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Government of South Australia

State Records of South Australia

General Disposal Schedule No. 28

Clinical and Client-Related Records of Public Health Units in South Australia

Disposal Schedule

Effective from 19 August 2014 to 30 June 2025

Edition **1**

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Preamble

Purpose of the Schedule

General Disposal Schedule 28 (GDS 28) authorises arrangements for the retention or destruction of records in accordance with Section 23(2) of the *State Records Act 1997 (SA)*.

GDS 28 is based on a review of RDS 2000/12 Version 1 and RDS 2000/13 Version 1 which were developed by State Records for SA Health in consultation with representative public health units and major stakeholders.

Application of the Schedule

Clinical and Client-Related Records of Public Health Units in South Australia

Approved Date: 19 August 2014

Effective Date: 19 August 2014 to 30 June 2025

Authorisation by State Records

This authorisation applies only to the disposal of the records described in the Schedule.

State Records' Contact Information

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Disposal of Official Records

Legislation

Section 23(1) of the *State Records Act 1997* states that an agency must not dispose of official records except in accordance with a determination made by the Manager [Director] of State Records with the approval of the State Records Council.

Section 23(2) states:

"If an agency requests the Manager to make a determination as to the disposal of official records, the Manager must, as soon as practicable:

(a) with the approval of the [State Records] Council, make a determination requiring or authorising disposal of the records in a specified manner; or

(b) make a determination requiring delivery of the records into the custody of State Records or retention of the records and later delivery into the custody of State Records."

The contents of GDS 28 constitute a determination within the meaning of the *State Records Act 1997*. GDS 28 provides public health units with the means of disposing of their operational records in an orderly, consistent and accountable manner.

Functions of the Schedule

A GDS plans the life of official records from the time of their creation to their disposal. It describes the records created and/or controlled by public health units, the disposal sentence specifying whether they are to be retained permanently as an archive or destroyed, and when this should occur.

GDS 28 has been developed by SA Health in consultation with key stakeholders. It determines the records which need to be kept because of their archival value and enables the disposal of records once they are no longer needed for administrative purposes. The assessment of the records takes into account their administrative, legal, evidential, financial, informational and historical values. The appraisal of the records is in accordance with the State Records' policy as documented in ***Appraisal of Official Records – Policy and Objectives*** - available from State Records' website (www.archives.sa.gov.au).

The Schedule complements the General Disposal Schedules (GDS) that are issued by State Records to cover generic administrative records common to most State Government agencies.

No modification of the minimum retention periods or disposal classes by end users is permitted, save with the approval of SA Health, State Records and the State Records Council.

GDS 28 has been issued in an electronic format only to allow ease of use, better version control, and greater accessibility. *GDS 28* is available via the State Records website (www.archives.sa.gov.au).

Using the Schedule

GDS 28 applies only to the records described within it, as created or received by certain agencies (or their predecessors) operating within one of the five Local Health Networks (LHN):

- Central Adelaide LHN
- Northern Adelaide LHN
- Southern Adelaide LHN
- Women's & Children's Health Network
- Country Health SA LHN.

Throughout GDS 28 such agencies are referred to as "public health units".

Organisations which are not considered "agencies" for the purposes of the State Records Act (such as private hospitals and clinics) are not required to use GDS 28. However, they ***may*** apply the disposal schedule as a matter of best practice so that their clinical or client-related records are retained for the same period as clinical or client-related records in the public health sector. There is no requirement for State Records to store any records of such organisations because their records are not "official" for the purposes of the State Records Act.

See also *Records excluded from* GDS 28 (pg. 30).

Layout

The Schedule is laid out as follows:

Item Number: Numbering in the Schedule is multi-level:

- Functions have single numbers (*e.g.* 1.)
- Activities and/or processes have two-level numbers (*e.g.* 1.1)
- Disposal classes have three-level numbers (*e.g.* 1.1.1).

Function: The general functions are shown in 12 point bold Arial upper case at the start of each section (e.g. **CLIENT CARE**).

Activity/Process: The activities and processes relating to each function are shown in 12 point bold Arial sentence case (e.g. **General Care**).

Description: Descriptions are in three levels ranging from broad functions to specific disposal classes:

- definitions of functions are shown at the start of each section in bold (e.g. **The function of client care can be defined as providing treatment or health care to clients within a public hospital, allied health or community health care setting.**)
- definitions of activities are located adjacent to the activity title in italics (e.g. *Care provided on an admitted or non-admitted, emergency or non-emergency basis at a public health unit).*
- descriptions of each disposal class are arranged in sequence under the activity definitions.

Disposal Action: Disposal actions relate to the disposal classes arranged under the activity descriptions. The status of the class is either PERMANENT or TEMPORARY with a disposal trigger and retention period given for all temporary records.

Retention Period of the Record

GDS 28 is used to sentence records. Sentencing involves applying the record retention periods within the GDS to the records of the public health unit. Decisions are made using the Schedule about whether records are to be retained and, if so, for how long, or when they are to be destroyed.

Retention periods in the GDS 28 reflect minimum clinical, legal and statutory requirements. Before seeking permission for destruction of temporary records from State Records, public health units should ensure that all legal requirements for the records as evidence and local clinical needs are considered.

There is no requirement to destroy temporary records if public health units have a need to retain them longer than the designated minimum retention period. However, in the interests of efficient and economic records management, public health units should take all steps to reduce the storage costs of time-expired records.

Retention periods are triggered by disposal actions listed in the Schedule.

Reactivation

Within GDS 28, the phrase "*after last contact*" is used as a trigger for a number of disposal actions. Activities identified as triggering the reactivation of records are considered an "after last contact" event from which the retention period is recalculated. If a record is reactivated once a retention period has commenced, the time is recalculated from the date of the subsequent last action.

The exception criteria, which means that records are sentenced according to the type of information they contain, and not just how old they are, were initially implemented in 2000 in RDS 2000/12 and RDS 2000/13. These RDS' were a prospective implementation, and not a retrospective process. However, if a reactivated pre-2000 record meets the exception criteria in this GDS, it needs to be sentenced accordingly.

However, because public health units use a clinical or client-related record (containing all details about the client's health experiences at a facility) the retention period applied as a result of reactivation will affect the whole clinical or client-related record and not just the information relating to the particular episode.

Custody and Transfer of the Record

Permanent Records

Section 19 of the *State Records Act 1997* includes provisions for the transfer of custody of an official record:

a) when the agency ceases to require access to the record for current administrative purposes or

b) during the year occurring 15 years after the record came into existence - whichever first occurs.

Official records that have been sentenced as permanent, in accordance with an approved disposal schedule, are required to be transferred to State Records.

SA Health has sought and been granted a global postponement from transfer for clinical and client-related records that are older than 15 years but still in ***active*** use. Once clinical and client-related records of permanent value are no longer active, however, public health units need to arrange for the transfer of such records to the custody of State Records.

It should be noted that postponement or exemption are only granted in exceptional circumstances.

Temporary Records

The custody of official records that have been sentenced as temporary is the responsibility of agencies. A policy and standards framework for the management and storage of temporary value official records has been established by State Records as documented in the *Management and Storage of Temporary Value Records with an Approved Service Provider (ASP) Standard*, the supporting *Guideline*, and the *Management and Storage of Temporary Value Records with an ASP – ASPL Guide (as amended).* Public health units need to comply with these policy documents - available from the State Records website (www.archives.sa.gov.au). It should be noted that temporary records are no longer accepted for storage by State Records, and if needed, arrangements will need to be made with an Approved Service Provider for off-site storage.

The custody of official records on networks or hard drives is also the responsibility of agencies. Public health units need to ensure that records in electronic format remain accessible to authorised users for the duration of the designated retention period. State Records is, however, currently examining options for the transfer of permanent value electronic records in digital form to its custody.

Destruction of Records

Prior to destruction, the following General Disposal Schedules (GDS) ***must*** be consulted:

- *GDS 16 Impact of Native Title Claims on Disposal of Records* to ensure records which are relevant to native title claims in South Australia are identified and preserved.
- *GDS 27 for Records Required for Legal Proceedings or Ex Gratia Applications Relating to Alleged Abuse of Former Children Whilst in State Care* to ensure the preservation of official records that may relate to the rights and entitlements of the individuals who present a court claim or apply for an ex gratia payment and of the State Government in defending or processing those claims and applications.
- *GDS 32 for Records of Relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse* to ensure the preservation of official records that may relate to government contact with individuals appearing before the Royal Commission.

When official records, in the public health unit's custody or housed in secondary storage, are due to be destroyed in accordance with the provisions of this or other disposal determinations, State Records is required to be notified via an Intention to Destroy Records Report. This form is available on the State Records website (www.archives.sa.gov.au).

Public health units must ensure that all destruction is secure and confidential and that a certificate confirming destruction is provided by private contractors.

Standard methods for destruction of paper are shredding, pulping or other means that are environmentally friendly.

Records in electronic format must only be destroyed by reformatting or rewriting to ensure that the data and any "pointers" in the system are destroyed. "Delete" instructions do not offer adequate security as data may be restored or recovered.

Public health units ***must*** keep their own record of all records destroyed (noting the relevant entry under GDS 15 9.34.3) ***for at least 50 years***. Proof of destruction may be required for legal purposes, or in response to FOI applications. When records are destroyed the systems that control them (ie Client Master Indexes or Registers) should also be updated by inputting destruction dates and relevant disposal authorities.

Sentencing Guidelines

Determining the appropriate minimum retention period of a clinical or client-related record is a process that needs to commence at record creation.

In general, records need to be sentenced by applying the appropriate disposal action within GDS 28 to indicate whether a record is permanent or temporary; and if temporary for how long that record needs to be kept before being destroyed.

In the case of legacy clinical or client-related records, whether stored onsite or with one of the temporary records storage Approved Service Providers (see pg. 23), as a minimum the following needs to occur:

- use appropriately trained and experienced sentencers
- check each clinical or client-related record to determine which disposal action or actions within GDS 28 apply
- apply the longest retention period if more than one disposal action is relevant
- ensure "date of last contact" has been confirmed and reactivation has not occurred
- indicate on each clinical or client-related record whether the record is permanent or temporary and if temporary include the destruction date – placing a sticker or neatly handwriting on the cover or using a form on the inside are all acceptable methods, or enter data into relevant field in electronic record system
- ideally, all parts of a clinical or client-related record should be sentenced with the same retention period. However, sometimes it is not practical for all parts of the record to be sentenced as one, e.g. a separate departmental record which is under the same unit record number, but is never married up with the medical record. If it is not practical to sentence the separate parts of the clinical or client-related record together, then each part can be sentenced as a separate item and either destroyed or kept according to the instructions in GDS 28. However, it may be that the parts to be destroyed contain information that is needed to understand the remaining parts of the record. In this case, retain all parts of the record until the part with the longest retention period is due for destruction
- do not cull or remove individual documents and records within a clinical or client-related record unless GDS 28 specifically states to do so – culling papers from a clinical or client-related record is usually inefficient and may compromise the integrity of the record
- if temporary records need to be retained for further periods before being destroyed it is recommended that these are boxed into consignments by year (or perhaps even in month and year if dealing with very large quantities) of destruction (e.g. all records that need to be retained until 2015 are kept together) so that destruction can occur in batches – pulling individual records from various boxes with a mixture of retention periods is labour intensive and can lead to half empty boxes being stored (and paid for if stored with an ASP)

- if the list of records identifies clients by name, check with the Crown Solicitor's Office if these records are permitted to be destroyed, as per GDS 16, GDS 27 and GDS 32

- complete and submit for approval to State Records *Notification of Intention to Destroy Records Reports* for any records due for destruction – as part of the report sufficient lists need to have been prepared

- annotate indexes/registers/control records, whether paper or electronic, to document what has occurred with each clinical or client-related record. Information documented should include when a record is due for destruction, under what disposal class and when the record was destroyed (if temporary) or transferred to State Records (if permanent). If this does not occur the *Notification of Intention to Destroy Records Reports* and associated lists must be retained to act as a "destruction register" to meet any future reference need (e.g. Freedom of Information, subpoena, legal discovery, Inquiry, etc) as well as any transfer paperwork in the case of records sentenced as permanent and subsequently sent to State Records for archival storage.

Reactivation Inclusions/Triggers

The reactivation of a record is triggered by the following activities and the sentencing period is calculated from these dates:

- date client is discharged

- date of the last service provision – as an inpatient, outpatient, emergency, outreach service (including hospital in the home), telephone consultation, community health or community-based treatment program

- date when a subpoena or medicolegal request is fulfilled (where known)

- date when record was accessed for research purposes

- date when the record is identified as being of significant risk management status

- date when record is identified as being required for possible legal proceedings

- date when a departmental separate file or sub-file, which is linked to the medical record, is reactivated

- date when record was retrieved for review of ongoing clinical care and/or client care follow-up purposes (refer to "Departmental or sub-file records", p.26)

- date when client did not attend for a scheduled appointment

- date of request for client information from outside the public health unit (eg GP, Community Health Centre). Includes consent from patient and

- receipt of a Guardianship of the Minister notification (as per the *Children's Protection Act 1993 (SA)*).

Reactivation exclusions

Date of "last contact" does ***not*** include:

- date when record retrieved from file for post-discharge completion or general clinical or client-related record processing, ie filing of laboratory results
- record assessed for education of health professionals
- date of death
- records accessed for the client's or deceased's next of kin
- records retrieved for peer/clinical review
- date when records retrieved as a result of requests from other agencies, e.g. community mental health teams requesting a copy of the discharge summary.

Special Note Regarding Freedom of Information Applications

It is State Records' advice that the documentation relating to an FOI application/process should ***not*** be included on the original client/patient case file but that a separate FOI case file should be created, managed and disposed of in accordance with GDS 15 (item 9.16).

For the purposes of FOI, the original client/patient case file should be retained "until all action completed and FOI appeal period has expired. Then dispose of in accordance with relevant disposal schedule, ie GDS 15 or an agency operational RDS" (disposal action for item 9.16.6, GDS 15 (8th ed)).

If copies of documents from the client/patient case file are kept on the FOI case file, these are disposed of with that FOI case file in accordance with item 9.16 of GDS 15.

Application of the GDS Exception Criteria

GDS 28 exception criteria apply to any newly created clinical and client-related records and to reactivated records.

Generally, the intention of the exception categories is to identify clinical or client-related records which are of significant research, continuing care and/or risk management value to ensure that they are not destroyed prematurely. Specific instructions on applying the exception criteria can be found in the previous sections titled "Sentencing Guidelines" (pg. 11) and "Retention Periods and Re-Activation" (pg. 8).

Access Rights and Responsibilities

Public health units need to ensure that records, irrespective of format, will remain accessible for the duration of the designated retention period. By "accessible" it is meant that the information contained within a record remains readable for the life of the record. In addition, "accessible" also refers to the retrievability and availability of a record. Whether stored on or off-site, a record needs to be able to be retrieved and made available as soon as practicable.

Public Access to Records in the Custody of a Public Health Unit

For records in the custody of public health units, conditions stipulated in the *Freedom of Information Act 1991 (SA)* and the *Information Privacy Principles Instruction* need to be adhered to.

Access to Records in the Custody of State Records

Public access to records in the custody of State Records is governed by section 26 of the *State Records Act 1997*, which stipulates:

> "The agency responsible for an official record in the custody of State Records may, in consultation with the Manager [Director], State Records – (a) determine that access to the record (other than by the agency) is not subject to any restrictions…; or (b) determine conditions excluding or restricting access to the record".

For further details on public access to records in the custody of State Records, public health units can refer to the *Public Access Determinations Guideline* (as amended) available from the State Records website (www.archives.sa.gov.au). This guideline explains the rights and responsibilities of agencies in defining public access determinations.

Agency access to records in the custody of State Records is governed by section 25 of the *State Records Act 1997*. Public health units are entitled to resume possession of an official record that has been in existence for more than 15 years if such a record is necessary for the proper performance of the functions of public health units. In some instances, in the interest of records preservation, public health units' access to official records may be subject to conditions negotiated with the Director [Manager], State Records.

Legal Deposit

Legal deposit refers to statutory provisions that oblige publishers to deposit copies of their publications in libraries in the country in which they are published. Under the Commonwealth *Copyright Act 1968* and various Australian State Acts, a copy of any work published in Australia must be deposited with (a) the National Library of Australia and (b) the appropriate State Library. Legal deposit extends not only to commercial publishers but also to private individuals, clubs, churches, societies and organisations.

In South Australia, one copy of publications produced for external use should be deposited with the State Library and the Parliamentary Library (s35, *Libraries Act 1982 (SA*)). Publications include books, newspapers, magazines, journals, pamphlets, maps, plans, charts, printed music, records, cassettes, films, video or audio tapes, computer software CD-ROMS, compact discs and other items made available to the public.

Amendments & On-going Review of GDS 28

State Records' disposal schedules apply for a period of ten years. Either SA Health or State Records may propose a review of the GDS 28 at an earlier time, in the event of changes to functions or procedures that affect the value of the records covered by the disposal authority. Reviews are especially necessary if there is significant administrative change that affects the currency and use of the records and/or the records are dispersed to other agencies.

The State Records Council needs to approve all amendments to the GDS 28. Officers using the GDS 28 should advise the Medical Records Advisory Unit of SA Health in the first instance.

Context of the Records Covered by the Schedule

Coverage of GDS 28

GDS 28 applies only to the records described within it, as created by agencies (or their predecessors) operating within one of the five Local Health Networks (LHN) of SA Health. It is intended to be a comprehensive guide incorporating all operational records of public health units (see *Using the Schedule* (pg. 7) for more information about what areas of SA Health are covered by GDS 28).

An extensive list of record series (GRS) is affected by GDS 28, as follows:

A. Ongoing series sentenced using either RDS 2000/12 or 2000/13 and **held** in the custody of State Records. **Covered by GDS 28.**

GRS	Series Title	Agency	Date Range
3148	Child health files/cards	Child & Youth Health	1954 --
3412	Client files - Northern Region, Elizabeth House	Child Guidance Clinic, Prospect (Mitchell House)	1953 --
3680	Client hearing assessment files	Child & Youth Health	1989 --
4441	Patient records/client case notes	Drug & Alcohol Services Council	1985 --
6310	Adolescent health unit files	Child & Youth Health	1979 --
8566	Aboriginal client files	Child & Youth Health	1983 --
9365	Patient case notes	SA Dental Service	1966 --
10621	Clinical case files of renal transplant patients	Queen Elizabeth Hospital	1959 --
10716	Neoplasm/deceased case files	Queen Elizabeth Hospital	1960 --
11372	Medical record files	St Margaret's Rehabilitation Hospital	1984 --
11384	Deceased patient medical records	Murray Bridge Soldiers' Memorial Hospital	1970 --
11736	ATSI school health screening files, alphabetical series	Child & Youth Health	1981 --
12026	Medical files, terminal digit series	Yorke Peninsula Health – Maitland Hospital	1971 --

B. **Ongoing** series registered and sentenced (or should be sentenced) using either RDS 2000/12 or 2000/13 but **not held** in the custody of State Records. **Covered by GDS 28**.

