

HEALTH SECTOR (CLINICAL RECORDS) RETENTION AND DISPOSAL SCHEDULE

Authorised 27 July 2021

An authorisation under s.26 of the *Public Records Act 2002* for the disposal of clinical records created by the health sector.

Where printed, this reproduction is only accurate at the time of printing.
The [Queensland Government \(For Government\) website](#) should always be referred to for the current, authorised version.

Using this schedule

The Health Sector (Clinical Records) retention and disposal schedule (Schedule) authorises the disposal of public records which can include data and information, created or received by Queensland Health. This may include, but is not limited to, Queensland Health, the Queensland Ambulance Service and the Hospital and Health Services. The Schedule applies to public records created in any format, unless otherwise specified in the disposal authorisation description.

The Schedule can be used in conjunction with the [General retention and disposal schedule](#) (GRDS) and the [General retention and disposal schedule – Lite](#) (GRDS Lite). Disposal authorisations in the Common Activities section of the GRDS and the GRDS Lite may be applied to any function undertaken by a public authority, provided the minimum retention period meets all of the public authority's specific regulatory requirements.

Any references to repealed legislation may be taken as a reference to current legislation if the context permits.

The Department of Health is responsible for the Schedule. In the event of an administrative change, or the transfer of a function from one public authority to another, this Schedule will continue to apply to the public records described by the Schedule. For further advice on authorised retention and disposal schedules following administrative change, please contact Queensland State Archives on (07) 3037 6777 or via the [Queensland Government \(For Government\) website](#).

Repealed Retention and Disposal schedules must not be used to dispose of public records. Repealed schedule/s include:

- QDAN 17 v.1 Queensland Health (Clinical Records) issued 1996
- QDAN 385 v.1 Queensland Health - Princess Alexandra Hospital issued 1999
- QDAN 428 v.1 Queensland Health - Communicable Diseases Unit issued 1999
- QDAN 428 v.2 Queensland Health - Communicable Diseases Unit issued 2000
- QDAN 522 v.1 Queensland Health - North Brisbane Oral Health Service (Dental School Patient Records) issued 2001
- QDAN 546 v.1 Queensland Health (Clinical Records) issued 2001
- QDAN 546 v.2 Queensland Health (Clinical Records) issued 2001
- QDAN 546 v.3 Queensland Health (Clinical Records) issued 2007
- QDAN 683 v.1 Health Sector (Clinical Records) issued 2012

Records relating to vulnerable persons

While using this Schedule, Queensland Health needs to carefully consider public records relevant to the proactive protection of vulnerable persons. Public records relevant to the proactive protection of the rights and entitlements of vulnerable persons are covered by disposal authorisations under COMMON ACTIVITIES – PROACTIVE PROTECTION OF VULNERABLE PERSONS-RELEVANT RECORDS in the [GRDS](#). The [Guideline on creating and keeping records for the proactive protection of vulnerable persons](#) provides assistance on identifying and managing public records related to vulnerable persons.

If there is an inconsistency in disposal authorisation between the public records related to vulnerable persons detailed in the GRDS and this Schedule, the disposal authorisation with the longest minimum retention period is applied.

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

When this schedule should not be used

It is an offence under the *Criminal Code Act 1899* (s.129) if 'a person, who knowing something is or may be needed in evidence in a judicial proceeding, damages it with intent to stop it being used in evidence'. A duty of care exists for public authorities to ensure public records are not disposed of which may be needed in evidence for a judicial proceeding, including any legal action or a Commission of Inquiry. Internal processes should be implemented to meet this obligation, which may include consultation with your legal or Right to Information area.

Schedule layout

Each disposal authorisation has been allocated a unique number to aid with the disposal of public records. Further implementation information is available on the [Queensland Government \(For Government\) website](#).

Disposal

This Schedule provides authorisation by the State Archivist for the disposal of public records as required under the *Public Records Act 2002*. No further notification of the disposal of public records by your public authority to Queensland State Archives is required. Approval from the Executive Officer or authorised delegate of your public authority is required prior to the disposal of public records. Disposal must also be appropriately documented in accordance with the [Records Governance Policy](#).

