

Operational Records Disposal Schedule

SA Health

Client Care, Clinical & Client Administration, Education & Health Promotion and Quality Improvement

RDS 2025/15 Version 1

Effective Dates: 27 January 2026 to 31 December 2027

This operational records disposal schedule (RDS) authorises disposal of official records (including destruction and transfer of records to State Records custody) as a determination in accordance with section 23(2) of the *State Records Act 1997*.

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RDS No	RDS 2025/15 Version 1
Disposal Schedule Type	Operational Records Disposal Schedule
Agency	SA Health
Records Scope	<p>Records documenting the function/s of Client Care, Clinical & Client Administration, Education & Health Promotion and Quality Improvement.</p> <p>This RDS applies only to the records described within it, as created or received by certain agencies (or their predecessors) operating within one of the 10 Local Health Networks (LHN):</p> <ul style="list-style-type: none"> • Barossa Hills Fleurieu LHN • Central Adelaide LHN • Eyre and Far North LHN • Flinders and Upper North LHN • Limestone Coast LHN • Northern Adelaide LHN • Riverland Mallee Coorong LHN • Southern Adelaide LHN • Women’s and Children’s Health Network • Yorke and Northern LHN
Records Coverage Dates	1 January 1977 – ongoing
Effective Dates	27 January 2026 to 31 December 2027
Status	Determined by Director State Records and approved by State Records Council on 9 December 2025
Associated RDS	This RDS replaces specific items in General Disposal Schedule 28 (GDS 28 v1) for Clinical and Client Records of Public Health Unit in South Australia (expired 30 June 2025).
Associated Document	This RDS has no Context Statement.

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Introduction

Scope

This RDS applies to official records in all formats including (but not limited to) those that were born digital in databases, email systems, office applications, digital cameras and video as well as physical records on paper, film, tape and other analogue media. Any common records of Government Agencies are covered under General Disposal Schedule for State Government Agencies (GDS 30).

This RDS excludes:

- all pre-1901 records. These are permanent in accordance with a motion approved by the State Records Council on 19 February 2008
- records of permanent value already in State Records custody
- destruction of physical records badly damaged by fire, flood, mould, etc, and neglect of physical, digital records which makes them unreadable and inaccessible
- records to be transferred as part of a privatisation or sale to a non-government organisation
- records not adequately covered within the scope of this RDS

If records fall into any of the above exclusions, please contact State Records for advice.

Objectives

The purpose of this RDS is to authorise the disposal of records in accordance with the *State Records Act 1997* including:

- records of enduring evidential or informational value that cannot be destroyed and must be preserved for future reference (identified as permanent - retain as State archives) in accordance with State Records appraisal criteria and
- authorising the destruction of records not of enduring evidential or information value (identified as temporary) after they have been retained a minimum period

Relationship to other disposal schedules

The General Disposal Schedule for State Government Agencies in South Australia (GDS 30, as amended) should be used by State Government agencies for common records documenting activities such as HR, financial management, policy and procedures.

Hardcopy source records dating from 1 January 2005 that are converted to digital format (digitised) as part of business processes can be disposed of under General Disposal Schedule 21 (GDS 21) where the conditions outlined in GDS 21 are met.

State Records issue general disposal schedules from time to time to implement disposal freezes, restricting disposal of records which might otherwise be authorised for destruction. To see the latest schedules implementing disposal freezes check State Records website <https://www.archives.sa.gov.au/managing-information/general-disposal-schedules-gds>.

Interpretation

This RDS establishes minimum periods before temporary value digital and physical records can be legally destroyed and identifies records of permanent value to be transferred to State Records' custody.

Status/Disposal action definitions

- **Permanent – retain as State archives**
The disposal action 'Retain as State archives' is used to identify those records of enduring evidential or informational value that cannot be destroyed and must be preserved for future reference. The permanent retention of these records as State archives has been identified in accordance with the State Records' appraisal criteria. These records are required to be transferred to State Records in accordance with State Records Transfer Standard (as amended).
- **Temporary – retain a minimum of [list specific period of time] after action completed, then destroy.**
The disposal action 'temporary' is used to identify records not of enduring evidential or informational value. These records are not considered to have continuing value to the agency or the State but must be retained for a minimum period. They can be destroyed after reaching this minimum period, and once any other disposal considerations have been taken into account.

