the theatre. • Register/indexes listing date of admission, length of stay, discharge status and destination, serial number of operation, time, patient's name, sex, age and unit record number, diagnosis and operative procedure, name of surgeon, assistant surgeon and anaesthetists, signatures of surgeon and anaesthetists, any anaesthetic complications and remarks.	Date authorised: 27 July 2021 Why are these records created: Disease and Operation Indices document the diseases and operations of patients/clients at Queensland Health facilities. Disease and Operation Indices are used in locating patient/client records in a numerical filing system linking the patient's name to the identification number. Why the records are retained for this retention period: Queensland Health advised that there is a long-term business need to retain these indexes not only for the life of the patient, but for the next 3 – 4 generations (approximately 120 years based on a generation being 25-30 years) Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Retain permanently (see 019.026.002) NSW: Retain permanently (see 2.1.2) NT: No specific record class for Disease and Operation Indices Registers SA: Retain permanently (see 2.8.2) TAS: Retain permanently (see 4.10.1) VIC: No specific record class for Disease and Operation Index Registers WA: Retain permanently (see 9.2). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.4 Disease and Operation Indexes - Retain for 120 years after last action

Disposal Authorisation	Record class and retention period	Justifying the retention period
	Disposal action – Temporary. Retain for 120 years after last action.	
2678	<i>Emergency and Outpatient Attendance Registers</i> Register listing in date and time order each patient/client attendance at a health facility emergency or outpatient department. Records may include, but are not limited to: • Date and time of attendance, name, sex, date of birth or age of patients/clients, attending medical officer. • Unit record number, address, reason for attendance, and where available, outcome of follow-up arrangements. • Patients/clients who were dead on arrival. Excludes any record listed above that relates to incidents, allegations, disclosures and investigations of abuse of vulnerable persons. These records must be retained for	Date authorised: 27 July 2021 Why are these records created: The Emergency and Outpatient Attendance Registers comprise registers that document the attendance of patients/clients at Queensland Health emergency and outpatient facilities. The registers comprise details of patient/client time and date of attendance, name, date of birth or age, gender and attending medical officer. Other details that may be included in the registers are the patient/client record number, address, reason for attendance and outcome of follow-up arrangements. Outpatient attendance registers are appointment scheduling records and contain no patient condition information. Why the records are retained for this retention period: Emergency and Outpatient Attendance Registers document in summary form each patient/client's attendance at Queensland Health emergency and outpatient facilities that would not be documented in the admission registers. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: Please see the following jurisdictions for the retention of clinical records for Emergency and Outpatient Attendance Registers: ACT: Retain permanently (see 019.026.008) NSW: Retain permanently (see 2.1.7) NT: No specific record class for Emergency and Outpatient Attendance Registers SA: Retain permanently (see 2.8.2)

Disposal Authorisation	Record class and retention period	Justifying the retention period
	100 years after creation of the record. See GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons. Disposal action – Temporary. Retain for 10 years after last action.	TAS: Destroy 7 years after date of last entry in register (see 4.7.1) VIC: No specific record class for Emergency and Outpatient Attendance Registers WA: Retain permanently (see 9.7). Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.5 Emergency and Outpatient Attendance Registers - Retain for 10 years after last action.
2679	<i>Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR)</i> Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR) record the names and unit record numbers of a patient/client who has received care at a health facility or where the intention is that they will receive a health service. Records may include, but are not limited to: Details which constitutes the patient master index such as the name of the health facility, patient's/client's unit record number, name, date of	Date authorised: 27 July 2021 Why are these records created: These records document the unique number allocated to each patient. Alternative names for this index include Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR). The registers comprise details of the name of the Queensland Health facility, patient's/client's number, name, date of birth, sex, address, and date of patient's/client's registration (i.e. the date that the unit record number was assigned). Traditionally these indices comprised large collections of index cards, but in recent decades, these records are created and maintained within electronic business systems. Why the records are retained for this retention period: Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR) form the master patient/client index and control record linking the names of Queensland Health's patient/clients to their record number. They have research value and warrant permanent retention. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log.