Any disposal of public records without authorisation from the State Archivist may be a breach of the *Public Records Act 2002* (s.13).

How we can help?

More information on implementing schedules is available on the [Queensland Government \(For Government\) website](#). Any enquiries about this schedule or recordkeeping should be directed in the first instance to your Records Manager. If further information is required, please contact Queensland State Archives on (07) 3037 6777 or via the [Queensland Government \(For Government\) website](#).

Approved by State Archivist: Irene Violet

Date: 27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Contents

CLINICAL RECORDS – GENERAL	6
Clinical records – Adults	6
Clinical records – Minors	7
Clinical records – Deceased Minors.....	8
CLINICAL RECORDS - EXCEPTIONS	11
COAL WORKERS’ PNEUMOCONIOSIS (BLACK LUNG DISEASE)	11
Coal Workers’ Pneumoconiosis (Black Lung Disease).....	11
CLINICAL RESEARCH RECORDS	11
Clinical Research Records – Adults.....	12
Clinical Research Records – Minors.....	13
DIAGNOSTIC IMAGING, AUDIO AND OTHER SIMILAR MATERIAL	13
Diagnostic Imaging, Audio and Other Similar Material	13
GENETIC HEALTH RECORDS	14
Genetic Health Records.....	14
HANDOVER WORKSHEETS	15
Handover worksheets.....	15
INAPPROPRIATE REFERRALS	15
Inappropriate Referrals.....	15
MENTAL HEALTH RECORDS	16
Mental Health Facility Clinical Records – Mental Health Act 2016 (Qld) Forensic Order and Treatment Support Order Patients	16
Mental Health Facility Clinical Records – <i>Mental Health Act 2000</i> (Qld) Special Notification Forensic Patients	17
NOTIFIABLE DISEASE TREATMENT RECORDS	18
Notifiable Disease Treatment Records	18

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

OBSTETRIC RECORDS.....	19
Obstetric Records without evidence of Artificial Insemination (AI) / In-Vitro Fertilisation (IVF).....	19
Obstetric Records with evidence of Artificial Insemination (AI) / In-Vitro Fertilisation (IVF)	20
Artificial Insemination (AI) / In-Vitro Fertilisation (IVF) Donor Records	21
Unborn Child at Risk Notifications	21
ORGAN AND TISSUE DONOR RECORDS.....	22
Organ and Tissue Donor Records	22
ROUTINE CLINICAL WORKSHEETS.....	23
Routine clinical worksheets	23
REGISTERS AND INDICES.....	24
Admission and Discharge Registers	24
Birth (Labour Ward) Registers	24
Death Registers.....	25
Diagnostic Images, Audio and Other Similar Material Registers	25
Disease and Operation Indices.....	26
Emergency and Outpatient Attendance Registers	26
Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR)	27
Mental Health Registers	28
Number Registers / Patient Number Registers / Client Number Registers	28
Operation/Theatre Registers	29
Short Term Registers	29
GLOSSARY	30

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

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	Description of records	Retention period & trigger	Date authorised
2654	<p>Clinical records – Adults</p> <p>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.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. • 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 	<p>Temporary.</p> <p>Retain for 10 years after last patient/client service provision or legal action, whichever is the later.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<p>diagrams, relevant video records and clinical photographs, radiologists working notes and microform master copies of clinical records and images.</p> <ul style="list-style-type: none"> • Consent or authority to carry out any treatment, procedure or release of information. Also, refusal of treatment or withdrawal of consent. • Copies of death notifications, autopsy and post-mortem reports. <p>See <i>Forensic and Scientific Services retention and disposal schedule for Coronial autopsies</i></p> <p>Excludes clinical records covered in <i>Clinical Records – Exceptions</i> of this Schedule.</p> <p>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.</p> <p>See <i>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons</i>.</p>		
2655	<p>Clinical records – Minors</p> <p>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.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. 	<p>Temporary.</p> <p>Retain for when patient/client reaches 28 years of age</p> <p>AND</p> <p>10 years after last patient/client service provision or legal action, whichever is the later.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<ul style="list-style-type: none"> • 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 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. <p>See <u><i>Clinical Records- Deceased Minors</i></u> for records of minors who have deceased before attaining 18 years of age.</p> <p>See <u><i>Obstetric records</i></u> for records relating to stillbirth</p> <p>Excludes clinical records covered in <u><i>Clinical Records – Exceptions</i></u> of this Schedule.</p> <p>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.</p> <p>See <u><i>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</i></u></p>		
2656	<p>Clinical records – Deceased Minors</p> <p>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.</p>	Temporary.	27 July 2021