Retain a record of records destroyed under this RDS

Agencies must keep their own record of all records destroyed under this RDS, noting the relevant disposal schedule entry and the authorisation for destruction. Temporary records should only be destroyed with the approval of the CE or delegate in accordance with the *Destruction of Official Records Guideline* issued by State Records of South Australia.

Compliance with the Determination

Failure to comply with this determination, or any directions in it, falls under Section 17 of the *State Records Act 1997*.

For more information

Refer to State Records sentencing, transfer and destruction guidelines on our website at www.archives.sa.gov.au.

State Records Contact Details

Contact details

Level 15, 10 Franklin Street
ADELAIDE SA 5000
GPO Box 464
ADELAIDE SA 5000
Tel (+61 8) 7322 7081

Web www.archives.sa.gov.au

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
1.2	Advice - General Information Services	<p><i>The activity of providing health information and advice to either clients or clinicians/consultants relevant to a specific service.</i></p> <p>Exclusions:</p> <ul style="list-style-type: none"> Records relating to individual, client-specific education – no current disposal coverage Client specific records including areas like crisis phone lines - no current disposal coverage Records of clients classified as Legally Disabled - no current disposal coverage 		
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, e.g. poisons, lactation, drug information.	TEMPORARY	Retain a minimum of 10 years after provision of advice, then destroy (applies to both adults & minors)
1.3	Advice - Non-Client Specific	<p><i>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.</i></p> <p>See Item 1.3.1 for phone registers and message books containing client-specific information.</p> <p>Inclusions:</p> <ul style="list-style-type: none"> 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. <p>Exclusions:</p> <ul style="list-style-type: none"> Records relating to individual client-specific advice - no current disposal coverage <p>Client specific records including areas like crisis phone lines - no current disposal coverage</p>		
1.3.1	Advice - Non-Client Specific	<p>Records that facilitate the provision of non-client specific advice provided by a public health unit clinician, consultant or Community Health Centre.</p> <p>Note: Phone registers and message books should <i>not</i> include both client and non-client specific information.</p>	TEMPORARY	Retain a minimum of 10 years after provision of advice, then destroy (applies to both adults & minors)

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<p>Examples include:</p> <ul style="list-style-type: none"> • Advice (unidentified client) via email & web interaction • Message Books • Phone Consultation • Registers • Telephone Record Forms 		
1.10	Dispensing	<p><i>The activity of administering, dispensing, prescribing and/or manufacturing drugs, medications and other pharmaceutical products.</i></p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Notifications of drugs of dependency – no current disposal coverage <p>Records of clients classified as Legally Disabled - no current disposal coverage</p>		
1.10.1	Dispensing	<p>Records relating to the dispensing or prescribing of drugs, medications and other pharmaceutical products to clients.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Inpatient Drug Sheets • Orders – Cytotoxic Medication, Intravenous Therapy, Infusion Pump/Infusion Therapy • Prescriptions – Inhalation Therapy, Discharge, Emergency Department, Consulting Clinics <p>Legislation</p> <ul style="list-style-type: none"> • <i>Controlled Substances Regulations (Poisons) 2011 (SA)</i> • <i>Controlled Substances Act 1984 (SA)</i> 	TEMPORARY	<p><i>Pharmacy/duplicate copy – Retain a minimum of 2 years after dispensing, then destroy (applies to both adults & minors)</i></p> <p><i>Clinical or client related record copy – no current disposal coverage</i></p>

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
1.10.2	Dispensing	<p>Records relating to ward drug dispensing and imprests.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Licence to Possess S4 and S8 Drug for Administration • Ward Imprest Record • Ward Supplies Register <p>Legislation</p> <ul style="list-style-type: none"> • <i>Therapeutic Goods Act 1989 (Cwth)</i> • <i>Controlled Substances Regulations (Poisons) 2011 (SA)</i> • <i>Controlled Substances Act 1984 (SA)</i> 	TEMPORARY	<p><i>Pharmacy/duplicate copy –</i></p> <p>Retain a minimum of 2 years after dispensing, then destroy (applies to both adults & minors)</p>
1.10.3	Dispensing	<p>Records relating to the manufacture of drugs, medication and/or other pharmaceutical products for individual clients.</p> <p>Legislation</p> <ul style="list-style-type: none"> • <i>Controlled Substances Act, Regulations (Poisons) 2008 (SA)</i> 	TEMPORARY	<p><i>Pharmacy/duplicate copy –</i></p> <p>Retain a minimum of 2 years after dispensing, then destroy (applies to both adults & minors)</p> <p><i>Clinical or client related record copy – no current disposal coverage</i></p>
1.11	Family/Carer Support	<p><i>The provision of support to family members or carers, as defined below:</i></p> <p><i>“A carer refers to a person who provides care, support and assistance for a family member or friend or as part of a kinship system. This includes someone who is frail, aged, has a disability, a medical</i></p>		