GRS	Series Title	Agency	Date Range
3148	Child health files/cards	Child & Youth Health	1954 --
3161	School entry screenings	Child & youth Health	1991 --
3162	Year 8 screenings	CAFHS	1992 --
3163	Scoliosis screenings	CAFHS	1992 --
3412	Client files - Northern Region, Elizabeth House	Child Guidance Clinic, Prospect (Mitchell House)	1953 --
3680	Client hearing assessment files	Child & Youth Health	1989 --
3981	Case records	Torrens House Mothercraft Hospital	1979 --
4132	Client files – Western Region	Western Team, Northern Child & Adolescent Mental Health Service	?1995 --
4676	Research files	Child & Adolescent Mental Health Service, later Northern CAMHS	1986 --
5202	Client files - Northern Country Service	Northern Child & adolescent Mental Health Service	1978 --
6217	Client case notes – Adelaide Branch	Second Story Youth Health Service	1990 --
6310	Adolescent health unit files	Child & Youth Health	1979 --
6459	Client files	Women's Health Statewide	1995 --
7650	Early childhood clinic files	Child & Youth Health	1976 --
8510	Patient medical records	Whyalla Hospital & Health Services Inc	nd --
8564	Allied health program	Child & Youth Health	1979 --
8733	Patient dental case note records	SA Dental Service	1987 --
11466	Project files	Adelaide Women's Community Health Centre; Women's Health Statewide	1976 --
11855	Patient records (children), alphabetical series	Community Dental Service, SA Dental Service	c1985 --

11856	Patient records (adults), alphabetical series	Community Dental Service, SA Dental Service	c1985 --
13459	Program files, artificial series by project	Centre for Health Promotion & predecessors	1986 --

C. **Closed** series sentenced using either RDS 2000/12 or 2000/13 or 1988 SAHC RDS (1% sample) and held in the custody of State Records– **Excluded from GDS 28**. Instead, continue to be covered by RDS 2000/12 or 13 or 1988 SAHC RDS (retired for the purposes of these series)

GRS	Series Title	Agency	Date Range
630	Client files, alphabetical series	Child Guidance Clinic, Prospect (Mitchell House)	c1966-1986
1424	Patient files – permanent research sample	SA Dental Service	?1987-1992
2474	Client files, annual single number series	Department of Psychiatry, Adelaide Children's Hospital	1968-1995
3003	Casualty registers	Royal Adelaide Hospital	1960-1988
3021	Register of unit record [UR] numbers	Royal Adelaide Hospital	1965-1985
3022	Register of inpatients	Royal Adelaide Hospital	1961-1982
3046	Operation registers	Royal Adelaide Hospital	1951-1952
3279	Patient records	Adelaide Children's Hospital	1941-1978
3284	Client files	Child Guidance Clinic, Adelaide (Cartref House) & Magarey House	1960-1989
3681	Client files – Eastern region) (pre-database)	Eastern Team, Child & Adolescent Mental Health Service	nd - 1982
3682	Client files – Eastern region) (post-database)	Eastern Team, Child & Adolescent Mental Health Service	nd-1982
4531	Client register	Alfreda Rehabilitation	1978-1996
4532	Client treatment files (1% permanent sample)	Alfreda Rehabilitation	1977-1986
4581	Statistical records	Willis House & Adolescent Day Service	1977-1992

4582	Patient records cards	Willis House & Adolescent Day Service	1976-1987
4586	Register of patients admitted	Willis House Psychiatric Adolescent Service	1974-1983
4588	List of patients	Willis House Psychiatric Adolescent Service	1979-1982
4589	Introductions register	Willis House & Adolescent Day Service	1983-1987
4637	Manometric pressure tracings	Gastrointestinal Medicine Unit, RAH	1979-1999
4672	Client summary information forms	Willis House Psychiatric Adolescent Service	1981-1986
5049	Clinical drug trial records	Gastrointestinal Medicine Unit, RAH	1983-1999
7969	Client files	Child & Adolescent Mental Health Service	1957-1986
8808	Aboriginal school health screen client files, numerical series	Child & Youth Health	1975-1996
8904	Reproductive medical records	Queen Elizabeth Hospital	1980-1996
11304	Statistical register of physiotherapy treatments	Magill Ward, RAH	1953-1959
11305	Register of x-rays	Neurosurgery, RAH	1955-1959
11307	Index to register of patients	Royal Adelaide Hospital	1960-1963
11308	Register of operations	Estcourt Hughes Clinic, RAH	1956-1963
11309	Vehicular accidents register	Royal Adelaide Hospital	1957-1958
11311	Plaster room patient register	Royal Adelaide Hospital	1950-1952
11313	Operation lists	Royal Adelaide Hospital	1946-1993
11314	Radiotherapy register	Royal Adelaide Hospital	1956-1959
11315	Register of operations	Hoare Clinic, RAH	1973-1983
11316	Operation lists	Wilson Clinic, RAH	1970-1975
11346	Register of operations	Campbell Clinic, RAH	1966-1976
11347	Operation registers	Smith Clinic, RAH	1971-1982
11348	Register of operations	Orthopaedic Clinic, RAH	1969-1977
11571	Register of operations	Venner Clinic, RAH	1971-1977

11572	Operations	Breat, Endocrine & Lymphona Unit, RAH	1987-1989
11815	Index book	Physical Therapy Dept, Adelaide Children's Hospital	1935-c1945
11816	Disease classification registers	Adelaide Children's Hospital	1928-1960
11817	Patient Master Index, compiled 1983	Adelaide Children's Hospital	1983
11818	Admission registers	Casualty, Adelaide Children's Hospital	1957-1991
11819	Admission registers	Private Ward, Adelaide Children's Hospital	1947-1955
11820	Admission registers	Inpatients, Adelaide Children's Hospital	1958-1989
11821	Birth registers	Labour Ward, Queen Victoria Hospital	1954-1995
11931	Premature births long term follow-up register	Queen Victoria Hospital	1981-1995
11932	Register of unit record (UR) numbers	Adelaide Children's Hospital, later Women's & Children's Hospital	1954-1991
11933	Record of deliveries	Labour Ward, Queen Victoria Hospital	1969-1980
11934	Admission registers	Queen Victoria Hospital	1931-1991
11935	Register of deaths	Adelaide Children's Hospital, later Women's & Children's Hospital	1959-1991
11936	Case book registers	Labour Ward, Queen Victoria Hospital	1945-1967
11937	Admission registers	Estcourt House	1941-1978
12318	Deep x-ray treatment books	Royal Adelaide Hospital	1931-1994 [with gaps]
13096	Admission registers	Mount Gambier Hospital, Mt Gambier & Districts Health Service	1869-1980
14515	Record of patients	Northfield Consumptive Home, later Morris Hospital	1934-1941

D. **Closed** series sentenced (or should be sentenced) using either RDS 2000/12 or 2000/13 or 1988 SAHC RDS (1% sample) but **not held** in the custody of State Records– **Excluded from GDS 28**. Instead, continue to be covered by RDS 2000/12 or 13 or 1988 SAHC RDS (retired for the purposes of these series)

GRS	Series Title	Agency	Date Range
630	Client files, alphabetical series	Child Guidance Clinic, Prospect (Mitchell House)	c1966-1986
1211	Patient operation cases – 'operation reports'	Royal Adelaide Hospital	?1940-1962
1645	Client files	Child & Adolescent Mental Health Service, Flinders Medical Centre	1979-1988
2111	Client files	Adelaide Women's Community Health Centre	1976-1995
2214	Monthly communicable disease reports – working papers	Women's & Children's Hospital	nd-nd
2474	Client files, annual single number series	Department of Psychiatry, Adelaide Children's Hospital	1968-1995
3020	Patient Master Index	Royal Adelaide Hospital	nd
3285	Client files	Adolescent Day Service	1959-1999
3681	Client files – Eastern region) (pre-database)	Eastern Team, Child & Adolescent Mental Health Service	nd - 1982
3682	Client files – Eastern region) (post-database)	Eastern Team, Child & Adolescent Mental Health Service	nd-1982
4499	Client treatment files	Alfreda Rehabilitation	1986-1996
4573	Clients referred but never seen	Willis House Psychiatric Adolescent Service	c1978-1985
4575	Outpatients' day book	Willis House Psychiatric Adolescent Service	1976-1984
4579	Nurses' report books	Willis House Psychiatric Adolescent Service	1974-1980
4580	Appointment and prescription books	Willis House Psychiatric Adolescent Service	1979-1980

4590	Client files	Willis House Psychiatric Adolescent Service	1980-1984
4672	Client summary information forms	Willis House Psychiatric Adolescent Service	1981-1986
4675	Progress notes and milieu reports	Adolescent Day Service	c1994
7969	Client files	Child & Adolescent Mental Health Service	1957-1986
8227	Client files	Salisbury West Community Health Centre, Northern Metropolitan Community Health Service	1985-1995

Please see also Records excluded from GDS 28 (pg. 30).

Complementary Schedules to GDS 28

- SA Ambulance Services RDS 2012/10 Version 1 (approved by State Records Council on 26 February 2013)
- Glenside Campus RDS 2008/10 Version 1 (approved by State Records Council on 10 February 2009)
- Department for Communities and Social Inclusion RDS 2013/19 Version 1 (approved by State Records Council on 20 August 2013)
- Various Schedules held by the Department for Health and Ageing and its predecessor agencies (currently expired as of May 2014)

Existing Disposal Schedules Superseded by GDS 28

GDS 28 Version 1 supersedes RDS 2000/12 Version 1 for Public Hospitals and RDS 2000/13 Version 1 for Community Health and Special Needs Services (approved by the State Records Council on 13 June 2000).

Public health units must ensure that disposal arrangements put in place in accordance with the superseded RDS 2000/12 and RDS 2000/13 are reviewed in the light of this new disposal schedule.

Public health units may be required through Freedom of Information requests to inform a member of the public that a clinical or client-related record has been destroyed and under which disposal authority this has been legally carried out. The following list details some of the disposal schedules for public health units and the timeframes when they were applied prior to the introduction of GDS 28:

RDS/GDS	Timeframe
RDS 2000/12 Version 1 for South Australian Public Hospitals and RDS 2000/13 version 1 for Community Health and Special Needs Services	Jul 2000 - Jun 2014
LB 163 20/12/1988 – Patient records created by units of South Australian Health Commission	20 Dec 1988 - 30 Jun 2000

Prior to 1988, there was no formal whole of public hospital or community health sector schedule. Retention of clinical records was managed via agency specific disposal schedules, e.g. RDS 1131 – RAH – Patient Files (approved 1991) and Libraries Board 25/8/1992 records of Child, Adolescent and Family Health Service.

Records Structure within Public Health Units

Generally, clinical or client-related records maintained within public health units are kept in a medical record, or are maintained separately to the record (such as with medical imaging, laboratory records or separate case-note files for sexual assault counselling).

These records are usually maintained in case notes, Unit Medical Records in hospitals, individual client/case files within most community health care settings, and centrally controlled by registers such as Patient Master Indices, or as entries in various electronic Patient Administration Systems such as HOMER and EPAS.

The necessities of country health-care sometimes result in duplicate records being created across several sites, such as faxes of referrals being filed on the receiving end, with the original then also kept on file. This practice is expected to reduce once EPAS is rolled out across SA Health.

See also “Alternative Record Formats” (pg. 26).

Broad Description and Purpose of the Records

The operational records covered in GDS 28 relate to the provision of clinical care and clinical/client related services delivered by public health units.

Clinical and client-related records are maintained primarily for health care reasons and continuity of client care, though a strong medico-legal and risk management focus is also factored into the collection and retention of health data.

Functions and Activities Documented by the Records

GDS 28 covers the following functions of public health units:

- **CLIENT CARE**
- **CLINICAL & CLIENT ADMINISTRATION**

- **CLINICAL & CLIENT RISK MANAGEMENT**
- **EDUCATION & HEALTH PROMOTION**
- **QUALITY IMPROVEMENT**
- **RESEARCH AND ETHICS.**

These functions were arrived at through interviews with relevant staff, combining existing categories within previous disposal schedules, and the researching of organisational resources and publications.

The functions INDEPENDENT LIVING SERVICES and RESIDENTIAL CARE SERVICES from RDS 2000/0013 Version 1 (Community Health and Special Needs RDS) are now covered by the Department for Communities and Social Inclusion's operational RDS 2013/19 Version 1 and have been removed from GDS 28.

The above operational functions are supported by the following activities:

- Advice - General Information Services
- Advice - Non Client Specific
- Advocacy
- Allegations
- Appeals
- Applications
- Appointment Scheduling
- Auditing
- Blood and Blood Product Transfusions
- Child Protection
- Client Accommodation & Transport Services
- Client Activity Monitoring
- Clients Under Legal Disability
- Committees
- Complaint Resolution
- Compliance
- Conflict of Interest
- Consent
- Controversial/Public Interest Records
- Course Development
- Customer Service
- Data Entry
- Data Management
- Dental Records
- Incident Reporting
- Indigenous Health Provision
- Informal Contacts
- Investigations - Non-Laboratory
- Legal Advice
- Litigation
- Medical Imaging
- Medical Malpractice/Negligence
- Modification to Protocol/Extension Requests
- Monitoring, Work Sheets and Workbooks/Journals
- Monitoring/Review
- Moulds, Casts and Study Models
- Neoplasms/Cancer Care
- Non-Attendances/Unattached Paperwork
- Notification/Reporting
- Obstetrics Care
- Organ Donation and Transplantation
- Pathology
- Policy
- Programs/Groups
- Provision
- Quality Control

- Detainee Clinical or client-related records
- Dispensing
- Enquiries
- Evaluation
- Evaluation/Program Appraisal
- Family/Carer Support
- Funding Application
- General Care
- Genetic Services
- Health Promotion
- Implants and Artificial Devices
- Implementation
- Record Tracking
- Recordings and Clinical Photographs
- Recruitment of Subjects
- Registration/Registers
- Reporting
- Reproductive Technology Services
- Research Practice/Activities
- Risk Assessment - Institutional
- Screening & Risk Factor Assessment
- Sexual Assault Counselling Records
- Sexual Reassignment
- Standards
- Supervision

Arrangement of the Records

Records of public health units are arranged differently from site to site, at the discretion of the local records manager/administrator. These are typically filed using terminal digit filing, or other local filing systems.

Electronic records (such as in OACIS or EPAS) are maintained in appropriate databases and are generally arranged by case or patient details.

Agency Creating the Records

The records are clinical or client-related records created by public health units within one of the five Local Health Networks (LHN). See also *Using the Schedule* (pg. 7) for which areas are covered by GDS 28. This includes hospitals, various community health bodies operating under the SA Health banner, and agencies such as Drug and Alcohol Services of South Australia (DASSA), SA Prison Health, and the SA Dental Service.

Agency Owning or Controlling the Records

Public Health Units administer the records covered by GDS 28 and also control and own them.

Date Range of the Records

Records Date Range: c.1977 to ongoing (previous records likely to have been accepted into GRG8 and GRG78).

Volume of the Records

The volume of permanent records held in State Records' custody and covered by GDS 28 equates to approximately 544.68 linear metres.

The existing volume of temporary records backlog stored offsite is approximately 50,000 linear metres. These are currently stored at Approved Service Providers (mostly Recall, but some companies such as Iron Mountain and Fort Knox still retain some SA Health records).

The annual accumulation rate of ongoing records is approximately 6000-9000 linear metres per annum. Approximately 5% of this backlog and accumulation figure are corporate records and not covered by GDS 28.

Special Custody Requirements

Under normal conditions, agencies are expected to transfer permanent records into the custody of State Records 15 years after the record is created. This is unlikely to happen within SA Health, and it is recognised by State Records that there is a business need to refer to and use such records beyond this period as part of client care. As such, State Records has granted an exemption from transfer for public health units within SA Health.

Please see the section titled "Woomera Hospital Records" under **Other Disposal Considerations** (pg. 26) for information about the Commonwealth's interest in these records.

Special Storage Requirements

There are no special storage requirements. Records storage processes as required by State Records should be adhered to – please refer to the "Temporary Records" page on their website for further information.

Issues Not Mentioned Previously

There are no issues that have not already been mentioned.

Comments Regarding Disposal Recommendations

Permanent Records Rationale

Records nominated for permanent retention in GDS 28 document the substantive processes and outcomes of services undertaken by public health units outlined above. As such the criteria they meet include the following:

Objective 2

To identify and preserve official records providing evidence of the deliberations, decisions and actions of the South Australian Government and public sector bodies relating to key functions and programs and significant issues faced in governing the State of South Australia.

Objective 3

To identify and preserve official records providing evidence of the legal status and fundamental rights and entitlements of individuals and groups.

Objective 4

To identify and preserve official records substantially contributing to the knowledge and understanding of the society and communities of South Australia.

Objective 5

To identify and preserve official records that contribute to the protection and well-being of the community or provide substantial evidence of the condition of the State, its people and the environment, and the impact of government activities on them.

Permanent records in the GDS 28 are as follows:

Item Number	Function	Activity
1.7.2	CLIENT CARE	Controversial/Public Interest Records
1.8.1-1.8.3	CLIENT CARE	Dental Records
1.14.1	CLIENT CARE	Indigenous Health Provision
2.3.1	CLINICAL & CLIENT ADMINISTRATION	Client Activity Monitoring
2.8.1-2.8.2	CLINICAL & CLIENT ADMINISTRATION	Registration/Registers
4.2.1	EDUCATION	Health Promotion
5.2.1-5.2.3	QUALITY IMPROVEMENT	Committees
5.7.1	QUALITY IMPROVEMENT	Policy
5.10.1	QUALITY IMPROVEMENT	Standards
6.1.1	RESEARCH AND ETHICS	Allegations
6.2.1	RESEARCH AND ETHICS	Appeals
6.3.1	RESEARCH AND ETHICS	Applications
6.4.1-6.4.3	RESEARCH AND ETHICS	Committees
6.5.1	RESEARCH AND ETHICS	Compliance
6.9.1	RESEARCH AND ETHICS	Evaluation/Program Appraisal
6.10.1	RESEARCH AND ETHICS	Funding Application

6.11.1	RESEARCH AND ETHICS	Modification to Protocol/Extension Requests
6.13.1	RESEARCH AND ETHICS	Policy
6.15.1	RESEARCH AND ETHICS	Reporting
6.17.1	RESEARCH AND ETHICS	Standards

Following a review of the summary of the appraisal decisions for the previous schedules (RDS 2000/0012 V1 Public Hospitals and RDS 2000/0013 V1 Community Health and Special Needs), several of the criteria for permanency have been reviewed in GDS 28.