This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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, 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 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. <p>See <u><i>Forensic and Scientific Services retention and disposal schedule</i></u> for Coronial autopsies See <u><i>Obstetric records</i></u> for records relating to stillbirth</p>	<p>Retain for 10 years from patient/client date of death AND 10 years after legal action, whichever is the later.</p>	

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<p>See <u>Clinical records - Minors</u> for records relating to individuals yet to attain 18 years of age</p> <p>Excludes clinical records covered in <u>CLINICAL RECORDS – EXCEPTIONS</u> of this Schedule.</p> <p>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.</p> <p>See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons</u>.</p>		

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

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	Description of records	Retention period & trigger	Date authorised
COAL WORKERS' PNEUMOCONIOSIS (BLACK LUNG DISEASE)			
2657	<p>Coal Workers' Pneumoconiosis (Black Lung Disease)</p> <p>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.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • Medical examinations and health assessments. • All medical imaging irrespective of format or storage medium. • Diagnostic measuring processes (e.g. audiology, spirometry, electroencephalograms, electrocardiograms, electromyograms or cardiocograms). <p>See <i>PUBLIC AND ENVIRONMENTAL HEALTH</i> in the <u>Health Sector (Corporate Records) retention and disposal schedule</u> for records relating to public and environmental health notifications and orders</p>	<p>Temporary.</p> <p>Retain for 85 years from patient's/client's date of birth</p> <p>AND</p> <p>10 years after last patient/client service provision or legal action, whichever is the later.</p>	27 July 2021

CLINICAL RESEARCH RECORDS

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.

Clinical records created before, during and after relating to clinical research (including clinical trials) where:

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<ul style="list-style-type: none"> 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 2.1.1 of the Australian Code for the Responsible Conduct of Research. 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). <p><i>For records created and maintained by Committees formed to oversee the conduct of research activities (e.g. Research Ethics Committees) see GRDS COMMON ACTIVITIES - Committees</i></p> <p><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></p>		
2658	<p>Clinical Research Records – Adults</p> <p>Clinical research records (including clinical trials) where the patients/clients or subjects were adults.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> 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. <p>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.</p>	<p>Temporary.</p> <p>Retain for 15 years from completion of clinical research/trial or after date of publication or termination of the study</p> <p>AND</p> <p>10 years after last patient/client service provision or legal action, whichever is the later.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<i>See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</u></i>		
2659	<p>Clinical Research Records – Minors Clinical research records (including clinical trials) where the patients/clients or subjects were minors. Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • Patient/client or subject’s consent for participation. • Patient/client or subject’s authorisation for use of his/her information from the study. • Laboratory results. • Other diagnostics or investigative reports. • Clinical questionnaire and surveys. <p>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.</p> <p><i>See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</u></i></p>	<p>Temporary. 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.</p>	27 July 2021
DIAGNOSTIC IMAGING, AUDIO AND OTHER SIMILAR MATERIAL			
2660	<p>Diagnostic Imaging, Audio and Other Similar Material 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:</p> <ul style="list-style-type: none"> • All medical imaging irrespective of format or storage medium. 	<p>Temporary. Retain for 7 years after image or recording was made.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<ul style="list-style-type: none"> • Duplicate reports (not sent to requesting clinician). • Production of grading, measurements and readings of organs and/or tissues. <p>See <u>CLINICAL RECORDS – GENERAL</u> for examples of other diagnostic imaging, audio and other similar material kept on the clinical record</p> <p>See <u>Obstetric Records</u> for diagnostic imaging, audio and other similar material related to obstetrics</p> <p>See <u>Routine clinical worksheets</u> for Sonographer worksheets</p> <p>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.</p> <p>See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons</u>.</p>		
GENETIC HEALTH RECORDS			
2661	<p>Genetic Health Records</p> <p>Records resulting from genetics consultations by clinical geneticists.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. 	Temporary. Retain for 120 years after last patient/client service provision.	27 July 2021

