Northern Territory Government

Department of Health and Community Services

Northern Territory Archives Service and Department of Health and Community Services

Disposal Schedule for Patient Records of Northern Territory Public Hospitals and Community Health Services

Disposal Schedule No.2002/1

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of Northern Territory Public Hospitals
and Community Health Services

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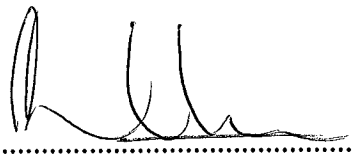
In accordance with NT Cabinet Decision No 3035 of 1983 authority is hereby granted for disposal of records in accordance with the provisions specified in this schedule.



..... Dated 4 / 11 / 02

Graham Symons
A/CEO Health and Community Services

..... Dated 4 / 11 / 2002

Greg Coleman
Director
Northern Territory Archives Service

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Authority

Patient Record Disposal Schedule No 2002/1 was compiled by the Northern Territory (NT) Department of Health and Community Services and the Northern Territory Archives Service (NTAS), under the direction of NT Cabinet Decision No 3035 of 1983. This states that no government agency can dispose of its records without approval from the NTAS.

Patient Record Disposal Schedule No. 2002/1 will be effective from date of authorisation until superseded.

Purpose of the Schedule

The purpose of the Schedule is to authorise appropriate retention and disposal of patient records of NT Public Hospitals and Community Health Services to:

- prevent the premature destruction of records required for medical, administrative, personal or legal purposes; and

- encourage the timely destruction of records which cease to have any medical, administrative, personal or legal value.

Scope

Patient Record Disposal Schedule No 2002/1 applies to patient records generated or received by all Public Hospitals and all urban and rural Community Health Services in the NT.

The records are commonly referred to as medical records, patient files, patient charts, tourist cards, temporary client cards, radiographic reports and films. They may include clinical notes, forms, reports, alerts, charts, correspondence and authorities.

These records may be paper-based records or radiographic films of admitted and non-admitted patients of Public Hospitals and Community Health Services including Hospital Emergency Department records and hospital inpatient and outpatient records.

Review Guidelines

The Schedule is subject to review under NTAS Guidelines. In addition, two Classes of records, Class 1.3.1 – records of Indigenous Australians born before 1980, and Class 1.4.1 – a Random Sample of records for social research, will be retained subject to further review of the value in continued retention of these records.

The collection of records of Indigenous Australians born before 1980 will be reviewed in year 2010, in accordance with Class 1.3.1. These records are retained to assist Indigenous Australians re-establish family and community links or establish Indigenous identity. This implements Recommendation 21: *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (*1997 p.347) which states –

> 'That no records relating to Indigenous individuals, families or communities or to any children, Indigenous or otherwise, removed from their families for any reason, whether held by government or non-government, be destroyed'.

The review of records in Class 1.3.1 will consider the value of continued retention of the collection of Indigenous Australian patient records, taking into account the amount and type of access that has occurred prior to 2010.

The Random Sample of individual patient records retained in accordance with Class 1.4.1 will be reviewed between January 2005 and June 2005 to assess the potential value of permanent retention of these records for the purposes of future social research.

Responsibility for conducting reviews of records in Classes 1.3.1 and 1.4.1 lies with Records Management Section, Department of Health and Community Services.

Custody of records

Temporary records required to be maintained for designated retention periods specified in the Schedule must be retained in the custody of the NT Department of Health and Community Services or with the NT Government Records Retention and Disposal Contractors (see Storage and Destruction of Records).

Status and Disposal Action

The right hand column of the schedule contains the status and disposal action for the records identified within that Class. The status of records is designated as either PERMANENT, TEMPORARY or REVIEW.

PERMANENT records are never to be destroyed and must be transferred to NTAS for retention as archives. TEMPORARY records have been appraised for destruction after a certain period of time. REVIEW records must not be destroyed and must be retained in the agency until the retention period of the records is determined.

The disposal action identifies the length of time the records must be retained. The prescribed length of time is the minimum retention period that the records must be retained. The department is free to retain the records longer than the periods prescribed in the schedule. The patient records are usually retained for a certain period of time after last access or after date of death.

Access Rights and Responsibilities

NT Public Hospitals and Community Health Services are responsible for ensuring access to their records by authorised parties, for the duration of the designated retention period. The information contained within the records must remain readable for the life of the record.

Random Sample Guidelines

In accordance with Class 1.4.1, a random sample of 1 in 100 records will be taken of records in Classes 1.2.1, 1.3.1, 1.5.1, 1.6.1, 1.7.1, 1.8.1, 1.9.1 and 1.10.1. The sample will comprise all records with a registration number ending in 00. A review of the value of the random sample will be undertaken between January 2005 and June 2005 (See Review Guidelines).