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		<p><i>condition, including terminal or chronic illness or who has a mental illness. Carers include children caring for parents and guardians.”¹</i></p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Client-identified records - no current disposal coverage. 		
1.11.1	Family/Carer Support	<p>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.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Aged Care Assessment Program Records • Aged Care Assessment Team approvals for respite • Residential Respite Care assessments • Parenting group records 	TEMPORARY	Retain a minimum of 10 years after action completed, then destroy (applies to both adults & minors)
1.15	Informal Contacts	<p><i>The provision of unidentified patient/client care that took place in the ordinary course of business.</i></p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Records relating to client-specific contacts - no current disposal coverage. • Records relating to customer feedback - no current disposal coverage. • Records relating to customer complaints - no current disposal coverage. 		
1.15.1	Informal Contacts	<p>Records relating to informal non-identified client contacts.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Contact Forms • Intake Forms 	TEMPORARY	Retain a minimum of 10 years after action completed, then destroy (applies to both adults & minors)

¹ SA Health Consumer, Carer and Community Engagement, Strategic Framework 2021-2025
Effective dates: 27 January 2026 to 31 December 2027

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
1.16	Investigations - Non-Laboratory	<p><i>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.</i></p> <p>See Item 1.17 for Medical Imaging</p> <p>See Item 1.18 for Workbooks and other monitoring</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Pathology laboratory records – no current disposal coverage <p>Records of clients classified as Legally Disabled no current disposal coverage</p>		
1.16.1	Investigations - Non-Laboratory	<p>Records associated with enabling the clinician to make an assessment of the client.</p> <p>Inclusions:</p> <ul style="list-style-type: none"> • Cardiovascular investigations • Gastrointestinal investigations • Neurological investigations • Respiratory medicine diagnostic services • Allied health assessment tools • 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 	TEMPORARY	<p>Retain until information summarised or edited, and placed on the clinical or client-related record, then destroy (applies to both adults & minors)</p> <p>If the information is not summarised or edited – no current disposal coverage</p>

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<ul style="list-style-type: none"> • Overnight Monitoring <p>Record examples:</p> <ul style="list-style-type: none"> • Request Forms • Spirometry Readings • Tracings 		
<p>1.17</p>	<p>Medical Imaging</p>	<p><i>The production of images of organs or tissues using any medical imaging technique.</i></p> <p>Exclusions:</p> <ul style="list-style-type: none"> • <i>Video recordings and clinical photographs - no current disposal coverage</i> • <i>Mandatory child-abuse related videos, recordings, photographs, slides and other media – no current disposal coverage</i> <p><i>Images of clients recognised to have a legal disability – no current disposal coverage</i></p>		
<p>1.17.1</p>	<p>Medical Imaging</p>	<p>Reports relating to the production of images of organs and/or tissues, using radiological or other diagnostic medical imaging procedures.</p> <p>Note: Generally, requests would not be filed in the clinical or client-related record but retained by the Imaging Department.</p> <p>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.</p> <p>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.</p>	<p>TEMPORARY</p>	<p><i>Medical Imaging Copy</i></p> <p>Retain a minimum 8 years after last image taken (Adults) or 8 years after child attains 18 years of age (Minors), then destroy.</p> <p><i>Clinical or client related record copy (including requests) – no current disposal coverage.</i></p>

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
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		<p>Inclusions:</p> <p>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.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Reports • Requests 		
1.17.2	Medical Imaging	<p>Images of organs and/or tissues, using radiological or other diagnostic medical imaging procedures.</p> <p>Inclusions:</p> <p>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.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Duplicate reports (not sent to requesting clinician) can be destroyed under NAP • Neonatal films & 3D images – no current disposal coverage • Obstetric films & 3D images – no current disposal coverage • Neonatal hepoximeter printouts – no current disposal coverage • Radiologists working notes – no current disposal coverage <p>Record examples:</p> <ul style="list-style-type: none"> • Angiogram Cinefilms, CDs or Photograph Stills 	TEMPORARY	<p><i>Medical Imaging Copy</i></p> <p>Retain a minimum 8 years after last film taken (Adults) or 8 years after child attains 18 years of age (Minors), then destroy.</p> <p><i>Clinical or client related record copy</i> (including requests) – no current disposal coverage.</p>