This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<p>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.</p> <p><i>See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</u></i></p>		
HANDOVER WORKSHEETS			
2662	<p>Handover worksheets</p> <p>Handover worksheets and notes made to facilitate the handover and change of shifts. Records may include, but are not limited to:</p> <ul style="list-style-type: none"> 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 including shift handover sheets and day/night reports). 	<p>Temporary.</p> <p>Retain until the accuracy of the outcomes/results have been transferred to the patient/client clinical record and have been verified.</p>	27 July 2021
INAPPROPRIATE REFERRALS			
2663	<p>Inappropriate Referrals</p> <p>Referrals for no further action where the patient/client is not treated because the patient/client is either deemed unsuitable or did not attend.</p> <p>The patient/client has no clinical record created within the health facility as a result of the inappropriate referral.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> Records of assessment that does not result in treatment or care but include records of triage activities (e.g. admission forms, general correspondence, letters, clinical notes, referral forms and investigation/pathology reports). 	<p>Temporary.</p> <p>Retain for 2 years after last action.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	See <u>Clinical Records – General</u> for records displaying evidence of clinical care and health status to an individual or groups or patients/clients.		
<p>MENTAL HEALTH RECORDS</p> <p><i>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 Mental Health Act 2016 (Qld).</i></p> <p><i>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 Mental Health Act 2000 (Qld) or Mental Health Act 1974 (Qld).</i></p> <p>See <u>CLINICAL RECORDS - GENERAL</u> for mental health clinical records not described below</p> <p>See <u>Mental Health Registers</u> for a central register for mental health patients</p> <p>See <u>MENTAL HEALTH in the Health Sector (Corporate Records) retention and disposal schedule</u> for non-clinical records related to mental health treatment and services</p> <p>See <u>Disability Services retention and disposal schedule</u> for records relating to forensic disability facilities</p> <p>Excludes records related to the abuse of vulnerable persons. See <u>GRDS Proactive Protection of Vulnerable Persons – relevant records</u></p>			
2664	<p>Mental Health Facility Clinical Records – Mental Health Act 2016 (Qld) Forensic Order and Treatment Support Order Patients</p> <p>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).</p> <p>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.</p> <p>These orders are subject to periodic review by the Mental Health Review Tribunal.</p> <p>Records may include, but are not limited to:</p>	<p>Temporary.</p> <p>Retain for 100 years from patient’s/client’s date of birth</p> <p>AND</p> <p>10 years after last patient/client service provision or legal action, whichever is the later.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<ul style="list-style-type: none"> Records made in accordance with the <i>Mental Health Act 2016</i> (Qld) or a repealed <i>Mental Health Act (Mental Health Act 2000</i> (Qld) or <i>Mental Health Act 1974</i> (Qld)) 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. <p>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.</p> <p>See <u><i>CLINICAL RECORDS - GENERAL</i></u> for mental health clinical records not described in 2664 and 2665</p> <p>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.</p> <p>See <u><i>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</i></u></p>		
2665	<p>Mental Health Facility Clinical Records – <i>Mental Health Act 2000</i> (Qld) Special Notification Forensic Patients</p> <p>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).</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> 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 with a 'Special Notification Forensic Patient' status. <p>Note: The category 'Special Notification Forensic Patient' has been repealed under the <i>Mental Health Act 2016</i> (Qld).</p>	<p>Temporary.</p> <p>Retain for 100 years from patient's/client's date of birth</p> <p>AND</p> <p>10 years after last patient/client service provision or legal action, whichever is the later.</p>	27 July 2021