As per the previous appraisal decisions, the above items continue to be classified as permanent because of one or more of the following:

- they have high research value within the medical field
- they cover areas where technological break throughs and medical advances are occurring
- they have significance for both the state and the nation
- they are not produced by all hospitals but a select few - services which generate such records are provided predominantly by tertiary hospitals linked to universities only
- they are of research interest to the wider community with regard to health developments in the 20th and 21st centuries
- they relate to treatments or care provision where adverse health effects may occur (in some cases not until years later) as a result of such treatments or care - while hospitals cannot be responsible for the onset of disease they may be held accountable for treatment provided
- they document the registration of patients admitted to hospital or returning, eg Patient Master Index, Accident & Emergency Register
- they relate to medical procedures and episodes not captured elsewhere, eg Donor Registers, Genetic Registers, Diagnosis Registers
- they record patient movements within a hospital, between hospitals or outside a hospital, eg Admission & Discharge Registers
- they relate to medical conditions required by legislation to be reported to the Department of Health and Ageing or similar body, eg Birth Defects, Notifiable Infectious Diseases.
- they are publications or curriculum developed by public health units
- they provide evidence at a strategic level of what decisions and policies are made within the public health unit environment with regard to benchmarking, service direction and improvement, and self-regulation and policing. Records such as committee minutes, final reports, submissions, policy statements, and key performance indicators provide insight into the culture of public health units and the way such institutions are assessed either by national bodies or themselves

- research and ethics records not only provide evidence of what research is conducted but how it is conducted with regards to subject recruitment and treatment and ethical behaviour.

Where there has been no legislative or operational reason for the retention of the permanent category, this has been reviewed in line with current practices, legislations, standards and comparison to interstate counterparts. Notably, the following items are now temporary in GDS 28:

- Genetic Services (item 1.12);
- Implants and Artificial Devices (item 1.13);
- Neoplasms/Cancer Care (item 1.21);
- Organ Donation and Transplantation (1.22); and
- Reproductive Technology Services (item 1.26).

Temporary Records Rationale

Records nominated for temporary status in GDS 28 document routine processes and/or transactions that support the activities documented in the permanent records. Retention periods have been determined by the legal, administrative, evidential and financial accountability requirements of public health units.

In the appraisal papers provided for the previous disposal schedules (RDS 2000/0012 & RDS 2000/0013), several classes of records were nominated as permanent above and beyond any legislative requirements. On review of these nominations, reduction of storage fees by sending records to State Records was cited as a driving factor behind some of these decisions. As part of the development of GDS 28, all permanent categories were reviewed, and retention periods reduced where there were no legislative or operative reasons to retain these permanently.

Following a review of the appraisal decisions attached to the previous Disposal Schedules, the following rationale still stands for temporary records sentenced under GDS 28:

Records of "General Care" have been sentenced as "*Destroy 15 years after last contact*" for the following reasons:

- brings South Australia in line with other states where disposal action is between 10 and 15 years[1]
- allows records of both mental and non-mental health patients to be sentenced the same
- allows for the provision of adequate patient care and good clinical practice, particularly in cases where complications, development of a disease or adverse reactions may not occur for some years and

[1] As determined when conducting the comparative analysis of interstate RDS' relating to health records.

- ensures adequate risk management where cases of litigation may take place.

Short-term temporary records have been deemed as such for some or all of the following reasons:

- they are of a facilitative nature only
- they are departmental copies of what exists in the Unit Medical Record which is classed as the 'official record'
- they are included elsewhere in a summarised format
- they are bulky and cause significant resource problems with regards to storage
- they are covered by existing legislation which requires that they only be retained for a short period , eg pharmaceutical dispensing records only need to be retained for 2 years in accordance with the *Controlled Substances Act and Regulations 1996*.

Long-term temporary records have been deemed as such for some or all of the following reasons:

- existence of legislative requirements
- existence of best practice standards which are officially recognised and applied within the health profession, e.g. *Retention of Laboratory Records & Diagnostic Material Standards* (NPAAC)
- litigious nature of the services which the records document, e.g. obstetric care, blood and blood product transfusions
- allows the patient whole-of-life access to their file.

Several Acts affect the temporary retention period of clinical and client related records as follows:

Item number	Legislation	Retention requirement
1.1.2 CLIENT CARE – General Care	*s45(2) Limitations of Actions Act 1936 (SA)*	6 years from the age of 18 years of age.
1.6 CLIENT CARE – Clients under a Legal Disability	*s45 Limitations of Actions Act 1936 (SA)*	30 years.
1.5 CLIENT CARE – Child Protection	*s72A Criminal Law Consolidation Act 1935 (SA)* *s67E Evidence Act 1929 (SA)*	Effectively indefinite – to be reviewed in 2023 following Royal Commission into Institutional Responses to Child Sexual Abuse
1.10 CLIENT CARE - Dispensing	*Controlled Substances Regulations (Poisons) 2011 (SA)* *Controlled Substances Act 1984 (SA)*	2 years

1.13 CLIENT CARE – Implants and Artificial Devices	*Therapeutic Goods (Medical Devices) Regulations 2002 (Cwth)*	30 years for Limitations of Actions, etc.
1.20.3 CLIENT CARE – Neoplasms/Cancer Care	*s43(3) Radiation Protection and Control (Ionising Radiation) Regulations 2000 (SA)*	Disposal must be approved by Minister, Environment Water and Natural Resources (agreement reached between SA Health and EPA with delegated authority to destroy as per GDS 28).
1.29 CLIENT CARE – Sexual Assault Counselling	*s72A Criminal Law Consolidation Act 1935 (SA)* *s67E Evidence Act 1929 (SA)*	50 years (in-line with SAPOL RDS – effectively indefinite)
2.6.2 CLINICAL AND CLIENT ADMINISTRATION - Notification Reporting	*Controlled Substances Regulations (Poisons) 2011 (SA)*	2 years after last entry
5.8.3 QUALITY IMPROVEMENT - Quality Control	*Therapeutic Goods Act 1989 (Cwth) (SA)*	8 years

Lastly, it should be noted that, as per item 1.22.1, local copies of *DonateLife* forms and consent forms are to be treated as a temporary record, on the basis that the Commonwealth *DonateLife* record/s are kept permanently.

Other Disposal Considerations

Department for Communities and Social Inclusion Records

The functions INDEPENDENT LIVING SERVICES and RESIDENTIAL CARE SERVICES from RDS 2000/0013 Version 1 (Community Health and Special Needs RDS) are now covered by the Department for Communities and Social Inclusion's (DCSI) operational RDS 2013/19 Version 1 and have been removed from GDS 28.

These were previously under the control of the old Department for Human Services, and following the restructuring of the departments in 2004 the responsibilities for these functions moved over to DCSI.

Indigenous Considerations

The determinations within *GDS 28* are consistent with Recommendation 21 of the *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families.*

The principles outlined in *GDS 16*, relating to Native Title claims, have also been considered in the development of this Schedule. GDS 28 does not have relevance to Native Title.

State Records endorses *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*. Recommendation 21 of the report states:

> *"That no record relating to Indigenous individuals, families or communities or to any children, Indigenous or otherwise, removed from their families for any reasons, whether held by government or non-government agencies, be destroyed."*

It is realised that it would not be practicable for every public health unit to identify and retain all possible clinical and client-related records relating to an indigenous person, family or community. However, public health units which specifically direct and provide services to Aboriginal and Torres Strait Islander communities should permanently retain clinical and client-related records of such communities. Such retention is authorised in GDS 28 by item **1.11** CLIENT CARE – Indigenous Health Provision.

Legal Disability

A person is under a "legal disability" while the person remains a child or while the person is subject to a mental deficiency, disease or disorder by reason of which the person is incapable of reasoning or acting rationally in relation to an action or proceeding that the person is entitled to bring (s45 (2) *Limitations of Actions Act 1936 (SA)*).

Where the time for bringing an action or proceeding is limited by the Limitation of Actions Act, or any other Act or law, and the person who is entitled to bring the action or proceeding is under a legal disability, the time for bringing that action or proceeding is extended by the period or periods for which the disability exists or continues after the time at which the right to bring the action or proceeding arose (s45 (1) Limitations of Actions Act). For persons under legal disability, no period of limitation can be extended to more than 30 years from the time at which the right to bring the action or proceeding arose (s45 (3) Limitations of Actions Act).

> **Example 1**: If as a result of the negligence of a health practitioner, a 10 year old (i.e. a "child" for the purposes of the Limitations of Actions Act) suffers an injury, the minor will have until age 21 to bring an action for damages, calculated as follows:
>
> - add eight years for the child to reach the age of eighteen, then

- allow the usual three year limitation period provided by section 36 of the Limitations of Actions Act.

Example 2: A person who is 25 years of age suffers an injury as a result of the negligence of a health practitioner. Under the Limitations of Actions Act, the person would normally have 3 years to commence an action. However if the person is under a legal disability for period of 6 months in each of the 2 subsequent years following the injury, such persons would have an additional year (over and above the usual 3 years) to bring an action for damages.

Records for a person under a "legal disability" are to be retained according to **1.6 Client Care – Clients Under Legal Disability** (except when the original category lists a longer retention period than 30 years, or is Permanent).

Examples of persons who are under a "legal disability" include the following:

- persons under the age of 18 years of age
- persons who suffer from a mental disability or impairment. For instance persons who have Downs Syndrome, persons who suffer from schizophrenia, persons with cerebral palsy and persons who are manic depressives.

Similar to the identification of Indigenous Records, it is recognised that it would also not be practical for every public health unit to identify and retain all possible clinical and client-related records relating to legally disabled clients. However, public health units which specifically direct and provide services to the legally disabled should retain these records to enable compliance with section 45 of the Limitation of Actions Act.

Legal Purposes, Inquiries and Investigations

Where public health units are aware that records may be required for use in litigation, for use in a government inquiry or the consideration of the Ombudsman, the records must not be destroyed. In such circumstances the records must be retained until two years after all cases and inquiries are complete (including appeals) and then have the original retention period applied to the records.

Medicare Records

Records that relate to Medicare processing, payments or claims are excluded from this Disposal Schedule, as these are Commonwealth records. The State Records Act specifically states that an "official record" does not include "a Commonwealth record as defined by the *Archives Act 1983* of the Commonwealth, as amended from time to time, or an Act of the Commonwealth enacted in substitution for that Act."

For advice on how to dispose of Medicare Records, please contact the Medical Records Advisory Unit on (08) 8226 8837.

National Pathology Accreditation Advisory Council (NPAAC) Requirements for the Retention of Laboratory Records and Diagnostic Material

The NPAAC Requirements for the Retention of Laboratory Records and Diagnostic Material were revised 3 times during the life of RDS 2000/0012 Version 1 for Public Hospitals. These RDS requirements were based on the 1998 (2nd) edition. There were subsequent revisions in 2007, 2009 and 2013.

Since the publication of the third edition of NPAAC, there have been significant developments in Australian laboratory practice. For example, all pathology laboratories are now required to maintain a formal quality system, and must be accredited to ISO 15189 (AS4633). In addition, new privacy principles and legislation have come into effect, legislation has clarified the status of retained human parts and tissues, and the Human Genetics Advisory Commission (HGAC) has been formed. To address these developments, NPAAC has completely revised the requirements for retention, and has adopted guiding principles to create a uniform and integrated approach to retention requirements.

Given the frequency of updates to the NPAAC Requirements, sections previously found in the Hospitals RDS 2000/12 should now be disposed of in accordance with this document instead. Categories no longer found in GDS 28 include:

- Blood and Blood Product Transfusions (excluding medical record copy)
- Diagnostic services – Clinical Chemistry/Chemical Pathology, Clinical Immunology, Microbiology/Infectious Diseases & Clinical Pharmacology
- Diagnostic services – Histopathology
- Genetic services (excluding medical record copy)
- Reference Laboratories.

Instead, **item 1.23 CLIENT CARE – Pathology** allows for the NPAAC requirements to be applied via GDS 28.

The following website hosts the latest version of the NPAAC Requirements:

http://www.health.gov.au/internet/main/publishing.nsf/Content/health-npaac-docs-RetLabRecDI.htm

Records of Sites previously administered by the Commonwealth

Woomera Hospital

Prior to 1993, the Woomera Hospital was a Commonwealth-run facility. While it has been transferred into the control of the Government of South Australia, the Commonwealth retains an interest in the records of patients that commenced treatment prior to July 1993. Prior to the

destruction of these records, please seek advice from the Medical Records Advisory Unit on (08) 8226 8837.

Repatriation General Hospital

Prior to 9th March 1995, the Repatriation General Hospital was a Commonwealth-run facility. While it has been transferred into the control of the Government of South Australia, the Commonwealth retains an interest in the records of patients that commenced treatment prior to this date.

As per the Arrangement Between the Commonwealth of Australia/The Repatriation Commission and the State of South Australia:

"The clinical records of eligible persons held by the RGHDP relating to periods prior to the date of the coming into force of this Arrangement (9/3/1995) will remain the property of the Commission. Those records which are inactive at that time will be returned to the Commission as soon as practicable. The Commission will, to the extent possible and practicable, ensure that the Australian Archives will authorise the transfer of custody of the active records to the RGHDP for clinical case management until such time as they are no longer active, after which they will be returned to the Commission. While in the custody of the RGHDP, active records will be made available to the Commission under arrangements to be agreed between the State and the Commission. Subject to the Privacy Act 1988 and Privacy Principle 4(b), the Commission will make available promptly to the State, at the State's request, inactive patient medical records of the Commission created solely for the purposes of RGHDP patient health care. The State shall, with its request, state the purposes for which the record is required. Inactive records will be made available to the State on request to the Commission for administrative purposes after 9 March 1995. The State agrees to do everything reasonably within its power to ensure that the Commission will not be in breach of the obligations imposed by the Privacy Act."

"Notwithstanding the above, should the period of time when such records would normally be subject to action under the State Medical Records Disposal Schedule **(ie GDS 28)** lapse, they will be referred to DVA for storage."

Prior to the destruction of records with admission dates prior to 9 March 1995, please seek advice from the Medical Records Advisory Unit on (08) 8226 8837.

Reformatting of Records and the Maintenance of Originals

Public health units need to refer to the following State Records publications, which are available from the State Records website (www.archives.sa.gov.au):

- *GDS 21 for management and disposal of source documents and digitised versions after digitisation (as amended)*
- *Digitisation of official records and management of source documents guideline (as amended).*

Prior to the commencement of any scanning/digitisation project please contact State Records – Government Recordkeeping for advice.

There are no other considerations for or against the retention or destruction of records affected by this GDS.

Disposal Recommendation Effect on Related Records

There are no related records affected by the disposal recommendations in this GDS.

Alternative Record Formats

Record Formats

GDS 28 applies to records in any format – including paper, electronic media, audio-visual, graphic media and microform (film or fiche) – which document the functions and activities described in this Schedule.

Departmental or sub-file records

It is the view of public health units that wherever possible a clinical or client-related record should be maintained. However, in some circumstances this may not be possible or conducive to good clinical/client care. In some instances statutory provisions such as the *Criminal Law Consolidation Act 1935 (SA)* and the *Evidence Act 1929 (SA)* do not permit certain information to be retained in the clinical or client-related record.

Generally, there are two types of departmental records, these being *sub-files* (usually copies) or *separate records*. Separate departmental records that exist without all documents being duplicated in the medical record are considered to be "official records"[2].

Where official records are created and maintained by departments, such departments have a responsibility to ensure that the minimum retention periods as defined in GDS 28 are applied to records and records disposed of accordingly.

Hybrid (electronic/paper) clinical or client-related records

Electronic clinical or client-related records that are introduced for existing clients or clients who also have a paper component are to be considered as essentially the same record, just in two formats: "one record, two formats". Given the health record function of continuing care, it is recommended that the paper record and the electronic record be sentenced as "one".

Hardcopy records will generally not identify that an electronic record exists and vice versa; however a search in EPAS Record Tracking will identify the existence of a hard copy.

[2] As defined by the State Records Act 1997.

See also *Management of Hybrid Files* via the State Records website (www.archives.sa.gov.au).

Electronic clinical or client-related records (such as created on EPAS)

Data, information and documents, whether digital or paper-based, become official records when they are created or received in the conduct of South Australian Government business.

Electronic records are a critical element in the conduct of the business of the Government of South Australia both for accountability and in the ongoing documentary heritage of the State. The Government, therefore, needs to strategically manage its electronic records.

All EPAS data is intended to be an enduring record, but not all is considered permanent according to archival conventions. This data is to be managed on an ongoing basis, and migrated to successor systems as needed. While technically some of these records can be destroyed according to GDS 28, there is no obligation to do so.

Public health units are responsible for ensuring that electronic records and their associated metadata are properly created and captured into official recordkeeping systems, survive without alteration or degradation, and remain in a readily accessible format (which includes content, structure and context) for the duration of prescribed retention periods.
State Records has released a number of standards and guidelines on specific types of electronic records and recordkeeping issues. These are available from the State Records website (http://www.archives.sa.gov.au).

Impact on Native Title Claims

There is no discernible relevance to Native Title Claims.

Scope Note

Records Covered by this Schedule

General Disposal Schedule (GDS) 28 applies to clinical and client-related records created or received by all public health units in South Australia (or their predecessors) operating within one of the five Local Health Networks (LHN):

- Central Adelaide LHN
- Northern Adelaide LHN
- Southern Adelaide LHN
- Women's & Children's Health Network
- Country Health SA LHN.

Throughout GDS 28 such agencies are referred to as "public health units".

This schedule makes no distinction between deceased or living clients. It is all encompassing for clinical or client-related records regardless of the type of client.

GDS 28 is intended to be a comprehensive schedule encompassing ***all*** clinical or client-related records. GDS 28 is not the standard for the ***types*** of information to be kept in the public health unit records, but rather the standard for ***retention*** of any records which may be created by the public health unit.

For records that are of a general administrative or financial nature, public health units should refer to *General Disposal Schedule No. 15 for State Government Agencies*. Cross-references to *GDS 15* (as amended), where appropriate, are set out in this Schedule.

See also Using the Schedule (pg. 7).

How to Apply this Schedule

Use in conjunction with GDS

This Schedule should be used in conjunction with GDS 15 (as amended) or its successor. Cross-references to the GDS 15 are included in this Schedule where appropriate.

To identify records that may be potentially relevant to native title claims, please refer to the guideline "Identifying documents which may be relevant to Native Title" attached to GDS 16. Where records sentenced for temporary retention are identified as having potential relevance to a native title claim, they need to be retained until 31 December 2024.

To identify records that may be potentially relevant to "*Legal Proceedings or Ex Gratia Applications Relating to Alleged Abuse of Former Children Whilst in State Care"*, please refer to GDS 27. Where records sentenced for temporary retention are identified as having potential relevance, they need to be retained until 31 December 2020.

"GDS 32 - Records of Relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse" is another over-riding Schedule recently implemented, and requires that all client-identified records be checked for relevance with the Crown Solicitor's Office prior to application to State Records for destruction of records. If found of possible relevance to the Royal Commission, these will need to be retained until at least 31 December 2023, and for any additional period determined by a review.

Use in conjunction with, or complementary to, other RDS

Please see Complementary Schedules to GDS 28 (pg. 15) for relevance prior to seeking approval from State Records.

Other RDS superseded by GDS 28

Please see Existing Disposal Schedules Superseded by GDS 28 (pg. 16) for further information.