Sentencing of Records

Sentencing is the process of implementing a disposal schedule - identifying and classifying records according to the schedule and applying the disposal action specified. It is strongly recommended that officers with a reasonable knowledge of agency activities, who are able to seek clarification from within the agency or from the NTAS, carry out this process.

Storage and Destruction of Records

The NTAS no longer provides storage for records of temporary value and will only accept those records that are deemed to be of archival or permanent value. The storage of temporary records may be provided by the Government contractors for records retention and disposal services, and the conditions of these contracts are to be adhered to for storing temporary value records off-site. Procedures for storing records with the contractors are available from the NTAS.

Records that have reached the specified retention period in the schedule and are determined to have no continuing evidential or research value should be destroyed in a confidential and secure manner by shredding, pulping or incineration.

Notification of Destruction of Records

Further authorisation by the NTAS for destruction of records in accordance with the provisions of this schedule is not required. However, notification of the destruction to the NTAS is required using the form 'Notification of Destruction of Records'. Copies may be made from the form that appears at the back of this schedule or contact the NTAS for an electronic version.

When records are destroyed in accordance with the provisions of this schedule an appropriate entry must be made in the *Register of Records Destroyed.*

Register of Records Destroyed

The Department of Health and Community Services Records Management Section is to maintain registers of all records destroyed in accordance with the schedule. The registers must be clearly identified as the *Register of Records Destroyed* and should include the name of the public hospital or Community Health Service, description of records destroyed, date range, quantity, date destroyed, disposal schedule number and disposal Class. The name of the public hospital or Community Health Service should appear on each loose sheet or on the cover if the register is in book format. The registers can be the same used for registering destruction of administrative records.

Contacts/Help Desk

For advice on implementing Patient Records Disposal Schedule No 2002/1, including advice on records appraisal, disposal, transfer and storage, contact either a qualified Health Information Manager/Medical Records Administrator, Hospital Services (NT Department of Health and Community Services) or the Records Retention and Standards Coordinator at the NTAS.

Acknowledgements

This Patient Record Disposal Schedule No 2002/1 was developed by the Department of Health and Community Services in collaboration with the NTAS.

The Project was overseen and assisted by the Health Information Records Steering Committee. The Steering Committee would like to thank the wider Research Community for its comments and feedback, in particular for practical information relating to establishment of research guidelines. All comments have proved invaluable to the development of a schedule that takes into account best patient care practices both clinically and for research.

Thanks are also extended to clinicians and other health staff who provided time in Project Working Groups, and individually gave feedback when requested.

The Indigenous Working Group is gratefully acknowledged for its guidance in issues of cultural sensitivity. Recommendation 21: *Bringing Them Home, National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, 1997 has proved an invaluable resource for guidelines for the retention of records of Indigenous Australians.

Health related Records Disposal Schedules from other Australian states were used as valuable references. Information and insights from Disposal Schedule Project staff in other states is acknowledged.

Class	Description of Records	Disposal Action
1	**PATIENT RECORDS** Individual hard copy records of the treatment of admitted and non-admitted patients of Public Hospitals and Community Health Services. The records are also commonly referred to as medical records, patient files, patient charts, tourist cards, temporary client cards, radiographic reports and films. They may include clinical notes, forms, reports, notices, charts correspondence, authorities and other documents relating to: • Accidents and Emergencies • admissions and discharges • anaesthetics • cardiography and coronary care • drug administration • dialysis • haematology • immunology • intensive care • mental health • mortality • natality • neurology • nursing care • nutrition • operations • obstetrics • paediatrics • pathology • radiology (except radiographic film. See Class. 2)	
1.1	**PATIENT RECORDS**	
1.1.1	Individual patient records of admitted and non-admitted patients of Public Hospitals and Community Health Services except for Classes 1.2.1, 1.3.1, 1.5.1, 1.6.1, 1.7.1, 1.8.1, 1.9.1 and 1.10.1 **NOTE:** *A random sample of these records to be retained as per Class 1.4.1*	**TEMPORARY** 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) **NOTE:** *Prior to destruction ensure that a random sample is retained in compliance with Class 1.4.1.*