This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<p>See <u>CLINICAL RECORDS – GENERAL</u> for mental health clinical records not described in 2664 and 2665</p> <p>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.</p> <p>See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons</u>.</p>		
NOTIFIABLE DISEASE TREATMENT RECORDS			
2666	<p>Notifiable Disease Treatment Records</p> <p>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 current list of all notifiable conditions.</p> <p>Examples of notifiable conditions include but are not limited to:</p> <ul style="list-style-type: none"> • Human immunodeficiency virus (HIV) • Leprosy • Q Fever • Severe Acute Respiratory Syndrome (SARS) • Syphilis • Tuberculosis. <p>See <u>CLINICAL RECORDS – GENERAL</u> for records for Hepatitis B and Hepatitis C</p>	<p>Temporary.</p> <p>Retain for 85 years from patient's/client's date of birth</p> <p>AND</p> <p>10 years after last patient/client service provision or legal action, whichever is the later.</p>	27 July 2021

This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
<p>OBSTETRIC RECORDS <i>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.</i></p>			
2667	<p>Obstetric Records without evidence of Artificial Insemination (AI) / In-Vitro Fertilisation (IVF) 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. Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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) 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 is not limited to Child/stillborn images, neonatal oximeter printouts and 3D images <p>See <u><i>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</i></u></p> <p>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.</p> <p>See <u><i>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</i></u></p>	<p>Temporary. Retain 28 years after last delivery AND 10 years after legal action, whichever is the later.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
2668	<p>Obstetric Records with evidence of Artificial Insemination (AI) / In-Vitro Fertilisation (IVF)</p> <p>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-vitro fertilisation (IVF) or/and use of semen, ova or embryos and the withdrawal of consent for such procedures.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 is not limited to Child/stillborn images, neonatal oximeter printouts and 3D images <p>See <u>Obstetric Records without evidence of Artificial Insemination (AI) / In-Vitro Fertilisation (IVF)</u> for records with no evidence of artificial insemination (AI) or in-vitro fertilisation (IVF) procedures,</p> <p>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.</p>	<p>Temporary.</p> <p>Retain 28 years after last delivery</p> <p>AND</p> <p>10 years after legal action, whichever is the later.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<i>See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</u></i>		
2669	<p>Artificial Insemination (AI) / In-Vitro Fertilisation (IVF) Donor Records</p> <p>Records relating to information about individual donors involved in artificial insemination (AI) or in-vitro (IVF) fertilisation procedures.</p> <p>Records may include, but are not limited to records relating to semen supply, including:</p> <ul style="list-style-type: none"> • 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. <p><i>See <u>Obstetric Records</u> for information relating to obstetrics.</i></p>	Permanent. Transfer to QSA after business action completed.	27 July 2021
2670	<p>Unborn Child at Risk Notifications</p> <p>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.</p> <p>This record class comprises of notifications where the patient/client does not present at that health facility for delivery.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • Child Safety HRA Form 1 – Unborn Child High Risk Alert Form: Request for immediate notification when pregnant woman presents for delivery. 	Temporary. Retain for 3 months after expected presentation date.	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<ul style="list-style-type: none"> • 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. <p>See <u>OBSTETRIC RECORDS</u> when the patient/client delivers at a health facility</p> <p>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.</p> <p>See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons</u>.</p>		
ORGAN AND TISSUE DONOR RECORDS			
2671	<p>Organ and Tissue Donor Records</p> <p>Organ and tissue donor records displaying evidence of clinical care to an individual patient/client who has donated organs/tissues.</p> <p>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 against autologous procedures.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. 	<p>Temporary.</p> <p>Retain for 50 years from last patient/client service provision or legal action, whichever is the later.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<ul style="list-style-type: none"> • 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): <ul style="list-style-type: none"> ○ 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. <p>See <u><i>Artificial Insemination (AI) / In-Vitro Fertilisation (IVF) Donor Records</i></u>. for donor records related to <i>Artificial Insemination (AI) / In-Vitro Fertilisation (IVF)</i></p>		
ROUTINE CLINICAL WORKSHEETS			
2672	<p>Routine clinical worksheets</p> <p>Routine clinical worksheets where the outcome/results are transferred to the patient's/client's clinical records.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • Records relating to frequent or continuous observation or monitoring (e.g. daily fluid balance sheets, frequent observations, worksheets, journals, daily ward diary). 	<p>Temporary.</p> <p>Retain until the accuracy of the outcome/results have been transferred to the patient's/client's clinical record and have been verified.</p>	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