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<ul style="list-style-type: none"> • 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 		
1.18	Monitoring, Work Sheets and Workbooks/ Journals	<p><i>The activity of frequent or continuous observations or monitoring.</i></p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Records of clients classified as Legally Disabled – no current disposal coverage 		
1.18.1	Monitoring, Work Sheets and Workbooks/ Journals	<p>Records relating to frequent or continuous observations or monitoring.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Cardiotocogram (CTG) • Electrocardiogram (ECG) • Electroencephalogram (EEG) • Electromyogram (EMG) • Fluid Balance Charts and Summaries • Frequent observations • ICU Circulation, Respiration & Oxygenation Monitoring Records 	TEMPORARY	<p>Retain until information summarised or edited, and placed on the clinical or client-related record, then destroy (applies to both adults & minors)</p> <p>If the information is not summarised or edited – no current disposal coverage.</p>

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<ul style="list-style-type: none"> • Observation Records • Overnight Monitoring Records • Pressure Recordings • Respiratory observations • Worksheets 		
1.18.2	Monitoring, Work Sheets and Workbooks/ Journals	<p>Records of working notes & observations generated by medical specialists, medical officers, allied health professionals, nurses, clerical officers, or other clinicians.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Daily ward diary • Journals • Workbooks • Work notes 	TEMPORARY	<p>Retain until information edited and placed in the clinical or client related record, then destroy.</p> <p>Record not edited – no current disposal coverage.</p>
1.19	Moulds, Casts and Study Models	<i>The activity of producing moulds, casts and study models by laboratories.</i>		
1.19.1	Moulds, Casts and Study Models	<p>Moulds, casts and study models produced within laboratories, eg orthotics, dentistry/orthodontics, podiatry.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Casts • Models • Plaster Moulds <p>See Item 1.19.2 for requests.</p>	TEMPORARY	Retain until 6 months after reference or treatment purpose ceases, then destroy (applies to both adults & minors).
1.19.2	Moulds, Casts and Study Models	<p>Requests for the production of moulds, casts or study models.</p> <p>Record examples:</p>	TEMPORARY	<i>Laboratory Copy – Retain until 18 months after request made,</i>

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<ul style="list-style-type: none"> • Request Forms <p>See Item 1.19.1 for moulds, casts and study models.</p>		<p>then destroy (applies to both adults & minors).</p> <p>Clinical or client related record – no current disposal coverage.</p>
2	CLINICAL & CLIENT ADMINISTRATION	<p>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.</p> <p>See GDS 30 v2 (as amended) for records of administrative functions and activities that are not specific to the public health unit environment</p> <p>See GDS 30 v2 (as amended) item 9.1 (various) INFORMATION MANAGEMENT- Case Management (FOI) for records of Freedom of Information matters.</p>		
2.1	Accommodation & Transport Services	<i>The activity of providing an accommodation or transport service to clients or relatives/associates.</i>		
2.1.1	Accommodation & Transport Services	<p>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.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Accommodation Registers • Boarder Forms 	TEMPORARY	<p>If maintained separately from clinical or client related record, retain a minimum of 8 years after last contact, then destroy.</p> <p>If on clinical or client-related record – no current disposal coverage.</p>
2.1.2	Accommodation & Transport Services	Records relating to the transport of clients (eg ambulance, taxi) between public health units and home.	TEMPORARY	If maintained separately from clinical or client related

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<p>Record examples:</p> <ul style="list-style-type: none"> • Cab charge • Client transport order • Client transport requests • Staff travel authority • Transport order books 		<p>record, retain a minimum of 8 years after last contact, then destroy.</p> <p>If on clinical or client-related record – no current disposal coverage.</p>
2.2	Appointment Scheduling	<p><i>The activity of making appointments for clients.</i></p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Records relating to obstetrics – no current disposal coverage 		
2.2.1	Appointment Scheduling	<p>Facilitative records relating to the making of appointments for clients and maintained as a departmental record.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Appointment & Booking Systems • Appointment Diaries • Outpatient Schedules/Books • Waiting Lists • Drug Diversion • Appointment Records 	TEMPORARY	Retain a minimum of 8 years after action completed, then destroy.
2.2.2	Appointment Scheduling	<p>Duplicate or facilitative information relating to the making of appointments for clients and maintained by individual case workers or health professionals.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Calendars 	TEMPORARY	Retain a minimum of 6 months after no longer required, then destroy