Class	Description of Records	Disposal Action
1.2	**DECEASED PATIENTS**	
1.2.1	Individual patient records of deceased admitted and non-admitted patients of Public Hospitals and Community Health Services except for Class 1.3.1. **NOTE:** *A random sample of these records to be retained as per Class 1.4.1*	**TEMPORARY** Destroy 10 years after date of death or 10 years after last access on behalf of deceased patient whichever is the latest, (provided the patient attained or would have attained the age of 25 years) **NOTE:** *Prior to destruction ensure that a random sample is retained in compliance with Class 1.4.1.*
1.3	**INDIGENOUS AUSTRALIAN PATIENTS**	
1.3.1	Individual patient records of admitted and non-admitted Indigenous Australian patients of Public Hospitals and Community Health Services born before 1980.	**REVIEW** Retain in agency for review. (See Review Guidelines)
1.4.1	**RANDOM SAMPLE**	
1.4.1.	Random sample of 1 in 100 individual patient records must be taken, in accordance with Random Sample Guidelines, from the following Classes 1.2.1, 1.3.1, 1.4.1.1, 1.5.1, 1.6.1, 1.7.1, 1.8.1, 1.9.1 and 1.10.1	**PERMANENT** Retain in agency for review. (See Review Guidelines)

Class	Description of Records	Disposal Action
1.5	**OBSTETRIC CARE**	
1.5.1	Individual patient records relating to obstetric care of patients including antenatal, delivery and post-natal care **NOTE:** *A random sample of these records to be retained as per Class 1.4.1*	**TEMPORARY** Destroy 25 years after last delivery or 15 years after last access whichever is the latest **NOTE:** *Prior to destruction ensure that a random sample is retained in compliance with Class 1.4.1*
1.6	**MALIGNANT NEOPLASMS (CANCER)**	
1.6.1	Individual patient records relating to treatment of malignant neoplasms (cancer) **NOTE:** *A random sample of these records to be retained as per Class 1.4.1*	**TEMPORARY** 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. **NOTE:** *Prior to destruction ensure that a random sample is retained in compliance with Class 1.4.1*

Class	Description of Records	Disposal Action
1.7	**TUBERCULOSIS**	
1.7.1	Individual patient records relating to treatment of tuberculosis	**TEMPORARY** 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.
	NOTE: *A random sample of these records to be retained as per Class 1.4.1*	**NOTE:** *Prior to destruction ensure that a random sample is retained in compliance with Class 1.4.1*
1.8	**BLOOD AND BLOOD PRODUCT TRANSFUSIONS**	
1.8.1	Individual patient records relating to blood and blood product transfusions	**TEMPORARY** 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.
	NOTE: *A random sample of these records to be retained as per Class 1.4.1*	**NOTE:** *Prior to destruction ensure that a random sample is retained in compliance with Class 1.4.1*

Class	Description of Records	Disposal Action
1.9	**TOURIST CARDS**	
1.9.1	Individual patient records for non-residents of the Northern Territory who receive 6 or less occasions of non-inpatient hospital care. The records are commonly referred to as tourist cards. **NOTE:** *A random sample of these records to be retained as per Class 1.4.1*	**TEMPORARY** Destroy 7 years after last attendance or after last access on behalf of patient whichever is the latest (provided the patient has attained the age of 25 years) **NOTE:** *Prior to destruction ensure that a random sample is retained in compliance with Class 1.4.1*
1.10	**TEMPORARY CLIENT CARDS**	
1.10.1	Individual patient records for residents and non-residents of the Northern Territory who receive 3 or less occasions of care in Community Health Services. The records are commonly referred to as temporary client cards **NOTE:** *A random sample of these records to be retained as per Class 1.4.1*	**TEMPORARY** Destroy 7 years after last attendance or after last access on behalf of patient whichever is the latest (provided the patient has attained the age of 25 years) **NOTE:** *Prior to destruction ensure that a random sample is retained in compliance with Class 1.4.1*

Class	Description of Records	Disposal Action
2	**RADIOLOGY RECORDS** Radiographic film of admitted and non-admitted patients of Public Hospitals and Community Health Services. The original of the report or a summary of the report is held in the patient record. (Where retained by hospital and not returned to patient at time of treatment)	
2.1	**RADIOGRAPHIC FILMS**	
2.1.1	Normal and abnormal radiographic films except those described in Classes 2.2.1 and 2.3.1	**TEMPORARY** 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)
2.2	**MALIGNANT NEOPLASMS (CANCER) FILMS**	
2.2.1	Normal and abnormal radiographic films relating to the treatment of malignant neoplasms (cancer)	**TEMPORARY** Destroy 10 years after date of death or if deceased status unknown then 25 years after last access
2.3	**TUBERCULOSIS FILMS**	
2.3.1	Normal and abnormal radiographic films relating to the treatment of tuberculosis	**TEMPORARY** Destroy 10 years after date of death or if deceased status unknown then 25 years after last access