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	Description of records	Retention period & trigger	Date authorised
2673	<p>Admission and Discharge Registers</p> <p>Register listing in date order of each patient/client admitted and discharged from a health facility.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> 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). 	<p>Permanent.</p> <p>Transfer to QSA after business action completed.</p>	27 July 2021
2674	<p>Birth (Labour Ward) Registers</p> <p>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.</p> <p>Records may include, but are not limited to:</p>	<p>Temporary.</p> <p>Retain for 120 years after last action.</p>	27 July 2021

This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<ul style="list-style-type: none"> 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 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. 		
2675	<p>Death Registers</p> <p>Register comprising details of deaths of patients/clients that occur at health facilities. Records may include, but are not limited to:</p> <ul style="list-style-type: none"> 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 Births, Deaths and Marriages. 	Temporary. Retain for 10 years after last action.	27 July 2021
2676	<p>Diagnostic Images, Audio and Other Similar Material Registers</p> <p>Register comprising details including location of diagnostic images, audio and other similar materials used for tracking purposes. Records may include, but are not limited to:</p> <ul style="list-style-type: none"> registers of radiographic images or diagnostically equivalent recording of medical images/material relating to the production of: <ul style="list-style-type: none"> 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. 	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	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
		<u>Material</u> of this Schedule.	
2677	<p>Disease and Operation Indices</p> <p>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.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. 	Temporary. Retain for 120 years after last action.	27 July 2021
2678	<p>Emergency and Outpatient Attendance Registers</p> <p>Register listing in date and time order each patient/client attendance at a health facility emergency or outpatient department.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. 	Temporary. Retain for 10 years after last action.	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
	<p>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.</p> <p><i>See <u>GRDS 1558 Incidents, allegations, disclosures and investigations of abuse – vulnerable persons.</u></i></p>		
2679	<p>Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR)</p> <p>Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR) records 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.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 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. <p><i>See <u>Number Registers / Patient Number Registers / Client Number Registers</u> for registers in number order</i></p> <p><i>See <u>Admission and Discharge Registers</u> where the MPI / PMI / MPR or their equivalent maintains a record of summary patient/client admission and discharge registration details not recorded elsewhere</i></p>	Permanent in agency.	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
2680	<p>Mental Health Registers</p> <p>Registers at health facilities 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)) relating to the summarisation of details in a central registration system to register or identify current and returning patients/clients.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ Mental Health Information Systems. ○ Consumer Integrated Mental Health and Addiction (CIMHA) application. ○ Electroconvulsive Therapy (ECT), sedation and seclusion registers 	Temporary. Retain for 120 years after last action.	27 July 2021
2681	<p>Number Registers / Patient Number Registers / Client Number Registers</p> <p>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.</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. <p><u>See <i>Master Patient Indices (MPI) / Patient Master Indices (PMI) / Master Patient Registers (MPR)</i></u></p>	Temporary. Retain until administrative use ceases.	27 July 2021

This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.

Disposal Authorisation	Description of records	Retention period & trigger	Date authorised
2682	<p>Operation/Theatre Registers</p> <p>Registers comprising details of patient/client's operations performed at health facilities. Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. 	Temporary. Retain for 120 years after last action.	27 July 2021
2683	<p>Short Term Registers</p> <p>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).</p> <p>Records may include, but are not limited to:</p> <ul style="list-style-type: none"> • 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. • 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). 	Temporary. Retain until administrative use ceases.	27 July 2021

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

GLOSSARY

Clinical Record	<p>A collection of data and information gathered or generated to record the clinical care and health status of an individual or group.</p> <p>NOTE:</p> <ol style="list-style-type: none"> 1. This includes information such as assessment findings, treatment details, progress notes, registration and information associated with care and health status. 2. Health records are made up of documents such as health record forms, clinical documents, legally authenticated documents and clinical referral letters received from clinical providers. 3. The term “clinical record” includes paper-based health records, medical records, digitized health records, Electronic Health Records (EHRs), healthcare records and personal health records. 4. Throughout the Schedule the term “clinical record” is used.
Electronic Health Record (EHR)	<p>A health record with data structured and represented in a manner suited to computer calculation and presentation.</p> <p>NOTE:</p> <p>When this term is used today it implies the ability to compute the content of the record. The EHR is often described as representing a lifetime record of health and care. An EHR may include digitized information, as well as born digital records and other database entries.</p>
Legal Action	<p>The term “legal action” includes an action relating to a legal process that has commenced or is reasonably anticipated including, for example:</p> <ul style="list-style-type: none"> • a proceeding in the courts instituted by one party against another • a demand or claim (demand for compensation made on an entity by a third party) • applications under <i>Right to Information Act 2009 (Qld)</i> or <i>Information Privacy Act 2009 (Qld)</i> (excluding Administrative Access) • a subpoena and other third-party requests for records including, but not limited to: • summons • search warrant • notice of non-party disclosure