Re-sentencing of records where schedules are superseded or particular entries within a schedule are superseded

Resentencing of existing records sentenced under RDS 2000/0012 or RDS 2000/0013 will be required prior to disposal lists being submitted for consideration.

Records excluded from GDS 28

This schedule is not intended for the records of the Department for Health and Ageing, Health Advisory Councils, the Health Performance Council and LHN Governing Councils, which operate under separate disposal schedules.

Existing record series held as part of Government Record Group (GRG) 8 or GRG 78 are excluded from GDS 28. These records have been deemed permanent in accordance with a disposal determination made for all GRGs by the Manager [Director] of State Records and approved by the State Records Council on 9 November 1999.

Records of organisations covered by existing disposal schedules, such as the SA Ambulance Service, are also excluded.

GDS 28 does not include the functions for "Independent Living Services" and "Residential Care Services" from RDS 2000/0013, whose functions have been transferred to the Department for Communities and Social Inclusion, and are now covered by their Operational Disposal Schedule.

Please see also *National Pathology Accreditation Advisory Council (NPAAC) Requirements for the Retention of Laboratory Records and Diagnostic Material* (pg. 25).

Please see also *Medicare Records* (pg. 25).

Application to records in all formats

GDS 28 applies to records in all formats, including databases and other electronic records. Public health units are required to ensure that records remain accessible for the duration of designated retention periods.

Interpretation of the Schedule

Minimum retention periods

Retention periods for temporary records shown in GDS 28 are minimum retention periods for which records need to be retained. It is at the discretion of public health units as to whether records are kept for longer than the minimum period.

Acronyms

- ATSI – Aboriginal and Torres Strait Islander
- CT - Computerised Tomography
- ECG - Electrocardiogram
- EEG - Electroencephalo-gram
- EMG - Electromyography
- EPAS – Electronic Patient Administration System
- FOI – Freedom of Information
- GDS – General Disposal Schedule
- HREC – Human Research Ethics Committee
- ICU – Intensive Care Unit
- KAAA – Keyword AAA
- LHN – Local Health Network
- LMH – Lyell McEwin Hospital
- MRAU – Medical Records Advisory Unit
- MRI - Magnetic Resonance Imaging
- NEAF - National Ethics Application Form
- NH&MRC – National Health & Medical Research Council
- NPAAC – National Pathology Accreditation Advisory Council
- OACIS – Open Architecture Clinical Information System
- PMI – Patient Master Index
- RAH – Royal Adelaide Hospital
- RDS – Records Disposal Schedule
- SA – South Australia
- SAAS – SA Ambulance Service
- SAPOL – South Australia Police

- TQEH – The Queen Elizabeth Hospital
- UMR – Unit Medical Record
- WCH – Women's and Children's Hospital

Definitions of terms specific to GDS 28

- **After last contact** – see "Reactivation" (pg. 9)
- **Agency** –a body such as a hospital or a Local Health Network incorporated by proclamation under the *Health Care Act 2008*, considered an "agency" for the purposes of the *State Records Act 1997*.
- **Allied Health** – Allied Health Professions include: Medical Radiation (including Diagnostic Radiography, Radiation Therapy and Nuclear Medicine), Occupational Therapy, Pharmacy, Physiotherapy, Podiatry and Psychology.
- **Boarder** - a person who is related to or associated with a client and who is receiving food and/or accommodation but for whom the public health unit does not accept responsibility for treatment and/or care.
- **Client** – Signifies a patient or other user of a public health unit, either in a hospital, allied health or community health setting.
- **Clinical or client-related record** – The central record of a client, with data and information gathered or generated to record the clinical care and health status of an individual or group.
- **Clinician** - a health care practitioner that works as a primary care giver of a patient/client in either a hospital setting, pre-hospital setting, clinic setting or in home health care.
- **Detainee** – person residing in immigration detention facilities under the care of the Commonwealth Department of Immigration and Border Protection and predecessor agencies.
- **Family carer** – is an unpaid or paid relative or friend of an aged, disabled or frail individual who helps that individual with his or her activities of daily living.
- **Health service** – health-related disability, palliative care, surgical or other related service.
- **Incorporated Hospital** – Public hospital incorporated under *s29 of the Health Care Act 2008* to provide health services and facilities in South Australia.
- **Keyword AAA** - is a thesaurus created by the State Records Authority of New South Wales. It is often used to classify documents in a document management system.
- **Legal Disability** – state of being a child or a person subject to a mental deficiency or other disorder as described in the *Limitations of Actions Act 1936, s45 (2)*
- **Legacy record** – closed records series, created under a previous/defunct recordkeeping system, under a defunct function or activity, or by a predecessor agency.
- **Litigation** – Court proceedings, claims for compensation or damages, or damages made prior to the commencement of any proceedings (eg Supreme Court Civil Rules 2006, Rule 33) and includes a notice of an intended action (under the *Limitations of Actions Act 1936, s45A*)

- **Local Health Network** – geographical or functional area of SA Health, covering a specified metropolitan region, with the exception of Country Health SA Local Health Network, and the Women's and Children's Local Health Network.
- **Medico-legal** – something that involves both medical and legal aspects
- **Minor** – person under the age of 18 years
- **Private hospital** – Health entity licensed under *s79 of the Health Care Act 2008*, operating as a private business.
- **Public health unit** – denotes any operational business unit that provides a health outcome under the brand name of SA Health, including hospitals, community health units, and allied health, and records dealing with health-related disability, palliative care, surgical or other related services.
- **Public health services** – As per "health service" definition above, but solely within the publicly funded health system.
- **Public hospital** – Hospital owned and administered by the Government of South Australia

Pre-1901 Records

All pre-1901 records are required to be **retained permanently** in accordance with a motion approved by the State Records Council on 19 February 2008. Public health units that still hold pre-1901 records need to contact the State Records Collection Management Services team (Email: srsaCollectionManagement@sa.gov.au) to discuss the transfer of these to the custody of State Records.

NOTE: This GDS does not cover any pre-1901 records.

Contacts/Help Desk

For advice on implementing GDS 28, as well as advice on records appraisal, disposal, transfer and storage, contact either State Records or a qualified Health Information Manager/Medical Record Administrator.

For changes or updates to GDS 28, please contact the Medical Record Advisory Unit of SA Health.

State Records
GPO Box 2343
ADELAIDE SA 5001

Ph: +61 8 82048791
Fax: +61 8 8204 8777
DX: 467 ADELAIDE
Email: srsaRecordsManagement@saugov.sa.gov.au
Web: www.archives.sa.gov.au

Medical Record Advisory Unit
Health System Performance Division
SA Health
PO Box 287, Rundle Mall, 5001

Ph: +61 8 8226 8837
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List of Functions and Activities in GDS 28

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.	**CLIENT CARE**	**The function of client care can be defined as providing treatment or health care to clients within a public hospital, allied health or community health care setting.** **A client can be defined as a person for whom a public health unit accepts responsibility for treatment and/or care. (taken from *National Health Data Directory*, Australia Institute of Health and Welfare 2012, Version 16). This signifies a patient or other user of a health service, either in a hospital, allied health or community health setting. "Client" takes on a broad meaning in this Schedule, and is intended to cover all applicable patient and user contact as previously classified in the previous Hospital Disposal Schedule (RDS 2000/0012) and the Community Health and Special Needs Services Disposal Schedule (RDS 2000/0013).** **It should be noted that the function of Client Care has been divided into two sections, these being General (item 1.1) and Exceptions (items 1.2-1.29). Users are advised that they may need to refer to a number of disposal classes within this GDS before definitively sentencing a record. Where records are described by more than one disposal class, such records should be sentenced in accordance with the disposal class with the longest retention period.**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.1	**General Care**	*Care provided on an admitted or non-admitted, emergency or non-emergency basis at a public health unit.* *Care may be provided by a wide range of clinical staff from various disciplines, eg medical, nursing, allied health, community health, dental health, mental health, child and adolescent health, independent living services, and residential care services.* *Activities represented in the records may include, but are not restricted to – assessment, observation, screening or monitoring, diagnosis, investigation, management and care planning, coordination, consultation, treatment, therapy, administering and procedural, follow up and referral, crisis and general counselling, allied health and general practice consultations, disease prevention, early intervention, liaison and support, and advice provision.* **Note**: Records may be held either in a centralised clinical or client-related record or separately by individual departments or services. **Inclusions:** • Deceased client histories • Public health unit employee clinical or client-related records, where staff attend as clients in their own right **Exclusions:** • Exception record categories (GDS 28: items 1.2-1.29) • For clients classified as Legally Disabled see **item 1.6 CLIENT CARE - Clients Under Legal Disability** • Public health unit employee clinical or client-related records, which relate to work assessments, counselling, monitoring or screening, see **GDS 15 (as amended): – item 11 OCCUPATIONAL HEALTH & SAFETY** • Clinical or client-related records used as the source document for a clinical trial – see items **6.3.1, 6.7.1, 6.8 and 6.14.1 RESEARCH AND ETHICS**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.1.1	General Care	Records relating to the provision of general care to adult (18 years of age or over) clients.	**TEMPORARY** Destroy 15 years after last contact	• Accident & Emergency Treatment Forms • Admission Forms • Adverse Incident Report • Authority for Removal of Tissue After Death for Transplant or Anatomical Purposes and for Post-Mortems • Alerts & Allergies Forms • Allied Health Forms/Reports • Anaesthetic Assessments & Reports • Assessment Forms • Autopsy or Post-Mortem Report • Care Plans • Certification by MO that Consent is Informed • Charts & Graphs • Consent Forms including for the following procedures: o Anatomical Examination o Blood Transfusion o Human Tissue – Living o Human Tissue – Post Mortem o Post Mortem o Surgery o Trial Drug Study • Specialised Treatment Forms/Reports (ie. restraint or seclusion of a psychiatric client, or administering non-psychiatric treatment to a psychiatric client. • Consultation Letters & Summaries • Correspondence – includes referral information • Death Certificates (triplicate form) • Doctor's or Physician's Orders • Dental Case Notes • Discharge Plans, Notes, Summaries & Letters • Driver Assessment Clinics Records • Drug Orders • Emergency Service Records	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.1.1 (cont'd)	General Care			• Epidural Forms • Examination Forms • GP Plus Health Care Centre Records • History & Examination Records • Investigation Reports • Management Plans • Mental Health Act records (Inpatient Treatment Orders and Consent forms) • Non-Admitted & Outpatient Notes • Medication or Drug Orders • Nursing Care Plans • Observation Reports • Operative Records • Orders for Treatment, Medication and/or Investigation • Client Election Records • Pre-Admission /Registration Form • Pre-Admission Assessments Prisoner health records • Problem List • Progress Notes	• Recovery Room Notes • Referrals, & Requests (Non-laboratory) • Refusal of Treatment Records • Resuscitation Records • Short Stay Treatment Records • Super Clinic Records • Surgical Procedure or Operation Records • Clinical or client-related records created during education (Student/Student or Teacher/Student) • Test Results • Therapeutic Treatment Records – Anti-Coagulant, Diabetic, Dialysis, Electric Shock Therapy, Electroconvulsive Therapy • Transfer of Client Records • Treatment Plans • Triage Forms

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.1.2	General Care	Records relating to the provision of general care to clients who are minors (ie under the age of 18 years). **Inclusions:** • All information retained as part of the clinical or client-related record of clients aged less than 18 years	**TEMPORARY** Destroy 15 years after last contact once child attains 18 years of age	• Record examples as for item 1.1.1	
1.2	**Advice - General Information Services**	*The activity of providing health information and advice to either clients or clinicians/consultants relevant to a specific service.* **Exclusions:** • Records relating to individual, client-specific education - see item **1.1 CLIENT CARE – General Care.** • Client specific records including areas like crisis phone lines - see item **1.1 CLIENT CARE - General Care** • Records of clients classified as Legally Disabled - see **item 1.6 CLIENT CARE - Clients Under Legal Disability**			
1.2.1	Advice - General Information Services	Records relating to the provision of health information and advice to either clients or clinicians/consultants relevant to a specific service, topic or issue, eg poisons, lactation, drug information.	**TEMPORARY** Destroy 10 years after provision of advice (Applies to both Adults & Minors)	• Departmental or Service-Specific Call Reports	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.3	**Advice - Non-Client Specific**	*The provision of non-client specific advice by a public health unit clinician or consultant to another clinician or consultant external to the public health unit.* **Inclusions**: • Advice that is not client identified and/or advice that is not specific to that client only For example, general information about a health session or program **Exclusions:** • Records relating to individual client-specific advice - see item **1.1 CLIENT CARE - General Care** • Client specific records including areas like crisis phone lines - see item **1.1 CLIENT CARE - General Care** • Phone registers and message books containing client-specific information **-** see item **1.18 CLIENT CARE - Monitoring, Work Sheets and Workbooks/Journals**			
1.3.1	Advice - Non-Client Specific	Records that facilitate the provision of non-client specific advice provided by a public health unit clinician, consultant or Community Health Centre. **Note:** • Phone registers and message books should ***not*** include both client and non-client specific information**.**	**TEMPORARY** Destroy 10 years after action completed (Applies to both Adults & Minors)	• Advice (unidentified client) via email & web interaction • Message Books • Phone Consultation Registers • Telephone Record Forms	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.4	**Blood and Blood Product Transfusions**	*The process of receiving blood products into one's circulation intravenously. Transfusions are used for various medical conditions to replace lost components of the blood. These components include red blood cells, white blood cells, plasma, clotting factors, and platelets.* **Minimum clinical or client-related record selection criteria**: ICD-10-AM code for blood and blood products transfusion (refer to SA Coding Standards - contact Medical Records Advisory Unit on (08) 82268837 to access this document if you are external to the SA Health intranet) transfusion sticker or special form in the Medical Record. **Please refer to NPAAC – *Retention of Laboratory Records and Diagnostic Material Standards* (Commonwealth of Australia) for laboratory records of blood products received and issued.** **Exclusions:** • Records relating to the registration of transfused blood and blood products – see **item 2.8 CLINICAL ADMINISTRATION – Registration/Registers** • Records of clients classified as Legally Disabled - see **item 1.6 - CLIENT CARE - Clients Under Legal Disability** • Laboratory-based pathology records - see **item 1.24 – CLIENT CARE - Pathology**			
1.4.1	Blood and Blood Product Transfusions	Record of blood and blood product transfusion details as captured in the clinical or client-related record.	**TEMPORARY** *Clinical or client-related record Copy* – As for item 1.1.1 (Adults) or item 1.1.2 (Minors)		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.5	**Child Protection**	*Records of specialised public health units providing assessment, services and treatment to children, young people and their families for whom there are concerns about child abuse and/or neglect. These specialised child protection units are currently based within the Women's and Children's Health Network, and also at Flinders Medical Centre.* **Note:** These records are very likely to be of interest to the Crown as per GDS 27 – *Records Required for Legal Proceedings Relating to Alleged Abuse of Former Children Whilst in State Care* and GDS 32 - *Records of Relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse.* Please consult with the Crown Solicitors Office prior to sending destruction lists containing these records to State Records.			
1.5.1	Child Protection	Records relating to public health units that provide child protection services	**TEMPORARY** Retain until 2023, retention subject to a review at that date.	• Clinical or client-related records • Consultations • Interviews • Videos, photographs and medical imaging • Other record examples as per 1.1.1 and 1.1.2	• *Criminal Law Consolidation Act 1935 (SA)* • *Child Protection Act 1993 (SA)* • *Evidence Act 1925 (SA)*

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.6	**Clients Under Legal Disability**	*The provision of client care by public health units whose services are specifically directed and provided to the disabled or those under legal disability* *OR* *The provision of client care to a legally disabled client of any age, regardless of whether the person has a pre-existing disability or was considered under legal disability after receiving care (where known).* *For the purposes of this section a person is under a legal disability in relation to an action or proceeding while he remains a child or while he is subject to a mental deficiency, disease or disorder by reason of which he is incapable of reasoning or acting rationally in relation to the action or proceeding that he is entitled to bring. – s45(2) Limitations of Actions Act 1936* **See Also:** • Legal Disability in the Introduction to GDS 28. **Note**: Public health units which specifically direct and provide services to the legally disabled should retain these records to enable compliance with section 45 of the Limitation of Actions Act. If unsure whether a record belongs in this section, please seek guidance from a clinician or from the Medical Records Advisory Unit.			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.6.1	Clients Under Legal Disability	Records relating to a person under a legal disability where a service or services are specifically directed and provided to such clients. OR Records relating to the provision of general care to all clients considered a person under a legal disability (where known).	**TEMPORARY** Destroy 33 years after last contact	• Case files • Client histories • X-Rays/Medical Images/Video • Community treatment orders • Crisis assessment team files • Individual service plans • Legal orders • Mobile support & treatment files • Other examples as per 1.1.1 and 1.1.2	• *s45 Limitations of Action Act 1936 (SA)*
1.7	**Contamination/ Exposure**	*Records of possible exposure to or contamination by adverse agents. These could be of a chemical, biological, radiological or nuclear nature, and include clinical or client-related records relating to asbestos and similar hazards.*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.7.1	Contamination/ Exposure	Records of clients with conditions associated with asbestos, dangerous chemicals, airborne asbestos, radiation, contaminated blood, excessive noise or similar hazards. **Minimum clinical or client-related record Selection Criteria for asbestos-related cases:** Minimum clinical or client-related record Selection Criteria: ICD-10-AM code for Asbestos associated conditions. Refer to SA Coding Standards (contact Medical Records Advisory Unit on (08) 82268837 to access this document if you are external to the SA Health intranet).	**TEMPORARY** Retain until 2040, retention subject to a review at that date		
1.7.2	Contamination/ Exposure	Records relating to issues, claims or case matters of major public interest or controversy, with regards to contamination or exposure.	**PERMANENT**	• Clinical or client-related records of Woomera Community Hospital	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.8	**Dental Records**	*The provision of dental care that includes specialist treatment and treatment of clients who are considered to have complex treatment needs (such as those who are medically compromised or who have severe disabilities). Services may be provided via the Statewide Dental Service, which incorporates the School Dental Service and the Community Dental Service, or the Adelaide Dental Hospital. Dental treatment and assessment services may also be provided by SA Dental Service staff in locations external to SA Dental Service clinics, such as Supported Residential Facilities (SRFs), Child Care Centres, Aged Care Facilities, Correctional facilities and other health service providers.* **Exclusions:** • Records of general and routine dental health services provided either by the SA Dental Service or by other health care providers within the public health system - see item **1.1.1 or 1.1.2 CLIENT CARE - General Care** • Records of dental health services provided as part of a targeted program for eligible Indigenous clients - see item **1.14.1 CLIENT CARE - Indigenous Health Provision** • Records of clients classified as Legally Disabled - see **item 1.6 - CLIENT CARE - Clients Under Legal Disability**			
1.8.1	Dental Records	Records relating to the provision of public oral and maxillofacial surgical services, including maxillofacial trauma service, dento-alvaeolar surgery, and major facial bone reconstruction.	**PERMANENT** (Applies to both Adults & Minors)	• Progress Notes • Pathology Reports/Results • Laboratory Forms • Referral Correspondence • Assessment Forms • Care Plans • Teeth Charts • Dental Cases Notes	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.8.2	Dental Records	Records relating to the provision of specialist consultative and treatment services within the discipline of Orthodontics.	**PERMANENT** (Applies to both Adults & Minors)	• Progress Notes • Pathology Reports/Results • Laboratory Forms • Referral Correspondence • Assessment Forms • Care Plans • Teeth Charts • Dental Cases Notes	
1.8.3	Dental Records	Records relating to the provision of specialist dental services to clients who are medically compromised (such as those with HIV/AIDS, Hepatitis C, Tuberculosis), or who have complex medical problems including those who have complex medication requirements that affect their ability to receive dental treatment (medications for treatment of cancer, medications for blood thinning, etc). **Note**: Generally such clients will be treated by the Special Needs Unit of the Adelaide Dental Hospital however treatment by this clinic does not automatically deem the records to be permanent in nature.	**PERMANENT** (Applies to both Adults & Minors)	• Progress Notes • Pathology Reports/Results • Laboratory Forms • Referral Correspondence • Assessment Forms • Care Plans • Teeth Charts • Dental Cases Notes	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.9	**Detainee Records**	*Clinical or client-related records created by public health units for treatment of Commonwealth detainees residing in immigration detention facilities under the care of the Department of Immigration and Border Protection (and its predecessor agencies).* **Note**: These records belong to the South Australian State Government, and are therefore covered by the provisions of the State Records Act. Despite ownership resting with South Australia, the Commonwealth has a right of access to the records where such access may be needed to fulfil a duty of care for a detainee client.			
1.9.1	Detainee Records	Detainee clinical or client-related records.	**TEMPORARY** Destroy 80 years after last contact	Examples include: • As per item 1.1.1 and 1.1.2 • Treatment records • Medication records • Dental and psychological records • Records of test undertaken • Medical reports (eg interpretation of x-rays and other medical scans)	• *Commonwealth DIAC Records Authority 2010 -20704* *(available from National Archives Australia)*
1.10	**Dispensing**	*The activity of administering, dispensing, prescribing and/or manufacturing drugs, medications and other pharmaceutical products.* **Exclusions*:*** • Notifications of drugs of dependency – see **2.4.4 CLINICAL ADMINISTRATION – Notification/Reporting**. • Records of clients classified as Legally Disabled - see **item 1.6 - CLIENT CARE - Clients Under Legal Disability**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.10.1	Dispensing	Records relating to the dispensing or prescribing of drugs, medications and other pharmaceutical products to clients.	**TEMPORARY** *Pharmacy/ duplicate copy* – Destroy 2 years after dispensing (Applies to both Adults & Minors) *Clinical or client-related record Copy* – As for item 1.1.1 (Adults) or item 1.1.2 (Minors)	• Inpatient Drug Sheets • Orders – Cytotoxic Medication, Intravenous Therapy, Infusion Pump/Infusion Therapy • Prescriptions – Inhalation Therapy, Discharge, Emergency Department, Consulting Clinics	• *Controlled Substances Regulations (Poisons) 2011 (SA)* • *Controlled Substances Act 1984 (SA)*
1.10.2	Dispensing	Records relating to ward drug dispensing and imprests.	**TEMPORARY** *Pharmacy/ duplicate copy* – Destroy 2 years after dispensing (Applies to both Adults & Minors)	• Licence to Possess S4 and S8 Drug for Administration • Ward Imprest Record • Ward Supplies Register	• *Therapeutic Goods Act 1989 (Cwth)* • *Controlled Substances Regulations (Poisons) 2011 (SA)* • *Controlled Substances Act 1984 (SA)*