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<ul style="list-style-type: none"> • Schedules • Daily Lists <p>See Item 1.18.2 for Monitoring, Work Sheets and Workbooks/ Journals</p>		
2.2.3	Appointment Scheduling	<p>Records relating to clients who do not attend an initial appointment and who have no further contact with the service.</p> <p>Inclusions:</p> <ul style="list-style-type: none"> • 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. <p>Record examples:</p> <ul style="list-style-type: none"> • Contact Forms • Correspondence • Intake Forms • Referrals • Registration Forms • Request Forms • Any other client identified documentation 	TEMPORARY	Retain a minimum of 8 years after last documented date, then destroy (applies to both adults & minors).
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.		

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		<p>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 47 v1 (as amended) – Records of relevance to allegations of Child Abuse matters.</p> <p>Please consult with the Crown Solicitors Office if in any doubt if the destruction of these records could be prejudicial to the interest of the agency, its clients or the Crown.</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Records of clients classified as Legally Disabled – no current disposal coverage • <i>Mental Health Act 2009</i> Leave of Absence paperwork – no current disposal coverage 		
2.3.1	Client Activity Monitoring	<p>Records relating to the admission and separation of clients to and from public health unit.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Admission & Discharge Registers/Cards • Admission, Transfer & Separation Records <p>See Item 2.3.2 for (Midnight) Bed Returns</p>	PERMANENT	Retain as State archives
2.3.2	Client Activity Monitoring	<p>Records relating to inter-ward transfers.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Daily Inpatient Census • (Midnight) Bed Returns • Ward Registers 	TEMPORARY	Retain a minimum of 8 years after last contact, then destroy.
2.3.3	Client Activity Monitoring	<p>Material relating to client tracking.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Bed Cards • Client Armbands • Client Labels 	TEMPORARY	Retain a minimum of 6 months after action completed, then destroy.

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<ul style="list-style-type: none"> • Daily check lists of client location 		
2.5	Data Entry	<p><i>Tasks associated with inputting of non-clinical or non-client related data to update any electronic databases.</i></p> <p>See Item 2.3 for Statistical returns related to client movements</p> <p>Exclusions:</p> <p>Data related to the Research/Ethics function – no current disposal coverage</p>		
2.5.1	Data Entry	Data input forms (which are a non-clinical or non-client related record) used to update any electronic databases.	TEMPORARY	Retain a minimum 12 months after data entered onto electronic database.
2.6	Notification / Reporting	<p><i>The activity of reporting by a public health unit to SA Health or other prescribed body on clinical or client-related information.</i></p> <p>See Item 2.8 for– Registration/Registers</p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Mandated child protection notifications (re: <i>Children’s Protection Act 1993 (SA)</i> (repealed), <i>Children and Young People (Safety) Act 2017 (SA)</i> – no current disposal coverage 		
2.6.1	Notification / Reporting	<p>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.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Annual Reports • Birth Defects Notification Form • Births, Deaths, Marriages • Blood alcohol form • (Forensics SA) – if not filed in the clinical or client-related record • Community Treatment Orders 	TEMPORARY	<p>If maintained separately – Retain a minimum of 10 years after action completed, the destroy</p> <p><i>Clinical or client related record Copy – no current disposal coverage.</i></p>

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<ul style="list-style-type: none"> • Consent to Electro-Convulsive Therapy (ECT) • Government Statistics • Inpatient Treatment Orders • Inventory Records • Mental Health • Monthly Reports • Notifiable Infectious Diseases Report • Paediatric Morbidity & Mortality Record • Program activity sheets and correspondence • Quarterly Reports • Reports to DASSA • SA Clean Needle • Supplementary Birth Record <p>Exclusions:</p> <ul style="list-style-type: none"> • Inpatient cases with a cancer registry notification – no current disposal coverage 		
2.6.2	Notification / Reporting	<p>Records relating to the reporting or notification of drugs of dependence for the purposes of regulating the availability of “poisonous” substances.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Drugs of Dependence Register <p>Legislation</p> <ul style="list-style-type: none"> • <i>Controlled Substances Regulations (Poisons) 2011 (SA)</i> 	TEMPORARY	Retain a minimum of 2 years after last entry, then destroy
2.7	Record Tracking	<p><i>The activity of recording the movement tracking of clinical or client-related records.</i></p> <p>Exclusions: Records of clients classified as Legally Disabled – no current disposal coverage</p>		