Disposal Authorisation	Record class and retention period	Justifying the retention period
	birth, sex, address, and date of patient's/client's registration (e.g. the date that the unit record number was assigned). MPI, PMI and MPR are keys to locating an individual patient/client record in a numerical filing system, by providing a link between the name of the patient/client and the health facility's unit record number. See Number Registers / Patient Number Registers / Client Number Registers for registers in number order See Admission and Discharge Registers where the MPI / PMI / MPR or their equivalent maintains a record of summary patient/client admission and discharge registration details not recorded elsewhere. Disposal action – Permanent in agency.	Comparison with other schedules' retention period: ACT: Retain permanently (see 019.026.001) NSW: Retain until no longer required for administrative purposes, then destroy (see 2.1.1) NT: No specific record class for Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR) SA: Retain permanently (see 2.8.1) TAS: Retain permanently (see 4.1.1) VIC: Destroy 75 years after last action (see 1.2.1) WA: Retain permanently (see 9.1). Other comments/factors for consideration: Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.7 Master Patient Indexes (MPI)/Patient Master Indexes (PMI)/Master Patient Registers (MPR) – Retain permanently.
2680	<i>Mental Health Registers</i> Registers at health facilities made in accordance with the <i>Mental Health Act 2016</i> (Qld)	Date authorised: 27 July 2021

or a repealed Mental Health Act (<i>Mental Health Act 2000</i> (Qld) or <i>Mental Health Act 1974</i> (Qld)) relating to the summarisation of details in a central registration system to register or identify current and returning patients/clients. Records may include, but are not limited to: The register of authorised doctors, register of patients/clients liable to be detained, restricted patient/client registers, seclusion registers, etc. Includes data sets contained within information systems which comprise the registers, such as: • Mental Health Information Systems. • Consumer Integrated Mental Health and Addiction (CIMHA) application. • Electroconvulsive Therapy (ECT), sedation and seclusion registers. Disposal action – Temporary. Retain for 120 years after last action.	Why are these records created: The Mental Health Registers are used to locate the patient/client record in a numerical filing system linking the patient's name to the identification number. Why the records are retained for this retention period: Mental Health Registers document in summary form a patient/client's treatment attendance at Queensland Health facilities in the area of mental health. Queensland Health advised that there is a long-term business need to retain these registers not only for the life of the patient, but for the next 3-4 generations (approximately 120 years based on a generation being 25-30 years). They have research value and warrant long term retention. The Mental Health Registers are to be kept at public and psychiatric hospitals under the <i>Mental Health Act 2016</i> (Qld). The registers are maintained on the Consumer Integrated Mental Health and Addiction (CIMHA) Application and World Health Organisation Mental Health Information Systems (MHIS). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: No specific record class for Mental Health Registers NSW: Registers or summary records documenting the administration of electro-convulsive therapy or sedation or seclusion of mental health patients - Retain minimum of 15 years after date of last entry, then destroy (2.1.12) NT: No specific record class for Mental Health Registers SA: No specific record class for Mental Health Registers TAS: No specific record class for Mental Health Registers VIC: No specific record class for Mental Health Registers WA: No specific record class for Mental Health Registers. Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.8 Mental Health Registers – Retain for 120 years after last action.
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Disposal Authorisation	Record class and retention period	Justifying the retention period
2681	<i>Number Registers / Patient Number Registers / Client Number Registers</i> Number Registers / Patient Number Registers / Client Number Registers list the unit record numbers in numerical order, and as each number is issued, records the name of the patient/client to whom the number has been issued. Records may include, but are not limited to: Registers (e.g. card register or equivalent) comprising details which constitute the Number Register such as unit record numbers, patient's/client's name, date of birth, sex, and date on which the number was issued. See <u>Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR)</u> Disposal action – Temporary. Retain until administrative use ceases.	Date authorised: 27 July 2021 Why are these records created: The Number Registers / Patient Number Registers / Client Number Registers document the unique number allocated to each patient/client. The patient/client number is used as the key identifier for their clinical records. These registers are a chronological list of unit record numbers in numerical order, and as each number is issued, records the name of the patient to whom the number has been issued. Why the records are retained for this retention period: As the information in these registers duplicates the information contained in the Patient Master Index, the Number Registers are a tool used to allocate patient numbers and only need to be retained until their administrative use has ceased. Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Retain permanently (see 019.026.001) NSW: Retain until no longer required for administrative purposes, then destroy (see 2.1.1) NT: No specific record class for Number Registers/Patient Number Registers/Client Number Registers SA: Retain permanently (see 2.8.1) TAS: Retain permanently OR Destroy when reference ceases (if duplicated in PMI) (see 4.4.1 OR 4.4.2) VIC: No specific record class for Number Registers/Patient Number Registers/Client Number Registers WA: Retain until no longer required for administrative purposes, then destroy (see 9.4.1).