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.10.3	Dispensing	Records relating to the manufacture of drugs, medication and/or other pharmaceutical products for individual clients.	**TEMPORARY** *Pharmacy copy* – Destroy 2 years after dispensing (Applies to both Adults & Minors) *Clinical or client-related record Copy* – As for item 1.1.1 (Adults) or item 1.1.2 (Minors)		• *Controlled Substances Act, Regulations (Poisons) 2008 (SA)*
1.10.4	Dispensing	Records relating to the manufacture of therapeutic goods ***not*** for specific clients.	**TEMPORARY** Destroy 1 year after expiry date or if no expiry date, 6 years after date of manufacture (Applies to both Adults & Minors)		
1.10.5	Dispensing	Client Eligibility forms.	**TEMPORARY** Destroy 5 years after action completed (Applies to both Adults & Minors)		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.11	**Family/Carer Support**	*The provision of support to family members or carers, as defined below:* *A family Carer is someone who provides care and support for their parent, partner, child or friend who has a disability, is frail, aged, or who has a chronic mental or physical illness. There is an important distinction between paid care workers who attend care recipients in a professional capacity and Carers, usually family members or close acquaintances, who provide for their care at all other times.-* SA Health Carer Participation Position Statement (2009) **Exclusions:** • Client-identified records - see **1.1 CLIENT CARE – General Care**			
1.11.1	Family/Carer Support	Records that are non-client identified relating to the provision of support to family members or carers. Includes parenting support, respite, and social/recreation/holiday support.	**TEMPORARY** Destroy 10 years after action completed (Applies to both Adults & Minors)	• Aged Care Assessment Program Records • Aged Care Assessment Team approvals for respite • Residential Respite Care assessments • Parenting group records	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.12	**Genetic Services**	*The process of genetic testing allows the genetic diagnosis of vulnerabilities to inherited diseases, and can also be used to determine a child's parentage (genetic mother and father) or in general a person's ancestry. In addition to studying chromosomes to the level of individual genes, genetic testing in a broader sense includes biochemical tests for the possible presence of genetic diseases, inherited disorders, or mutant forms of genes associated with increased risk of developing genetic disorders. Genetic testing identifies changes in chromosomes, genes, or proteins.* **Minimum Clinical or client-related record Selection Criteria**: Attendance at a specialist genetics clinic, or treatment by a unit under the care of a clinical geneticist.			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.12.1	Genetic Services	Records resulting from genetic testing by laboratories, including investigations conducted by metabolic laboratories. May also include routine genetic screening, including antenatal and newborn screening, as well as metabolic screening. OR Records resulting from genetics consultations by clinical geneticists, including genetic counselling and the diagnosis of genetic diseases and birth defects.	**TEMPORARY** Destroy 100 years after action completed (Applies to both Adults and Minors)	• Blood and/or Bone Marrow Slides • Cytopreservation Files • Diagnostic & Investigation Reports • Guthrie Cards Test Follow-up Forms • Microscopic Slides • Molecular Genetics Data Reference Cards • Photographic Film Strips • Request Forms • Tissue/Cell Cultures • Tissue Samples • Workbooks/Day Books • Clinical Genetics Data • Consultation Records • Family/Pedigree Charts • Referral Letters	• National Pathology Accreditation Advisory Council – *Retention of Laboratory Records and Diagnostic Material Standards* (*Cwth*)

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.12.2	Genetic Services	Neonatal screening cards (dried blood spot).	**TEMPORARY** Destroy 25 years after action completed	• Guthrie Cards	• National Pathology Accreditation Advisory Council – *Retention of Laboratory Records and Diagnostic Material Standards* (*Cwth*)

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.13	**Implants and Artificial Devices**	*The process of implanting a medical device manufactured to replace a missing biological structure, support a damaged biological structure, or enhance an existing biological structure. Also refers to re-implants and removals of implants and artificial devices.* **Minimum Clinical or client-related record Selection Criteria**: ICD-10-AM code for implants and artificial devices (Refer to SA Coding Standards - contact Medical Records Advisory Unit on (08) 82268837 to access this document if you are external to the SA Health intranet). **Note:** The criteria for transplants and implants are not meant to cover all types of transplants and devices undertaken by public health units, but are limited to specific target types that are considered of significance. **Minimum Clinical or client-related record Selection Criteria:** ICD-10-AM code for implants and artificial devices (refer to South Australian Morbidity Coding Standards & Guidelines). • The main focus is to identify cases of biomedical implants and allografts. This list of trigger codes excludes orthopaedic implants, fixations and arthroplasties, in addition to cardiovascular bypasses that utilise synthetic materials and devices. Codes included in the trigger code list have generally been limited to include those specifying bioprosthesis, allografts, xenografts, homografts and heterografts, apart from the cardiac pacemaker and electrodes and augmentation mammoplasty codes. • If public health units wish to add codes to the list to cover new trends & changes in technology, please notify the Medical Records Advisory Unit. **Exclusions***:* • Records relating to the registration of implant and artificial device recipients – see **item 2.6 CLINICAL ADMINISTRATION – Registration/Registers**. • Records relating to autologous skin/tissue grafts and hormone implants – see **item 1.1 CLIENT CARE – General Care**. • Records of clients classified as Legally Disabled see **item 1.6 CLIENT CARE - Clients Under Legal Disability**		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.13.1	Implants and Artificial Devices	Records relating to permanent implants into the body of significant biomedical or artificial material, devices or prostheses via an operating room surgical procedure. Also includes biomedical engineering, re-implants and removals.	**TEMPORARY** Destroy 30 years after last contact (Applies to both Adults & Minors)	• Clinical or client-related record examples as per 1.1.1 or 1.1.2.	• *Therapeutic Goods (Medical Devices) Regulations 2002 (Cwth)*
1.14	**Indigenous Health Provision**	*The provision of client care by public health units or programs whose services are specifically directed and provided to Aboriginal and Torres Strait Islander communities.* **See Also**: • Indigenous Considerations in the introduction to the GDS 28. **Exclusions:** • Records of indigenous individuals receiving care or being admitted to public health unit where the service is not directed or coordinated specifically to Aboriginal and Torres Strait Islander communities – see **items 1-30 CLIENT CARE**			
1.14.1	Indigenous Health Provision	Records relating to indigenous clients where a service or services are specifically directed and provided to such clients.	**PERMANENT**	• Clinical or client-related record examples as per 1.1.1 or 1.1.2.	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.15	**Informal Contacts**	*The provision of unidentified patient/client care that took place in the ordinary course of business.* **Exclusions:** • Records relating to client-specific contacts - see **item 1.1.1 (Adults) or 1.1.2 (Minors) CLIENT CARE – General Care** • Records relating to customer feedback - see **GDS 15 (as amended) item 1.8.2 COMMUNITY RELATIONS – Public Reaction** • Records relating to customer complaints - see **item 3.2 CLINICAL RISK MANAGEMENT – Complaint Resolution**			
1.15.1	Informal Contacts	Records relating to informal non-identified client contacts.	**TEMPORARY** Destroy 10 years after action completed (Applies to both Adults & Minors)	• Contact Forms • Intake Forms	
1.16	**Investigations - Non-Laboratory**	*The activity of conducting investigations to assist with the diagnosis of a disorder or disease or as part of a review of treatment or ongoing management.* **Exclusions:** • Pathology laboratory records – see **item 1.24 CLIENT CARE - Pathology** • Medical imaging **-** see **item 1.17 CLIENT CARE - Medical Imaging** • Workbooks and other monitoring - see **item 1.18 CLIENT CARE - Monitoring & Worksheets** • Records of clients classified as Legally Disabled - see **item 1.6 CLIENT CARE - Clients Under Legal Disability**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.16.1	Investigations – Non-Laboratory	Records associated with enabling the clinician to make an assessment of the client. **Inclusions:** • Cardiovascular investigations • Gastrointestinal investigations • Neurological investigations • Respiratory medicine diagnostic services • Allied health assessment tools	**TEMPORARY** 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)	• Allied health assessment tools – booklets • Booklets that ask the client to draw a circle, copy a letter, colour in etc • Cardiotocogram • Electrocardiograms (ECGs) Charts/Graphs • Electroencephalo-grams (EEGs) • Electromyographies (EMGs) • Endoscopy Reports • Lung Function Data • Overnight Monitoring Records • Request Forms • Spirometry Readings • Tracings	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.17	**Medical Imaging**	*The production of images of organs or tissues using any medical imaging technique.* **See Also:** • Item **1.28 CLIENT CARE - Screening & Risk Factor Assessment** **Exclusions:** • Video recordings and clinical photographs - see **item 1.26 – CLIENT CARE - Recordings & Clinical Photographs** • Mandatory child-abuse related videos, recordings, photographs, slides and other media – see **item 1.5 CLIENT CARE – Child Protection**. • Images of clients recognised to have a legal disability – see **item 1.6 CLIENT CARE - Clients Under Legal Disability**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.17.1	Medical Imaging	Reports relating to the production of images of organs and/or tissues, using radiological or other diagnostic medical imaging procedures. **Note:** Generally requests would not be filed in the clinical or client-related record, but retained by the Imaging Department. The clinical or client-related record Copy of the "Request forms" is listed under this item as there may be situations where the requests are filed in the record. In such cases the request would be left in and not pulled out separately. Eg. The request includes pertinent diagnostic information that was not able to be reported on the report filed in the clinical or client-related record, and thus in the interests of complete documentation, the request would also be filed in the record. **Inclusions:** • Reports for all medical imaging, irrespective of format or storage medium, ie applies to hardcopy films as well as CD-ROMS, digital tape, magneto-optical disc, etc.	**TEMPORARY** *Medical Imaging Copy* –Destroy 8 years after last image taken (Adults) or 8 years after child attains 18 years of age (Minors) *Clinical or client-related record copy* (including requests) – as for item 1.1.1 (Adults) or 1.1.2 (Minors)	• Reports • Requests	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.17.2	Medical Imaging	Images of organs and/or tissues, using radiological or other diagnostic medical imaging procedures. **Inclusions:** • All medical imaging, irrespective of format or storage medium, ie applies to hardcopy films as well as CD-ROMS, digital tape, magneto-optical disc, etc. **Exclusions:** • Duplicate reports (not sent to requesting clinician) can be destroyed under NAP • Neonatal films & 3D images - see item **1.1.2 – CLIENT CARE - General Care Minors** • Obstetric films & 3D images - see item **1.22 – CLIENT CARE - Obstetrics** • Neonatal hepoximeter printouts – see item **1.1.2 – CLIENT CARE - General Care Minors** • Radiologists working notes – see items **1.1.1 & 1.1.2 – CLIENT CARE – General Care**	**TEMPORARY** Destroy 8 years after last film taken (Adults) or 8 years after child attains 18 years of age (Minors)	• Angiogram Cinefilms, CDs or Photograph Stills • Computerised Tomography (CTs) • Digital/electronic images • Magnetic Resonance Imaging (MRI) films or electronic images • Mammographies • Nuclear medicine • Telemedicine recordings • Ultrasound Films • Ultrasound videos • X-ray (radiology) films	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.18	**Monitoring, Work Sheets and Workbooks/ Journals**	*The activity of frequent or continuous observations or monitoring.* **See Also:** • **Item 1.16 CLIENT CARE – Investigations / Non-Laboratory** • **Item 1.22 CLIENT CARE – Obstetrics** **Exclusions:** • Records of clients classified as Legally Disabled - see **item 1.6 - CLIENT CARE - Clients Under Legal Disability**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.18.1	Monitoring, Work Sheets and Workbooks/Journals	Records relating to frequent or continuous observations or monitoring.	**TEMPORARY** 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)	• Fluid Balance Charts • Fluid Balance Summaries • Frequent observations • ICU Circulation, Respiration & Oxygenation Monitoring Records • Overnight Monitoring Records • Observation Records • Pressure Recordings • Respiratory observations • Electrocardiogram (ECG) • Electroencephalogram (EEG) • Electromyogram (EMG) • Cardiotocogram (CTG) • Worksheets	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.18.2	Monitoring, Worksheets, and Workbook/Journals	Records of working notes & observations generated by medical specialists, medical officers, allied health professionals, nurses, clerical officers, or other clinicians.	**TEMPORARY** Destroy when information edited & placed in the clinical or client-related record If the information is not edited – as for item 1.1.1 (adults) or item 1.1.2 (minors)	• Workbooks • Worknotes • Journals • Daily ward diary	
1.19	**Moulds, Casts and Study Models**	*The activity of producing moulds, casts and study models by laboratories.*			
1.19.1	Moulds Casts and Study Models	Moulds, casts and study models produced within laboratories, eg orthotics, dentistry/orthodontics, podiatry.	**TEMPORARY** Destroy 6 months after reference or treatment purpose ceases (Applies to both Adults & Minors)	• Casts • Models • Plaster Moulds	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.19.2	Moulds Casts and Study Models	Requests for the production of moulds, casts or study models.	**TEMPORARY** *Laboratory Copy* - Destroy 18 months after request made (Applies to both Adults & Minors) *Clinical or client-related record Copy* – As for item 1.1.1 (Adults) or item 1.1.2 (Minors)	• Request Forms	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.20	**Neoplasms/ Cancer Care**	*The activity of providing care to clients with **malignant** neoplasms/cancer.* ***Minimum Clinical or client-related record Selection Criteria**:* All malignant primary neoplasms, including: • Melanoma (D03) • Carcinoma in situ of breast (D05) • Carcinoma in situ of bladder (D09.0) • Polycythaemia vera (D45) • Myelodysplastic syndromes (D46) • Other neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic & related tissue (D47) • Lymphomatoid papulosis (L41.2) • Client attends or has attended an outpatient specialist treatment clinic specific to the treatment of cancers including oncology, chemotherapy and radiotherapy **Exclusions:** • Records of malignant neoplasm of skin, except lip (C44.0), perineum anus & perinatal (C44.5) – see **item 1.1 CLIENT CARE – General Care** • Records of secondary neoplasms (C77, C78, C79) – see **item 1.1 CLIENT CARE – General Care** • Records of unifocal langerhans cell histiocytosis (C69.6) – see **item 1.1 CLIENT CARE – General Care**		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.20.1	Neoplasms/Cancer Care	Records relating to inpatient cases with an ICD-10-AM diagnosis code as described above.	**TEMPORARY** Destroy 15 years after death of patient, or 100 after birth date if date of death is unknown	• Consent Forms • Cytotoxic Medication Orders • Drug Charts • Histopathology Reports • Laboratory test results (electronic) • Medical Imaging Records Procedure notes • Progress Notes • Referral Letters • Summaries • Worksheets – if not summarised/edited & placed on the clinical or client-related record	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.20.2	Neoplasms/Cancer Care	Records relating to client attendance at a specialist treatment clinic specific to the treatment of cancers.	**TEMPORARY** Destroy 15 years after death of patient, or 100 after birth date if date of death is unknown	• Consent Forms • Cytotoxic Medication Orders • Drug Charts • Histopathology Reports • Laboratory test results (electronic) • Medical Imaging Records Procedure notes • Progress Notes • Referral Letters • Summaries • Worksheets – if not summarised/edited & placed on the clinical or client-related record	
1.20.3	Neoplasms/Cancer Care	Radiotherapy treatment records.	**TEMPORARY** Destroy 15 years after death of patient, or 100 after birth date if date of death is unknown		• *s43(3) Radiation Protection and Control (Ionising Radiation) Regulations 2000*