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
2.7.1	Record Tracking	Records relating to the movement of client-specific records. Record examples: <ul style="list-style-type: none"> • Tracer Cards • Electronic Audit Trails See Item 2.7.2 for movement of non-client specific records.	TEMPORARY	Retain a minimum of 8 years after last access, then destroy
2.7.2	Record Tracking	Records relating to the movement of records that are not client specific. See Item 2.7.1 for movement of client specific records.	TEMPORARY	Retain a minimum of 6 months after action completed, then destroy
2.8	Registration/ Registers	<i>The activity of registering clients or summarising and indexing client information for reference and research purposes.</i> See Item 2.3 for records of admissions, transfers and separations See Item 2.6.2 for Drugs of dependence registers Exclusions: Community-health based registration forms placed on Clinical or client-related record - no current disposal coverage		
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. Record examples: <ul style="list-style-type: none"> • Patient Master Index (PMI) • Admission Registers 	PERMANENT	Retain as State archives
2.8.2	Registration/ Registers	Records of other registration providing summary detail of medical procedure or episode or disease that is not captured elsewhere.	PERMANENT	Retain as State archives

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		<p>Record examples:</p> <ul style="list-style-type: none"> • 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. • Accident and Emergency Registers • Birth Defects Registers • Birth Registers • Blood products register • Death Certificate Books (now superseded) • Diagnosis Registers • Donor Registers • Genetic Registers • Implant/Device Registers • Maternity Register • Operation/Theatre Registers • Outpatient Attendance Registers 		
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	Retain a minimum of 8 years after action completed, then destroy.
4	EDUCATION &	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		

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
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	HEALTH PROMOTION	<p>includes the training of students (undergraduate, graduate or postgraduate), clients and clinical staff.</p> <p>See GDS 30 v2 (as amended) 5.17 (various) EMPLOYEE MANAGEMENT – Training for records relating to non-medical specific education and training.</p>		
4.2	Health Promotion	<p><i>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.</i></p> <p>See GDS 30 v2 (as amended) 6.7 (various) FINANCIAL MANAGEMENT – Grant Funding for records related to seeking grants.</p>		
4.2.1	Health Promotion	<p>Records relating to the formulation of significant 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.</p> <p>Such campaigns, projects and initiatives may be significant because of degree of financial input, scale or scope or state-wide or national recognition.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Agreements • Final Reports • Funding approvals • Policy Papers • Printed resources (booklets, posters, postcards, etc) <p>See Item 4.2.2 for minor health promotion campaigns, projects and initiatives.</p>	PERMANENT	Retain as State archives

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
4.2.2	Health Promotion	<p>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.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Agreements • Final Reports • Funding approvals • Policy Papers • Printed resources (booklets, posters, postcards, etc) <p>See Item 4.2.1 for significant health promotion campaigns, projects and initiatives.</p>	TEMPORARY	<p>Retain a minimum of 10 years after action completed, then destroy</p> <p>Subject to Legal Deposit requirements.</p>
4.3	Provision	<p><i>The activity of providing education to clients, staff, nursing staff or medical students.</i></p> <p>Exclusions:</p> <ul style="list-style-type: none"> • Client-identified records relating to individual client education, practical training (where not an informal student on- student practical exercise) or records of group programs – no current disposal coverage 		
4.3.1	Provision	<p>Records that are <i>not</i> client-identified relating to group programs conducted as part of client education.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Attendance Records • Statistical Data 	TEMPORARY	<p>Retain a minimum of 10 years after action completed, then destroy (applies to both adults & minors)</p>
5	QUALITY IMPROVEMENT	<p>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.</p>		

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No	Function/Activity	Description including Records Examples	Status	Disposal Action
		See GDS 30 v2 (as amended) 13 (various) STRATEGIC MANAGEMENT for Non-public health unit specific quality improvement exercises.		
5.8	Quality Control	<i>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.</i>		
5.8.2	Quality Control	<p>Records relating to equipment (non-laboratory) temperature charts and maintenance checks.</p> <p>Record examples:</p> <ul style="list-style-type: none"> • Daily checklists for fridge temperature (blood or staff or vaccine fridge) • Emergency bells checklist • O2 suction checklist • Resus box contents checklist <p>Exclusions:</p> <ul style="list-style-type: none"> • Temperature charts relating to laboratory equipment – see NPAAC requirements 	TEMPORARY	Retain a minimum of 3 years after action completed, then destroy