Disposal Authorisation	Record class and retention period	Justifying the retention period
		Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.9 Number Registers/Patient Number Registers/Client Number Registers – Retain until administrative use ceases.
2682	<i>Operation/Theatre Registers</i> Registers comprising details of patient/client's operations performed at health facilities. Records may include, but are not limited to: • Details of serial number of operation, date, time, patient's/client's name, sex, age and unit record number, diagnosis and operative procedure, name of surgeon, assistant surgeon and anaesthetists. • Includes both paper-based registers and electronic registers. Disposal action – Temporary. Retain for 120 years after last action.	Date authorised: 27 July 2021 Why are these records created: The Operation/Theatre Registers document patient/client operations performed at Queensland Health facilities. Why the records are retained for this retention period: The registers comprise details of serial number of the operation, date, time, patient/client name, sex, age and record number, diagnosis and operative procedure, name of surgeon, assistant surgeon and anaesthetists. Queensland Health advised that there is a long-term business need to retain these registers not only for the life of the patient, but for the next 3 – 4 generations (approximately 120 years based on a generation being 25 – 30 years). Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: ACT: Retain permanently (see 019.026.011) NSW: Retain permanently (see 2.1.8) NT: No specific record class for Operation/Theatre Registers SA: Retain permanently (see 2.8.2) TAS: Retain permanently (4.10.1) VIC: No specific record class for Operation/Theatre Registers

Disposal Authorisation	Record class and retention period	Justifying the retention period
		WA: Retain permanently (see 9.10). Other comments/factors for consideration: Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.10 Operation/Theatre Registers – Retain 120 years after last action.
2683	<i>Short Term Registers</i> Registers with the sole purpose of providing information of temporary, short term value to assist in the routine administration of hospital wards and the changing shifts of staff or information already recorded and available in an acceptable medium (e.g. paper-based or electronic) elsewhere in the health facility (e.g. admission registers). Any pertinent information is to be transposed into the relevant clinical record(s). Records may include, but are not limited to: • Bed Return or Daily Bed Return – daily midnight census for a ward, listing all inpatients admitted, discharged, transferred, died and those remaining in at midnight.	Date authorised: 27 July 2021 Why are these records created: The Short Term Registers locate the patient/client record in linking the patient/client name to the identification number. Why the records are retained for this retention period: The Short Term Registers provide information of temporary, short term value to assist in the routine administration of hospital wards and the changing shifts of staff or information already recorded and available in an acceptable medium (e.g. paper-based or electronic) elsewhere in the health facility (e.g. admission registers). Other information contained in the registers relating to the patient's/client's condition and their admission/discharge is captured in their clinical records and the admission and discharge registers Applicable legislation/standards: See the list of applicable legislation and standards for public records created, kept and managed by the Health Sector located at the beginning of this appraisal log. Comparison with other schedules' retention period: Please see the following jurisdictions for the retention of clinical records for Short Term Registers: ACT: No specific record class for Short Term Registers NSW: Retain minimum of 2 years after date of last entry, then destroy (see 2.2.1) NT: No specific record class for Short Term Registers SA: No specific record class for Short Term Registers TAS: No specific record class for Short Term Registers VIC: No specific record class for Short Term Registers WA: Destroy when reference ceases (see 9.12).

Disposal Authorisation	Record class and retention period	Justifying the retention period
	• Daily Inpatient Census – listing of all inpatients within a health facility at the time that the list was created. List may also include current ward of inpatients, visitor access permission and a generic statement in regard to each patient's general condition. • Ward Registers – daily cumulative listing of inpatient movement within that ward (e.g. admissions, bed transfers, discharges). Disposal action – Temporary. Retain until administrative use ceases.	Other comments/factors for consideration: Previous schedule references: Health Sector (Clinical Records) Retention and Disposal Schedule: QDAN 683 v.1 Reference 3.11 Short Term Registers – Retain until superseded.