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.21	**Obstetrics Care**	*The activity of providing care during the antenatal, labour, delivery and postpartum stages of a pregnancy.* **Inclusions:** • Care provided during the antenatal, labour, delivery and postpartum stages of a pregnancy • Records of clients who did not attend an obstetric appointment			
1.21.1	Obstetrics Care	Records relating to attendance or admittance to the following: antenatal clinics, post natal clinics; delivery, obstetric or birthing wards/units; or any other inpatient, outpatient and/or emergency care related to obstetrics.	**TEMPORARY** Destroy 33 years after last obstetric care contact (which includes antenatal, delivery and post natal care)	• Antenatal or prenatal treatment • Apgar Scores • CTG Findings • Delivery Data • Epidural forms • Hepoximeter printouts • Newborn record • Obstetric record (mother's record) • Perinatal morbidity statistics record • Postnatal Domiciliary Visit Referrals • Postnatal, Feeding, Foetal Growth Records • Progress of labour • Clinical or client-related record	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.22	**Organ Donation and Transplantation**	*Relates to donation and transplantation of human organs and tissues, including the heart, cardiac, heart-lung, intestine, kidney/renal, lung, pancreas, ureters, limbal stem cells, cornea, bone marrow, or bone. Includes local copies of* DonateLife *records.* **Minimum Clinical or client-related record Selection Criteria**: ICD-10-AM code for transplants (refer to SA Morbidity Coding Standards & Guidelines - Inpatients). If public health units wish to add codes to the list to cover new trends & changes in technology, please notify the Medical Records Advisory Unit. The focus of the codes range is to identify transplants utilising biomaterials from another person or species as against autologous procedures. **Exclusions:** • Records relating to registration of transplantation donors and recipients – see **item 2.8 CLINICAL ADMINISTRATION – Registration/Registers**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.22.1	Organ Donation and Transplantation	Records relating to permanent transplantation of whole body organs or tissues via an operating room surgical procedure. **Exclusions:** • Records of transplantation of reproductive tissue – see **item 1.26 CLIENT CARE – Reproductive Technology Services**	**TEMPORARY** Destroy 50 years after last contact (Applies to both Adults & Minors)	• Anaesthesia Records • Diagnostic & Investigation Reports • Observation Records • Operation/Procedure Notes • Progress Notes • Referral Correspondence • Test Results • Donation forms (local copy)	• *Transplantation and Anatomy Act 1983 (SA)*
1.22.2	Organ Donation and Transplantation	Records relating to the donation of organs or tissues via a surgical procedure. **Exclusions:** • Donor registers - see **item 2.8.2 – CLINICAL AND CLIENT ADMINISTRATION – Registration/Registers**	**TEMPORARY** *Clinical or client-related record* Destroy 50 years after last contact (Applies to both Adults & Minors)		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.23	**Pathology**	*The precise study and diagnosis of disease, in a laboratory setting. The function of reference laboratories is the same as other laboratories but reference laboratories also conduct an additional service of providing specialist advice outside of their parent hospital or organisation.* **Exclusions:** • Records of clients classified as Legally Disabled - see **item 1.6 - CLIENT CARE - Clients Under Legal Disability**			
1.23.1	Pathology	Requests, reports, samples and specimens relating to diagnostic services, such as cultural/chemical, histopathological, pathological, clinical immunology, microbiology/infectious diseases, and clinical pharmacology.	**TEMPORARY** Dispose of in accordance with the *"National Pathology Accreditation Advisory Council (NPAAC) Requirements for the Retention of Laboratory Records and Diagnostic Material" (hyperlink via the introduction)*	• Reports • Slides • Blocks • Reports • Workbooks • Request forms • Body fluid samples • Specimens • Cultures – cell, tissue	
1.24	**Programs Management**	*Group therapy or programs related to client-care.* **Exclusions:** • Program/group records that are client-identified - see **item 1.1 CLIENT CARE – General Care**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.24.1	Programs Management	Records that are <u>non-client identified</u> relating to services provided on a <u>specialised or general/therapeutic group basis.</u>	**TEMPORARY** Destroy 10 years after action completed (Applies to both Adults & Minors)	• Group Attendance Forms • Evaluation Forms • Program Notes	
1.25	**Recordings and Clinical Photographs**	*Recordings (eg pathology swallowing, physiotherapy gait assessments, telemedicine consultations) or clinical photographs.* **Exclusions:** • Mandatory child-abuse related videos, recordings, photographs, slides and other media – see **item 1.5 CLIENT CARE – Child Protection**. • Recordings or photographs relating to a sexual assault – see **item 1.28.1 CLIENT CARE – Sexual Assault Counselling Records** • Videos or photographs of a client who is classified as being under a Legal Disability – see **item 1.6 CLIENT CARE – Clients Under Legal Disability**. • Videos or photographs relating to obstetrics – see **item 1.21 – CLIENT CARE - Obstetrics**			
1.25.1	Recordings and Clinical Photographs	<u>Reports</u> that summarise or provide a written record of what is captured either in recordings or clinical photographs.	**TEMPORARY** File in clinical or client-related record and destroy in accordance with item 1.1.1 (Adults) or 1.1.2 (Minors)	• Diagnostic & Investigation Reports	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.25.2	Recordings and Clinical Photographs	Recordings that are aggregate, client-identified or de-identified.	**TEMPORARY** Destroy 12 months after last action (Applies to both Adults & Minors)	• Telemedicine recordings • Video Recordings/Tapes/ DVDs	
1.25.3	Recordings and Clinical Photographs	Clinical photographs.	**TEMPORARY** *Departmental Copy* – Destroy 12 months after last action (Applies to both Adults & Minors) *Clinical or client-related record Copy* – as for item 1.1.1 (Adults) or 1.1.2 (Minors)	• Clinical Photographs or Slides	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.26	**Reproductive Technology Services**	*Reproductive Technology is defined as the branch of medical science concerned with artificial fertilisation. It includes artificial insemination and artificial fertilisation, including in vitro fertilisation procedures.* ***Minimum Clinical or client-related record Selection Criteria**:* *Attendance at or admittance under the care of a registered medical practitioner or licensed programme under the conditions of the Assisted Reproductive Treatment Act 1988 (SA).* **Exclusions:** • Records relating to general infertility investigations or treatment – see **item 1.1 CLIENT CARE – General Care** • Donor registers – see **item 2.8 – CLINICAL ADMINISTRATION – Registration/Registers**			
1.26.1	Reproductive Technology Services	Records relating to artificial insemination and/or artificial fertilisation including in vitro fertilisation procedures as conducted by a registered medical practitioner or licensed programme under the conditions of the *Reproductive Technology Act* (as amended).	**PERMANENT**	• Client Histories • Consent Forms • Correspondence • Counselling Notes • Diagnostic & Investigation Reports • History & Examination • Investigation Summaries • Management Plans • Operation Notes • Progress Notes • Treatment Notes	• *Assisted Reproductive Treatment Act 1988* (SA)

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.27	**Screening & Risk Factor Assessment**	*Activities associated with the asymptomatic screening or early detection of disease through programs such as those for breast or cervical cancer.* **Exclusions:** • Records of clients classified as Legally Disabled - see **item 1.6 - CLIENT CARE - Clients Under Legal Disability**			
1.27.1	Screening & Risk Factor Assessment	Records of screening services provided to clients.	**TEMPORARY** As for item 1.1.1 (Adults) or item 1.1.2 (Minors)	• Registration Forms • Counselling Records • Assessment Forms • Referral Correspondence • Intake/Contact Forms • Pathology Reports • Request Forms • Treatment Details • Results Letters • Results Notifications	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.27.2	Screening & Risk Factor Assessment	Images of organs and/or tissues, using radiological or other diagnostic medical imaging procedures. **See Also:** • Item 1.17 **CLIENT CARE - Medical Imaging**	**TEMPORARY** *If on Clinical or client-related record* – As for item 1.1.1 (Adults) or item 1.1.2 (Minors) *If maintained separately* – Destroy 8 years after last film taken (Adults) or 8 years after child attains 18 years of age (Minors)	• Xray Films • Mammograms • Ultrasound Films • Specimen Images • "Work-up" Images	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.28	**Sexual Assault Counselling**	*Any therapeutic counselling services provided for victims of sexual assault in South Australia. Sexual assault counselling records may be held by various SA public health units, such as Yarrow Place, Women's Health Statewide, Child and Adolescent Mental Health Service (CAMHS), Second Storey, GP Plus, or any other services where therapeutic counselling for the effects of sexual assault occur in South Australia.* **Note:** At times people who have been victims of sexual assault in another Australian state or territory will seek counselling services in South Australia. As the Criminal Law Consolidation Act and the Evidence Act are only applicable in the South Australian Criminal jurisdiction there may be occasions where their disclosure in other legal proceedings are sought. Advice will need to be sought from the appropriate SA Health Clinical Governance Unit should this occur. **Exclusions:** • Records relating to a Child Protection Service – see **item 1.5 CLIENT CARE – Child Protection**			
1.28.1	Sexual Assault Counselling	Records of Sexual Assault Referral Clinics, where documentation is maintained separately from the individual clinical or client-related record.	**TEMPORARY** Destroy 100 years after last contact		• *s72A Criminal Law Consolidation Act 1935 (SA)* • *s67E Evidence Act 1929 (SA)*
1.29	**Sexual Reassignment**	*Sexual reassignment is defined as a medical or surgical procedure or combination of both, to alter the genitals and other sexual characteristics of a person, identified by birth certificate as male or female, so that the person will be identified as a person of the opposite sex and includes, in relation to a child, any such medical or surgical procedure or combination of to correct or eliminate ambiguities in the child's sexual characteristics.*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
1 CLIENT CARE					
1.29.1	Sexual Reassignment	Records relating to a reassignment procedure or associated treatment as defined by the Sexual Reassignment Act (as amended) and associated regulations. This includes records relating to the mental condition of a person who proposes to undergo, is undergoing, or has undergone a reassignment procedure, records relating to the personal circumstances or lifestyle of such a person, records relating to the procedures or treatment that such a person is to undergo, is undergoing or has undergone.	**TEMPORARY** Destroy 100 years after action completed	• Client Histories • Consent Forms • Correspondence • Counselling Notes • History & Examination Management Plans • Investigation summaries • Operation Notes • Progress Notes • Treatment Notes	• *Sexual Reassignment Act 1988 (SA)*

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2	**CLINICAL & CLIENT ADMINISTRATION**	**The function of clinical administration can be defined as the unique administrative processes that support and coordinate client or client care services in an agency, including activities undertaken to meet associated internal and external reporting and accountability requirements.** **Exclusions:** • Records of administrative functions and activities that are not specific to the public health unit environment – see **GDS 15 (as amended)** • Records of Freedom of Information (FOI) matters - see **GDS 15 (as amended) item 9.86 INFORMATION MANAGEMENT – Reporting or item 16.86 STRATEGIC MANAGEMENT – Reporting**			
2.1	**Accommodation & Transport Services**	*The activity of providing an accommodation or transport service to clients or relatives/associates.*			
2.1.1	Accommodation & Transport Services	Records relating to the provision of an accommodation service to boarders. A boarder may be defined as being a person who is related to or associated with a client and who is receiving food and/or accommodation but for whom the public health unit does not accept responsibility for treatment and/or care. A boarder is not admitted to the public health unit, however, the boarder may be registered.	**TEMPORARY** *If on clinical or client-related record* – as for item 1.1.1 (Adults) or 1.1.2 (Minors) *If maintained separately from clinical or client-related record* – Destroy 8 years after last contact	• Accommodation Registers • Boarder Forms	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.1.2	Accommodation & Transport Services	Records relating to the transport of clients (eg ambulance, taxi) between public health units and home.	**TEMPORARY** *If on clinical or client-related record* – as for item 1.1.1 (Adults) or 1.1.2 (Minors) *If maintained separately from clinical or client-related record* – Destroy 8 years after last contact	• Cab charge • Client transport order • Client transport requests • Staff travel authority • Transport order books	
2.2	**Appointment Scheduling**	*The activity of making appointments for clients.* **Exclusions:** • Records relating to obstetrics - see **item 1.22 CLIENT CARE – Obstetrics Care**.			
2.2.1	Appointment Scheduling	Facilitative records relating to the making of appointments for clients and maintained as a departmental record.	**TEMPORARY** Destroy 8 years after action completed	• Appointment & Booking Systems • Appointment Diaries • Outpatient Schedules/Books • Waiting Lists • Drug Diversion Appointment Records	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.2.2	Appointment Scheduling	Duplicate or facilitative information relating to the making of appointments for clients and maintained by individual case workers or health professionals. **See Also:** • Item **1.18.2 CLIENT CARE - Monitoring, Work Sheets and Workbooks/Journals**	**TEMPORARY** Destroy 6 months after no longer required	• Calendars • Schedules • Daily Lists	
2.2.3	Appointment Scheduling	Records relating to clients who do not attend an initial appointment and who have no further contact with the service. **Inclusions*:*** • Correspondence or request to access information of clients subsequently found unregistered; usually from other clinicians sent in anticipation that the client will attend in the near future. • Documents received by a health care facility about individuals who have not subsequently attended as a client.	**TEMPORARY** Destroy 8 years after last documented date (applies to both Adults & Minors)	• Correspondence • Referrals • Request Forms • Contact Forms • Intake Forms • Registration Forms • Any other client identified documentation.	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.3	**Client Activity Monitoring**	*The activities associated with documenting client movement within a public health unit, between public health units or outside a public health unit.* **Note:** Records identifying which patients/clients are allocated to staff (rosters etc) are very likely to be of interest to the Crown as per GDS 27 – *Records Required for Legal Proceedings Relating to Alleged Abuse of Former Children Whilst in State Care* and GDS 32 - *Records of Relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse.* Please consult with the Crown Solicitors Office prior to sending destruction lists containing these records to State Records. **Exclusions:** • Records of clients classified as Legally Disabled - see **item 1.6 - CLIENT CARE - Clients Under Legal Disability** • *Mental Health Act 2009* Leave of Absence paperwork – see **item 1.1.1 or 1.1.2 CLIENT CARE – GENERAL CARE**			
2.3.1	Client Activity Monitoring	Records relating to the admission and separation of clients to and from public health unit. **Exclusions**: • (Midnight) Bed Returns – see **item 2.3.2. CLINICAL AND CLIENT ADMINISTRATION - Client Activity Monitoring**	**PERMANENT**	• Admission & Discharge Registers/Cards • Admission, Transfer & Separation Records	
2.3.2	Client Activity Monitoring	Records relating to inter-ward transfers.	**TEMPORARY** Destroy 8 years after last contact	• (Midnight) Bed Returns • Daily Inpatient Census • Ward Registers	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.3.3	Client Activity Monitoring	Material relating to client tracking.	**TEMPORARY** Destroy 6 months after action completed	• Bed Cards • Daily check lists of client location • Client Armbands • Client Labels	
2.3.4	Client Activity Monitoring	Records relating to the change-over of nursing staff and the documentation of any events required by the next shift. Refers to records created as part of patient monitoring and/or shift activities. It also includes records relating to information communicated between shifts.	**TEMPORARY** *If information is transcribed, summarised or edited, and placed on clinical or client-related record –* Destroy 6 months after action completed *If information is not transcribed, summarised or edited, and placed on the clinical/client-related record –* Destroy 15 years after last contact (Applies to both adults & minors)	• Handover sheets • Patient Allocations • Day/Night Reporting	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.4	**Committees (Health)**	*The activities associated with the management of health committees and task forces. Includes Client Activity Monitoring, and Quality and Research.* **See Also:** • **Item 5.2 QUALITY IMPROVEMENT – Committees (Health)** • **Item 6.4 RESEARCH & ETHICS – Committees (Health)** **Note:** Duplicate copies held for reference purposes only can be destroyed in accordance with NAP (as explained in GDS 15 (as amended), p.29-32). **Exclusions***:* • Records of committees not relevant to the function of Client Activity Monitoring - see: o **GDS 15 item 16.20.1-16.20.6 Strategic Management – Committees** o **GDS 15 item 16.70.1-16.70.3 Strategic Management – Meetings**			
2.4.1	Committees (Health)	Records relating to non-strategic committees or work groups established to formulate or monitor and report upon service coordination on a departmental basis. This includes multi-disciplinary meetings held between clinical areas, allied health, and community outreach programs.	**TEMPORARY** Destroy 10 years after action completed	• Minutes of Committee Meetings • Agendas • Reports • Submissions & other Meeting Papers	
2.4.2	Committees	Records relating to the establishment of non-strategic, external and inter-agency (minimal input) committees, including the appointment of members.	**TEMPORARY** Destroy 10 years after action completed	• Terms of Reference • Appointment Records	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.4.3	Committees (Health)	Records documenting administrative arrangements relating to committee meetings. Includes contact lists, venue bookings, hire or equipment, catering, etc.	**TEMPORARY** Destroy 2 years after action completed		
2.5	**Data Entry**	*Tasks associated with inputting of data to update any electronic databases.* **Exclusions:** • Data related to the Research/Ethics function – see **item 6.8 RESEARCH & ETHICS – Data Management** • Statistical returns related to client movements – see **item 2.3 CLINICAL ADMINISTRATION – Client Activity Monitoring**			
2.5.1	Data Entry	Data input forms (which are a non-clinical or client related record) used to update any electronic databases.	**TEMPORARY** Destroy 12 months after data entered onto electronic system or into register		
2.5.2	Client Activity Monitoring	Data input forms (which are a non-clinical or client-related record) used to update any electronic databases. OR Records of statistical returns generated periodically regarding client movements within public health units.	**TEMPORARY** Destroy 6 months after data entered onto electronic system or into register and verified as accurate	• Daily Returns of Patient Changes	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.6	**Notification / Reporting**	*The activity of reporting by a public health unit to SA Health or other prescribed body on clinical or client-related information.* **See Also:** • Item **2.8 CLINICAL ADMINISTRATION – Registration/Registers** **Exclusions:** • Mandated child protection notifications (re: Children's Protection Act 1993 (SA)) - see **item 1.5 CLIENT CARE – Child Protection**			
2.6.1	Notification Reporting	Records relating to the reporting or notification of medical conditions or non-medical conditions other than drugs of dependence to SA Health or other prescribed body as required by legislation. **Exclusions:** • Inpatient cases with a cancer registry notification - see **item 1.20.1 CLIENT CARE – Neoplasm/Cancer Care**	**TEMPORARY** *Clinical or client-related record Copy* – as for item 1.1.1 (Adults) or 1.1.2 (Minors) *If maintained separately* – Destroy 10 years after action completed	• Birth Defects Notification Form • Community Treatment Orders • Consent to Electro-Convulsive Therapy (ECT) • Inpatient Treatment Orders • Notifiable Infectious Diseases Report • Paediatric Morbidity & Mortality Record • Supplementary Birth Record	• Births, Deaths, Marriages • Blood alcohol form (Forensics SA) – if not filed in the clinical or client-related record • Government Statistics • Inventory Records • Mental Health • Reports to DASSA • SA Clean Needle Program activity sheets and correspondence • Monthly Reports • Quarterly Reports • Annual Reports