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

- notice to produce
- other requests made under for example:
 - *Evidence Act 1977* (Qld) [s.134A]
 - *Personal Injuries Proceedings Act 2002* (Qld) [s.9] and *Personal Injuries Proceedings Regulation 2014* (Qld) [s.5]
 - *Motor Accident Insurance Act 1997* (Qld) [s.37] and *Motor Accident Insurance Regulation 2004* (Qld) [s.19]
 - *Workers' Compensation and Rehabilitation Act 2003* (Qld) [s.519]
 - *Police Powers and Responsibilities Act 2000* (Qld) [s.547]
 - *Industrial Relations (Tribunals) Rules 2011* (Qld) [Part 2, Division 2, Subdivision 7 Part 3, Division 5]
 - *Queensland Civil and Administrative Tribunal Act 2009* (Qld) [s.97]
 - *Coroners Act 2003* (Qld) [s.37]

Note:

Where doubt exists as to whether an action is covered by the term “legal action”, legal advice should be sought from a lawyer in the Department of Health or Hospital and Health Service, whichever is applicable.

[Definition of “legal action” as advised by Legal Services, Department of Health]

Patient

One or more persons scheduled to receive, receiving, or having received a health service.

NOTE:

- The term “patient” includes client, consumer and subject of care.
- Throughout the Schedule the term “patient/client” is used.
- Hospitals are known to use the term “patient” and other health facilities such as community health clinics are known to use the term “client”.

When the word “AND” is used in disposal actions in this Schedule it means that both retention periods must be met concurrently. For example in Clinical research records – adult, when the 15 years for the research has been reached, and there are 5 years remaining from their last date of attendance, then there will be 5 years remaining before the records can be considered for disposal.

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*

Examples of public records considered by Queensland Health to be clinical records include:

- admission/discharge forms
- history/referral information
- examination reports
- pathology/diagnostic records
- interpretive reports
- reports of treatment provided
- obstetric records
- drug/medication orders and administrations
- imaging records, photographs, audio-visual materials
- signed patient/client consent forms
- copies of statutory health reports and notifications where the original document has been forwarded to the governing body
- examples include records fulfilling obligations under the *Births, Deaths and Marriages Registration Act 2003* (Qld) and *Coroners Act 2003* (Qld)
- maintenance and sterilisation records of clinical equipment that are linked to one unit record number and relates to the provision of a clinical service e.g. Sterilisation Production Record (linked to a patient/client)
- mental health act forms

Examples of public records not considered by Queensland Health to be clinical records include:

- clinical ward/unit/divisional management records including statistical reports
- scientific services record inclusive of forensic science and public health science records
- personnel records of medical, nursing and allied health staff
- clinical equipment maintenance records and sterilisation records that are not linked to a unit record number and do not relate to the provision of a clinical service
- patient/client billing records
- patient/client travel subsidy scheme records and patient/client transport records
- patient/client complaints
- clinical trial records held by a clinical trial coordinator/data custodian
- clinical research records held by clinical research teams
- vaccination register and vaccination register forms

Note:

The records not considered clinical records are still public records and must not be disposed of without authorisation from the State Archivist in accordance with s.13 of the *Public Records Act 2002* (Qld).

*This retention and disposal schedule should be used in conjunction with the **General retention and disposal schedule (GRDS) – Proactive Protection of vulnerable persons – relevant records**. For any records relating to abuse of vulnerable persons, the GRDS disposal authorisations should apply unless existing minimum retention periods in this schedule are greater than, or equal to, those specified in the GRDS.*