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.6.2	Notification Reporting	Records relating to the reporting or notification of drugs of dependence for the purposes of regulating the availability of "poisonous" substances.	**TEMPORARY** Destroy 2 years after last entry	• Drugs of Dependence Register	• *Controlled Substances Regulations (Poisons) 2011 (SA)*
2.6.3	Notification Reporting	Records relating to the reporting or notification of non-medical conditions other than drugs of dependence to SA Health or other prescribed body as required by legislation.	**TEMPORARY** Destroy 8 years after action completed	• Inventory records • Government statistics	
2.7	**Record Tracking**	*The activity of recording the movement tracking of clinical or client-related records.* **Exclusions:** • Records of clients classified as Legally Disabled - see **item 1.6 - CLIENT CARE - Clients Under Legal Disability**			
2.7.1	Record Tracking	Records relating to the movement of client-specific records.	**TEMPORARY** Destroy 8 years from last access date	• Tracer Cards • Electronic Audit Trails	
2.7.2	Record Tracking	Records relating to the movement of records that are not client-specific.	**TEMPORARY** Destroy 6 months after action completed		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.8	**Registration/ Registers**	*The activity of registering clients or summarising and indexing client information for reference and research purposes.* **Exclusions:** • Records of admissions, transfers and separations – see **item 2.3 CLINICAL ADMINISTRATION – Client Activity Monitoring** • Drugs of dependence registers – see **item 2.6.2 CLINICAL ADMINISTRATION – Notification/Reporting** • Community-health based registration forms placed on Clinical or client-related record - see **item 1.1 CLIENT CARE – General Care**			
2.8.1	Registration/ Registers	Records relating to the summarisation of clients' personal details in a central registration system in order to register new clients or identify returning clients and current inpatients.	**PERMANENT**	• Patient Master Index (PMI) • Admission Registers	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.8.2	Registration/ Registers	Records of <u>other registration</u> providing summary detail of medical procedure or episode or disease that is <u>not captured elsewhere</u>. **Inclusions:**: • Registers/indexes comprising details of client's disease and operations such as client's record number, name, sex, age, date of admission, length of stay, discharge status and destination, responsible Medical Officer or unit, ward, principal diagnosis and other disease or condition, operation and procedure codes related to that admission	**PERMANENT**	• Accident and Emergency Registers • Birth Registers • Birth Defects Registers • Death Certificate Books (now superseded) • Diagnosis Registers • Donor Registers • Genetic Registers • Implant/Device Registers • Maternity Register • Operation/Theatre Registers • Outpatient Attendance Registers • Blood products register	
2.8.3	Registration/ Registers	Records of duplicate or facilitative registration systems maintained by individual case workers, health professionals or in hospital/public health unit departments.	**TEMPORARY** Destroy 8 years after action completed		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
2 CLINICAL & CLIENT ADMINISTRATION					
2.8.4	Registration/ Registers	Patient property registers.	**TEMPORARY** Destroy 12 months after action completed		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
3 CLINICAL & CLIENT RISK MANAGEMENT					
3.	**CLINICAL & CLIENT RISK MANAGEMENT**	**The function of clinical risk management focuses on improving the quality and safety of health care services by identifying the circumstances and opportunities that put clients at risk of harm and acting to prevent or control those risks. (Medical Indemnity Industry Association of Australia)** **Exclusions:** • Clinical risk management in relation to clients with a legal disability – see **item 1.6 CLIENT CARE – Clients under a Legal Disability** • Freedom of Information (FOI) matters - see **GDS 15 (as amended) item 9 INFORMATION MANAGEMENT – Cases** or **item 16 STRATEGIC MANAGEMENT - Reporting** • Risk Management matters which are not of a clinical nature, such as property, worker's compensation, vehicles, etc - see **GDS 15 (as amended) item 16 STRATEGIC MANAGEMENT** or contact the Insurance Services Unit of SA Health • Work Health and Safety matters not relating to clients - see **GDS 15 (as amended) item 11 OCCUPATIONAL HEALTH AND SAFETY (OH&S)** Within this GDS, public health unit clinical or client-related records relating to medical and dental malpractice or misconduct have been sentenced as temporary. It is to be noted that a permanent record of malpractice and misconduct cases heard before Professional Conduct Tribunals is already maintained by the Courts Administration Authority (in accordance with items 3.1.1 of the Courts Administration Authority RDS 2012/06 v1). Public health unit records relating to coronial and inquest enquiries have been sentenced as temporary within this GDS. It is to be noted that a permanent record of coronial and inquest cases heard before the Coroner's Court is maintained by such a Court (in accordance with items 2.2.1 and 2.2.2 of the Courts Administration Authority RDS 2012/06 v1). If legal proceedings are anticipated or have commenced or if claims are made, or notices given, for compensation or damages, public health units are urged to seek advice from the SA Health – Insurance Services unit on (08) 8463 6096.			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
3 CLINICAL & CLIENT RISK MANAGEMENT					
3.1	**Advocacy**	*Activities associated with those services provided to clients that allow access to an advisor or advocate in their dealings with a public health unit.* **Exclusions:** • Records of complaint resolution and litigation cases - see: • **item 3.2 CLINICAL & CLIENT RISK MANAGEMENT – Complaint Management or** • **item 3.6 CLINICAL & CLIENT RISK MANAGEMENT – Litigation**			
3.1.1	Advocacy	Records relating to the provision of client advocacy which do not lead to formal complaints or litigation cases. (**Note:** Refer to definition of "litigation")	**TEMPORARY** Destroy 15 years after action completed	• Contact Summary Forms • Correspondence	
3.2	**Complaint Management**	*The process of handling complaints made to the public health unit by clients directly, the Ombudsman, Member of Parliament and/or relatives on behalf of a living or deceased client.* **Note:** Refer to definition of "litigation". **Exclusions*:*** • Records of complaints leading to litigation – see **item 3.6 CLINICAL RISK MANAGEMENT – LITIGATION** • Records relating to complaints relating to the conduct of research – see **item 6.1 RESEARCH & ETHICS – ALLEGATIONS** • Records relating to the Australian Incident Monitoring Study (AIMS) forms & database or the Safety Learning System – see **item 5.4.1 – QUALITY IMPROVEMENT – Customer Service**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
3 CLINICAL & CLIENT RISK MANAGEMENT					
3.2.1	Complaint Management	Records relating to <u>complaints</u> made to the public health unit by clients directly, the Ombudsman, Member of Parliament and/or relatives on behalf of a living or deceased client which do not give rise to legal proceedings or claims for damages or compensation.	**TEMPORARY** Destroy 15 years after action completed	• Complaint Files, including Contact Summary Forms, Correspondence	
3.3	**Coronial/Police Enquiries**	*Responses by public health units to the process followed by the State Coroner, SAPOL, and the Child Death & Serious Injury Committee when it is deemed necessary to hold an inquest to determine the cause and circumstances of a death.*			
3.3.1	Coronial/Police Enquiries	Records relating to <u>police, coronial and/or Child Death & Serious Injury Committee enquiries</u> which do not give rise to legal proceedings or claims for damages or compensation.	**TEMPORARY** Destroy 31 years after action completed	• Court Orders • Consent Forms • Copies of Death Certificate Stubs • Coronial Files • Subpoenas • Warrants • Risk Management Copy of Client or Clinical record.	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
3 CLINICAL & CLIENT RISK MANAGEMENT					
3.4	**Incident Reporting**	*The activity of reporting mishaps that cause injury or damage. Includes damage or injury to property of clients, visitors or the general public while on the agency's premises (KAAA).* **Exclusions**: • Incident reports relating to clients or employees treated by the public health unit as a client in their own right - see **item 1.1 CLIENT CARE – General Care** • Incident reports of OHS&W-related incidents involving public health unit employees - see **GDS 15 (as amended) – item 2 COMPENSATION or item 11 OCCUPATIONAL HEALTH & SAFETY (OH&S)** • Infection control records, sterilisation records - see **item 3.8 CLINICAL RISK MANAGEMENT – Risk Assessment**				
3.5	**Legal Advice**	*The activities associated with providing legal opinions and advice on medico-legal matters. Includes legal advice received from in-house consultants and external sources, including the Crown Solicitor's Office.* **Exclusions:** • Records relating to clients classified as Legally Disabled - see **item 1.6 - CLIENT CARE - Clients Under Legal Disability** • See **GDS 15 (as amended) item 10.5.2 - LEGAL SERVICES – ADVICE** for legal advice relating to: ° interpretation of legislation administered by the agency ° precedent-setting matters ° matters generating substantial public interest ° matters resulting in substantial changes to agency policy and procedures.				
3.5.1	Legal Advice	Records relating to the provision of advice on medico-legal matters.	**TEMPORARY** Destroy 10 years after action completed	• Memos • Letters • Abstracts	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
3 CLINICAL & CLIENT RISK MANAGEMENT					
3.6	**Litigation (Health)**	*The activities involved in managing lawsuits or legal proceedings between the public health unit and other parties. Litigation also refers to court proceedings, claims for compensation or damages made prior to the commencement of any proceedings (eg Supreme Court Civil Rules 2006, Rule 33) and that the term would include a notice of an intended action (e.g. under s45A of the Limitations of Actions Act 1936 (SA))* **Note:** Risk Management forms kept within the clinical or client-related record are to be sentenced with the clinical or client-related record. **Exclusions*:*** • Records of complaints NOT leading to litigation - see **item 3.2 CLINICAL AND CLIENT RISK MANAGEMENT - Complaint Resolution** • Records of allegations in a research/ethics setting - see **item 6.1 RESEARCH & ETHICS - Allegations**			
3.6.1	Litigation (Health)	Records relating to cases of litigation.	**TEMPORARY** Destroy 10 years after action completed	• Correspondence • Memos • Enquiries • Subpoenas • Court Orders • Warrants • Risk Management Copy of medical record	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
3 CLINICAL & CLIENT RISK MANAGEMENT					
3.7	**Medical Malpractice / Negligence**	*The processes associated with dealing with accusations of improper or negligent treatment of a client by a health practitioner, resulting in death, injury, damage, or loss.* **Exclusions:** • Records of accusations that proceed to a court case - see **item 3.6 CLINICAL & CLIENT RISK MANAGEMENT - Litigation**			
3.7.1	Medical Malpractice Negligence	Records relating to the treatment of clients where a health practitioner or a public health unit is accused of medical malpractice or negligence.	**TEMPORARY** *Risk Management Copy* - Destroy 75 years after date of birth or 20 years after claim is closed, whichever is the later *Clinical or client-related record* – as for item 1.1.1 (Adults) or 1.1.2 (Minors)	Risk Management Copy, including: • Incident Notification Forms • Charts & Observation Records • Reports	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
3 CLINICAL & CLIENT RISK MANAGEMENT					
3.8	**Risk Assessment**	*Risk assessment is the process of risk identification, risk analysis and risk evaluation. In a health setting, risk assessment can include infection control records, sterilisation records, and investigation of adverse events amongst others.* **See Also:** • item 5.8 QUALITY IMPROVEMENT – Quality Control **Exclusions*:*** • Records of legally disabled clients - see **item 1.6 CLIENT CARE – Clients under Legal Disability** • Reports of incidents - see **item 3.4 CLINICAL RISK MANAGEMENT – Incident Reporting** • Records of medical malpractice/negligence – see **item 3.6.1 CLINICAL RISK MANAGEMENT – Medical Malpractice/Negligence** • Infection Control Committee records **-** see **item 5.2 QUALITY IMPROVEMENT - Committees** • Records that pertain to information at a client-identified level **-** see **item 1.1 CLIENT CARE – GENERAL CARE** • Records relating to other inspections **–** see **GDS 15 (as amended) item 11.55 OCCUPATIONAL HEALTH & SAFETY – INSPECTIONS**		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
3 CLINICAL & CLIENT RISK MANAGEMENT					
3.8.1	Risk Assessment	Records relating to <u>risk assessment at the public health unit level.</u> **Exclusions:** • Minutes of Infection Control Committee Meetings - see **item 5.2.4 QUALITY IMPROVEMENT – Committees**	**TEMPORARY** Destroy 10 years after action completed	• Infection Control Notes/ Records • Investigations of adverse events • Reports to the Department for Health and Ageing • Theatre Checklists • Root Cause Analysis (RCA) copies of documents collected in the course of investigating client related incidents under the *Health Care Act 2008 (SA)*	
3.8.2	Risk Assessment	Records relating to sterilisation of instruments and other equipment.	**TEMPORARY** *Batch copies* – Destroy 15 years after action completed *Clinical or client-related record Copy* – As for item 1.1.1 (Adults) or item 1.1.2 (Minors)	• Steriliser Checklists and other documents as listed in the AS/NZS4187	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
3 CLINICAL & CLIENT RISK MANAGEMENT					
3.8.3	Risk Assessment	Records relating to the inspection of public health unit sites by external authorities to ensure legislative/standards compliance.	**TEMPORARY** Destroy 10 years after action completed	• Reports of inspections of premises by Council Environmental Health Officers under the Food Act • Other inspection records ie. engineering	
3.8.4	Risk Assessment	Records relating to patient menus and service of food within a public health unit	**TEMPORARY** Destroy 12 months after action completed	• Patient menus	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
4 EDUCATION & HEALTH PROMOTION					
4	**EDUCATION & HEALTH PROMOTION**	**The function of providing education in medicine and healthcare either as a public health unit-only initiative or as a joint venture with a university/higher education institution. Such education includes the training of students (undergraduate, graduate or postgraduate), clients and clinical staff.** **Exclusions:** • Records relating to non-medical specific education and training – see **GDS 15 (as amended) item 15- STAFF DEVELOPMENT.**			
4.1	**Course Development**	*The activity of developing course material for training students or public health unit staff on clinical issues and accepted practice.*			
4.1.1	Course Development	Records relating to the development of course material for training students, public health unit staff or other health workers on clinical issues and accepted practice.	**TEMPORARY** Destroy 7 years after course superseded or discontinued (subject to Legal Deposit requirements)	• Curriculum Documentation • Course Notes • Program Evaluations	
4.1.2	Course Development	Copies of programs, handouts, workshop notes, etc.	**TEMPORARY** Destroy 6 months after action completed		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
4 EDUCATION & HEALTH PROMOTION					
4.2	**Health Promotion**	*Activities associated with the promotion and awareness of health, whether aimed at public health unit staff or the community a public health unit serves. Also includes public health units partnering with other organisations.* **Exclusions:** • Records related to seeking grants - see **GDS 15 (as amended) item 5.4.7 - FINANCIAL MANAGEMENT – GRANT FUNDING**			
4.2.1	Health Promotion	Records relating to the formulation of <u>significant</u> health promotion campaigns, projects and initiatives which aim to achieve organisational development, community awareness or community participation with relation to health improvement and preventative health. Such campaigns, projects and initiatives may be significant because of degree of financial input, scale or scope or state-wide or national recognition.	**PERMANENT**	• Final Reports • Policy Papers • Agreements • Funding approvals • Printed resources (booklets, posters, postcards, etc)	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
4 EDUCATION & HEALTH PROMOTION					
4.2.2	Health Promotion	Records relating to the development of minor health promotion campaigns, projects and initiatives which aim to achieve organisational development, community awareness or community participation with relation to health improvement and preventative health.	**TEMPORARY** Destroy 10 years after action completed (subject to Legal Deposit requirements)	• Examples as in 4.2.1	
4.3	**Provision**	*The activity of providing education to clients, staff, nursing staff or medical students.* **Exclusions**: • Client-identified records relating to individual client education, practical training (where not an informal student-on-student practical exercise) or records of group programs - see item **1.1 CLIENT CARE – General Care**			
4.3.1	Provision	Records that are *not* client-identified relating to group programs conducted as part of client education.	**TEMPORARY** Destroy 10 years after action completed (Applies to both Adults & Minors)	• Attendance Records • Statistical Data	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
4 EDUCATION & HEALTH PROMOTION					
4.3.2	Provision	Records relating to staff or medical student education, or provision of other peer education, where the education provider is a Registered Training Organisation.	**TEMPORARY** Destroy 30 years after qualification or attainment of units of competency	• Assessments • Results	• *Standards for NVR Registered Training Organisations 2012*, 12.3 or 23.3
4.3.3	Provision	Records relating to staff or medical student education, or provision of other peer education. **Exclusions:** • Record kept on personal file - see **GDS 15 (as amended) item 12 PERSONNEL**	**TEMPORARY** *Local File Copy* – Destroy 10 years after action completed	• Attendance Records • Progress Reports • Assessments • Results • Student-on-student "mock" medical records	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
5 QUALITY IMPROVEMENT					
5	**QUALITY IMPROVEMENT**	**The function of systematically reviewing the procedures used for diagnosis, care and treatment and examining how associated resources are used within a public health unit to enhance organisational performance, and stimulate service improvement.** **Exclusions:** • Non-public health unit specific quality improvement exercises – see **GDS 15 (as amended) item 17 STRATEGIC MANAGEMENT**			
5.1	**Auditing**	*The activities associated with officially checking quality assurance and operational records and systems to ensure they have been kept and maintained in accordance with agreed or legislated standards or codes of practice and that they correctly record the events, processes and business of a public health unit in a specified period.*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
5 QUALITY IMPROVEMENT					
5.1.1	Auditing	Records relating to Quality Management audits conducted at the organisational level in accordance with corporate policies.	**TEMPORARY** Destroy 10 years after action completed	• Evaluation and Quality Improvement Program (EQUiP) Reports • Clinical or client-related record Audits • National Mental Health Standards Reports • WorkCover Reports • Coding Audits • National Safety and Quality Health Service Standards Audit Reports	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
5 QUALITY IMPROVEMENT					
5.2	**Committees (Health)**	*The activities associated with the management of health committees and task forces.* **See Also:** • **Item 2.4 CLINICAL & CLIENT ADMINISTRATION – Committees (Health)** • **Item 6.4 RESEARCH & ETHICS – Committees (Health)** **Note:** Duplicate copies held for reference purposes only can be destroyed in accordance with NAP (as explained in GDS 15 (as amended), p.29-32) **Exclusions*:*** • Records of committees not relevant to the function of Client Activity Monitoring - see: **o GDS 15 (as amended) item 16.20.1-16.20.6 STRATEGIC MANAGEMENT – Committees** **o GDS 15 (as amended) item 16.70.1-16.70.3 STRATEGIC MANAGEMENT – Meetings**			
5.2.1	Committees (Health)	Records of high level agency committees or task forces, eg strategic management or corporate executive committees, established to formulate and approve quality improvement policy or major quality improvement initiatives and programs on a public health unit-wide basis.	**PERMANENT**	• Minutes of Committee Meetings • Agendas • Reports • Submissions & other Meeting Papers	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
5 QUALITY IMPROVEMENT					
5.2.2	Committees (Health)	Records of external or inter-agency committees or task forces for which a public health unit provides the secretariat, or provides integral operational advice, or has other major involvement.	**PERMANENT**	• Minutes of Committee Meetings • Agendas • Reports • Submissions & other Meeting Papers	
5.2.3	Committees (Health)	Records relating to the establishment of high level agency, external or inter-agency committees, including the appointment of members.	**PERMANENT**	• Terms of Reference • Appointment Records	
5.2.4	Committees (Health)	Records relating to non-strategic committees or work groups established to formulate or monitor and report upon quality improvement policy and initiatives on a departmental basis.	**TEMPORARY** Destroy 10 years after action completed	• Minutes of Committee Meetings • Minutes, agendas and papers of Infection Control Committee meetings • Agendas • Reports • Submissions & other Meeting Papers	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
5 QUALITY IMPROVEMENT					
5.2.5	Committees (Health)	Records relating to external or inter-agency committees or task forces for which the public health unit does not provide the secretariat and does not have significant input.	**TEMPORARY** Destroy 10 years after action completed	• Minutes of Committee Meetings • Agendas • Reports • Submissions & other Meeting Papers	
5.2.6	Committees (Health)	Records relating to the establishment of non-strategic, external and inter-agency (minimal input) committees, including the appointment of members.	**TEMPORARY** Destroy 10 years after action completed	• Terms of Reference • Appointment Records	
5.2.7	Committees (Health)	Records documenting administrative arrangements relating to committee meetings. Includes contact lists, venue bookings, hire or equipment, catering, etc.	**TEMPORARY** Destroy 2 years after action completed		
5.3	**Customer Service**	*The activities associated with the planning, monitoring and evaluation of services provided to customers by the organisation (KAAA).*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
5 QUALITY IMPROVEMENT					
5.3.1	Customer Service	Records relating to the application of quality management practices in order to improve services provided to clients.	**TEMPORARY** Destroy 10 years after action completed	• Australian Incident Monitoring Study (AIMS) forms & database • Safety Learning System	
5.4	**Evaluation**	*The process of determining the suitability of potential or existing programs, items of equipment, systems or services in relation to meeting the needs of the given situation (KAAA).*			
5.4.1	Evaluation	Records relating to the evaluation of processes and systems employed by a public health unit in providing its services.	**TEMPORARY** Destroy 10 years after action completed	• Quality Register • Australian Incident Monitoring Study (AIMS) forms & database • Safety Learning System	
5.5	**Implementation**	*The activities associated with carrying out or putting into action, plans, policies, procedures or instructions, all of which could be internally or externally driven (KAAA).*			
5.5.1	Implementation	Records relating to the implementation of the Quality Management system, eg Evaluation and Quality Improvement Program (EQUiP), National Accreditation Scheme – National Safety and Quality Health Service Standards.	**TEMPORARY** Destroy 10 years after action completed	• Self-Assessment Workbooks • Review Workbooks	
5.6	**Policy**	*The activities associated with developing and establishing decisions, directions and precedents which act as a reference for future decision making, as the basis from which the organisation's operating procedures are determined (KAAA).*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
5 QUALITY IMPROVEMENT					
5.6.1	Policy	Records relating to the development of public health unit-wide policies relating to quality improvement.	**PERMANENT**	• Policy Statements • Final Reports	
5.6.2	Policy	Supplementary records relating to the background and development of public health unit quality improvement policies.	**TEMPORARY** Destroy 5 years after action completed	• Working Papers • Interim and Draft Reports • Surveys • Proposals Not Adopted	
5.7	**Procedures**	*Standard methods of operating laid down by an organisation according to formulated policy (KWAAA).*			
5.7.1	Procedures	Master copy of agency circulars, manuals, handbooks, instructions, or other information relating to operational procedures. **Exclusions**: • OH&S information and procedure manuals - see GDS 15 (as amended) item 11.50.1 OH&S – Health Promotion	**PERMANENT**		
5.7.2	Procedures	Records relating to the development and implementation of operational health procedures.	**TEMPORARY** Destroy 5 years after action completed		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
5 QUALITY IMPROVEMENT					
5.8	**Quality Control**	*The examination of a product, service, or process for certain minimum levels of quality. It may include whatever actions a public health unit deems necessary to provide for the control and verification of certain characteristics of a product or service. The basic goal of quality control is to ensure that the products, services, or processes provided meet specific requirements and are dependable, satisfactory, and/or fiscally sound.*			
5.8.1	Quality Control	Records relating to laboratory methods and/or procedures.	**TEMPORARY** Destroy 3 years after superseded	• Lab methods & procedures (manuals) • Quality assurance documents	
5.8.2	Quality Control	Records relating to equipment (non-laboratory) temperature charts and maintenance checks. **Exclusions***:* • Temperature charts relating to laboratory equipment - see NPAAC requirements	**TEMPORARY** Destroy 3 years after action completed	• Daily checklists for fridge temperature (blood or staff or vaccine fridge) • Emergency bells checklist • O2 suction checklist • Resus box contents checklist	
5.8.3	Quality Control	Notifications relating to product recalls, drug recalls and material use.	**TEMPORARY** Destroy 8 years after action completed	• Product recalls from TGA • Product recalls for public health unit equipment • Letters from TGA regarding use of materials • Drug recalls from TGA	• *Therapeutic Goods Act 1989 (Cwth)*

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
5 QUALITY IMPROVEMENT					
5.9	**Reporting**	*The processes associated with initiating or providing a formal response to a situation or request (either internal, external or as a requirement of corporate policies), and to provide formal statements or findings of the results of the examination or investigation (KAAA).*			
5.9.1	Reporting	Development of formal reports to external agencies, eg Approved National Safety and Quality Health Service Standards Accrediting Agencies, as required.	**TEMPORARY** Destroy 10 years after action completed		
5.9.2	Reporting	Periodic internal or system reports on quality improvement matters used to monitor and document recurring activities.	**TEMPORARY** Destroy 5 years after action completed		
5.10	**Standards**	*The process of developing or implementing industry or agency benchmarks for services and processes to enhance the quality and efficiency of the agency (KAAA).*			
5.10.1	Standards	Records relating to the formulation of key performance indicators or clinical indicators by a public health unit and applied at the institutional level.	**PERMANENT**	• Accrediting Body Reports	
5.10.2	Standards	Supplementary records relating to the development of indicators or standards by the public health unit.	**TEMPORARY** Destroy 5 years after action completed	• Reference Material • Working Papers • Drafts	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6	**RESEARCH AND ETHICS**	**The function of ethical investigation or study of a health/medical subject in order 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 (HREC) set up within public health units to monitor and advise on ethical behaviour within the pursuit of research.** **Note:** As per the *Australian Code for the Responsible Conduct of Research* item 2, clinical or client-related records used as the source document for a clinical trial may need to be retained according to categories in this Activity, and not as per standard clinical or client-related records. Relevant items to be aware of include 6.3.1, 6.7.1, 6.8 and 6.14.1. **Exclusions:** • Records of non-medical/health research – see **GDS 15 (as amended) items 14 PUBLICATION or 16 STRATEGIC MANAGEMENT** • Records of ethical behaviour not related to the conduct of medical research – see **GDS 15 (as amended) item 12 PERSONNEL – Discipline** • Records of research conducted on clients with a legal disability – see item **1.6 CLIENT CARE – Clients under a Legal Disability – (except when category has a PERMANENT retention period)**		
6.1	**Allegations**	*The activities associated with allegations of misconduct by public health unit researchers.*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.1.1	Allegations	Records relating to misconduct allegations against researchers that are deemed as legitimate, are sustained and result in a formal inquiry.	**PERMANENT**	• Written Complaints • Correspondence to Public health unit CEO • Notification of Actions • Written Statements of Allegations • CEO Reports • Notifications of Inquiry • Accused Researchers Written Responses • Findings of Inquiry	• *Australian Code for the Responsible Conduct of Research* item 2.5.4
6.1.2	Allegations	Records relating to the initial inquiry of misconduct allegations against researchers that are proved unsubstantiated or unjustified and do not lead to further investigation or a formal inquiry.	**TEMPORARY** Destroy 10 years after action completed	• Written Complaints • Correspondence to Public health unit CEO • Notification of Actions • Written Statements of Allegations • CEO Reports	
6.1.3	Allegations	Records relating to misconduct allegations against researchers that are deemed as legitimate but cannot be sustained and therefore do not lead to a formal inquiry.	**TEMPORARY** Destroy 10 years after action completed	• Written Complaints • Correspondence to public health unit CEO • Notification of Actions • Written Statements of Allegations • CEO Reports	

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.2	**Appeals**	*The activity of lodging an appeal against a finding of professional misconduct.*			
6.2.1	Appeals	Records relating to appeals lodged by researchers found of misconduct by a formal inquiry.	**PERMANENT**		• *Australian Code for the Responsible Conduct of Research* item 2.5.4
6.3	**Applications**	*The activities associated with the preparation and submission of applications by public health unit staff to conduct research.*			
6.3.1	Applications	Records relating to the screening of applications, including the approval or rejection of applications by Human Research and Ethics Committees.	**PERMANENT**	• Applications • Checklists • Surveys • Information Sheets • Interview Schedule • Letter of introduction • Consent forms • Peer review • Amendment requests	• *National Statement on Ethical Conduct in Human Research* 2007 item 5.2.25
6.4	**Committees (Health)**	*The activities associated with the management of health committees and task forces.* **Note:** Duplicate copies held for reference purposes only can be destroyed in accordance with NAP (as explained in GDS 15 (as amended), p.29-32). **See Also:** • Item **5.2 QUALITY IMPROVEMENT – Committees (Health)**			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.4.1	Committees (Health)	Records of meetings of committees and task forces established to approve and oversee research conducted by public health units, community health or special needs services, eg Human Research Ethics Committees (HREC).	**PERMANENT**	• Appointment Records • Minutes & Agendas • Reports (including Annual & Final) • Submissions • Applications • Protocols • Information Sheets • Requests for Extensions/ Modifications	• *National Statement on Ethical Conduct in Human Research 2007* • *Australian Code for the Responsible Conduct of Research.*

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.4.2	Committees (Health)	Terms of reference, HREC Membership, & HREC Decisions.	**PERMANENT**	• Letter of appointment • CVs • Signed confidentiality agreement • Letter of resignation • Letter of reappointment • Approval letter • Rejection letter • Request for further information • Conditional approval letter • Approval of amendments • Adverse events letter	
6.4.3	Committees (Health)	Register of research applications and committee decisions.	**PERMANENT**	• Database/spreadsheet containing: o Details of Principal Investigator/s o Summary of research proposal o HREC committee approval date o Funding amounts	• *National Statement on Ethical Conduct in Human Research 2007 item 5.2.24*

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.5	**Compliance**	*The activities associated with complying with mandatory or optional accountability, fiscal, legal, regulatory or quality standards or requirements to which the organisation is subject. Includes compliance with legislation and with national and international standards, such as ISO 9000 series (KAAA).*			
6.5.1	Compliance	Records relating to meeting the reporting requirements of the National Health and Medical Research Council.	**PERMANENT**	• Annual Reports	• *National Health and Medical Research Council*
6.5.2	Compliance	Supplementary records relating to the preparation of reports required for the National Health and Medical Research Council.	**TEMPORARY** Destroy 5 years after action completed		
6.6	**Conflict of Interest**	*The activity of disclosing a conflict of interest whereby a person has a private or personal interest sufficient to appear to influence the objective exercise of his or her official duties.*			
6.6.1	Conflict of Interest	Records relating to the disclosure of a conflict of interest in research by a research worker.	**TEMPORARY** Destroy 15 years after research project completed		• *National Health & Medical Research Council requirements are incorporated into this GDS item*
6.7	**Consent**	*The activity of obtaining informed consent from participants of a project, program, trial or other initiative of an organisation.*			
6.7.1	Consent	Records relating to obtaining informed consent from subjects taking part in research projects or trials.	**TEMPORARY** Destroy 15 years after research project completed	• Information sheets • Consent Forms	*The following requirements are incorporated into this GDS item:* • *National Health & Medical Research Council*
6.8	**Data Management**	*The activity of collecting, managing and maintaining research data.*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.8.1	Data Management	All research data, including electronic data.	**TEMPORARY** Destroy 15 years after research completed or last contact, whichever is later	• Statistical Packages • Survey Forms • Databases • Spreadsheets	• *Data must be recorded in a durable and appropriately referenced format and comply with relevant privacy protocols. Ref. Section 2.1 of* Australian Code for the Responsible Conduct of Research *(NH&MRC, Australian Research Council and Universities Australia)*
6.9	**Evaluation/ Program Appraisal**	*The activity of either self-evaluation and appraisal of research programs and services or the conduct of evaluation by any external agency or unit, eg the National Health & Medical Research council.*			
6.9.1	Evaluation Program Appraisal	Records relating to the evaluation of <u>significant public health unit research programs</u>. Programs may be significant because of ° the level of funding allocated, ° being a joint initiative involving federal, state and/or local authorities/organisations ° If the program creates controversy or public/media reaction.	**PERMANENT**	• Evaluation Reports	*The following requirements are incorporated into this GDS item:* • *National Health & Medical Research Council*

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.9.2	Evaluation Program Appraisal	Records relating to evaluation of minor public health unit research programs.	**TEMPORARY** Destroy 15 years after action completed		*The following requirements are incorporated into this GDS item:* • *National Health & Medical Research Council*
6.9.3	Evaluation Program Appraisal	Records relating to authorisation of a project via the Research Governance process.	**TEMPORARY** Destroy 10 years after action completed	• Completed Site Specific Assessment (SSA) • Notification of Authorisation • Amendments to SSA	
6.9.4	Evaluation Program Appraisal	Support documentation related to the Research Governance process.	**TEMPORARY** Destroy once the Site Specific Assessment has been completed.	• Surveys • Information Sheets • Interview schedule • Letter of introduction • Consent forms • National Ethics Application Form	
6.10	**Funding Application**	*The activities associated with the application for and receipt of project funding.*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.10.1	Funding Application	Records relating to obtaining resources to undertake significant research projects. Projects may be significant because of the degree of financial input, for joint initiatives involving federal, state and/or local authorities/organisations, areas of controversy or due to public/media reaction.	**PERMANENT**	• Project Plans • Grant Proposals • Funding Applications	*The following requirements are incorporated into this GDS item:* • *National Health & Medical Research Council*
6.10.2	Funding Application	Records relating to obtaining resources to undertake minor research projects.	**TEMPORARY** Destroy 8 years after action completed	• Project Plans • Grant Proposals • Funding Applications	*The following requirements are incorporated into this GDS item:* • *National Health & Medical Research Council*
6.10.3	Funding Application	Records relating to unsuccessful applications	**TEMPORARY** Destroy 5 years after action completed	• Project Plans • Grant Proposals • Funding Applications	
6.11	**Modification to Protocol/ Extension Requests**	*The activity of seeking a modification to an approved protocol or an extension to the period for which approval is given for research projects.*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.11.1	Modification to Protocol/ Extension Requests	Records relating to researchers seeking modification to an approved protocol or seeking an extension of the period for which approval is given.	**PERMANENT** *Research & Ethics Committee Copy* **TEMPORARY** *Researcher Copy* – Destroy 15 years after research completed	• Reports • Applications for Extension	*The following requirements are incorporated into this GDS item:* • *National Health & Medical Research Council*
6.12	**Monitoring/ Review**	*The activities involved in monitoring and reviewing the progress and status of research projects. Includes recommendations and advice resulting from these activities.*			
6.12.1	Monitoring/ Review	Records relating to the monitoring of research progress and/or status.	**TEMPORARY** Destroy 15 years after research project completed	• Annual Progress Reports Generated by Researchers • Other Reports as Required of Researchers by Research & Ethics Committees	*The following requirements are incorporated into this GDS item:* • *National Health & Medical Research Council*
6.13	**Policy**	*The activities associated with developing and establishing decisions, directions and precedents which act as a reference for future decision making, as the basis from which the organisation's operating procedures are determined (KAAA).*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.13.1	Policy	Records relating to the development of agency-wide public health unit policies relating to research and ethical research conduct.	**PERMANENT**	• Policy Statements • Final Reports • Terms of Reference	
6.13.2	Policy	Supplementary records relating to the background and development of public health unit or service policies relevant to research.	**TEMPORARY** Destroy 5 years after action completed	• Working Papers • Interim and Draft Reports • Surveys • Policy Proposals Not Adopted	
6.14	**Procedures**	*Standard methods of operating laid down by an organisation according to formulated policy (KWAAA).*			
6.14.1	Procedures	Master copy of agency circulars, manuals, handbooks, instructions, or other information relating to operational procedures. **Exclusions**: • OH&S information and procedure manuals - see GDS 15 (as amended) item 11.50.1 OH&S – Health Promotion	**PERMANENT**		
6.14.2	Procedures	Records relating to the development and implementation of operational health procedures.	**TEMPORARY** Destroy 5 years after action completed		

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.15	**Recruitment of Subjects**	*The activity of recruiting subjects for medical/health research projects.*			
6.15.1	Recruitment of Subjects	Records relating to the recruitment of subjects by researchers.	**TEMPORARY** Destroy 15 years after research project completed		• *National Health and Medical Research Council*
6.16	**Reporting**	*The processes associated with initiating or providing a formal response to a situation or request (either internal, external or as a requirement of corporate policies), and to provide formal statements or findings of the results of the examination or investigation (KAAA).*			
6.16.1	Reporting	Master copy of final reports, including journal articles, published or unpublished, produced by researchers after completion of a research project.	**PERMANENT**	• Final Reports	
6.17	**Research Practice/ Activities**	*The activities involved in the actual performance or carrying out of research by research workers, including analysis, interviews, questionnaires and trials.*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.17.1	Research Practice Activities	Records relating to the actual practice or performance of research, including clinical trials sponsored by pharmaceutical companies.	**TEMPORARY** Destroy 15 years after research project completed	• Results • Notes • Samples & Specimens • Application form • Completed questionnaires • Signed consent forms • Adverse events • Research reports • Data • Study findings	• *National Health and Medical Research Council* • *Australian Code for the Responsible Conduct of Research 2.1.1* • *NOTE: the disposal action of "15 years after project completed" is a minimum requirement. Where pharmaceutical company sponsors stipulate longer retention, researchers may adhere to such requirements.*
6.18	**Standards**	*The process of developing or implementing industry or agency benchmarks for services and processes to enhance the quality and efficiency of the agency (KAAA).*			
6.18.1	Standards	Records relating to the development and implementation of research and ethics standards by an agency public health unit and applied at the institutional level.	**PERMANENT**	• Codes of Conduct • Key Performance Indicators	
6.18.2	Standards	Supplementary records relating to the development of research and ethics standards by the public health unit.	**TEMPORARY** Destroy 5 years after action completed	• Reference Material • Working Papers • Drafts	
6.19	**Supervision**	*The activity of formally supervising medical/health research projects by chief investigators.*			

Item No.	FUNCTION Activity / Process	Description / Disposal Class	Disposal Action	Record Examples	Requirements/Remarks
6 RESEARCH AND ETHICS					
6.19.1	Supervision	Records relating to the supervision of research or research projects by chief investigators, including the observance of any responsibilities as supervisors set out in guidelines or standards and the appointment of a person as a supervisor.	**TEMPORARY** Destroy 15 years after research project completed	• Reports • Supervision/ Observation Notes • Supervisor Details	• *National Health and Medical Research Council*

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