State Archives and Records Authority of New South Wales

General Retention and Disposal Authority: GDA17

This authority covers records documenting the function of the provision of health care to patients and clients of New South Wales public offices

This general retention and disposal authority is approved under section 21(2)c of the *State Records Act 1998* following prior approval by the Board of the State Archives and Records Authority of New South Wales in accordance with section 21(3) of the Act.

 First published 2004/Revised 2006 (Amendment to entry 9.1.1 and updating of section 2.4 of guidelines only/ Revised 2009 (Inclusion of reference to *General retention and disposal authority – Financial and accounting records* in section 2.1 of guidelines) / Revised 2011 (Additional guidance in class 1.5.2)/Revised 2019.

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State Archives and Records Authority of New South Wales

General Retention and Disposal Authority

Authority no	**GDA17**

SR file no	**19/0035**

Scope	This general retention and disposal authority covers records documenting the provision of health care to patients and clients of New South Wales public offices.

Public office	This authority applies to: • any organisation, facility or service which is part of the New South Wales public health system • NSW public offices who provide health care services to clients, such as NSW universities.

Approval date	19/5/2004
Amended	30 May 2019 **See Part 1 for details of amendments to the authority.**

Part 1: The general retention and disposal authority

GDA17 was originally issued in 2004 with a number of minor amendments in 2006, 2009 and 2011. In 2019 the entire authority was reviewed.

The tables below illustrate:

- where there are no changes to disposal outcomes
- entries where descriptions and disposal actions were amended
- entries removed.

A consolidated table of all changes to GDA17 is also available from the NSW State Archives and Records website.

Schedule of amendments 2019

No changes:

No. Ref.	Comments
1.1.1, 1.1.2, 1.1.3	
1.2.3, 1.2.5, 1.2.7	no change but combined with entry 1.2.1
1.2.8	
1.4.2	no change but description amended.
1.5.1	
1.6.1 and 1.6.2	
1.12.1	
1.14.6	
1.15.1	
1.16.1	no change but moved to 2.3.1
1.18.1	
2.1.1	
2.1.2	
2.1.4, 2.1.5, 2.1.6, 2.1.7, 2.1.8	no change but combined with 2.1.2
2.1.10	
2.3.1	
2.5.1	No change but moved to 2.1.10
2.6.1	No change but moved to 2.1.1
3.2.1	

3.2.2	No change but moved to 3.1.1
3.4.1	
4.2.7	
4.3.3	No change but moved to 4.3.2
5.1.2, 5.1.3, 5.1.5, 5.1.6, 5.1.7	
5.1.8	No change but moved to 5.1.3
5.1.9	
6.1.1	
6.2.1	
6.2.3	No change but moved to 6.2.2
7.3.1, 7.3.2	
8.1.1, 8.1.2	
8.1.3	No change but moved to 8.1.1
8.1.4	No change but moved to 8.1.2
8.1.5	
10.1.0	

Schedule of amendments 2019

Changes to scope and disposal action

Function - Activity	No. Ref.	Details of amendments
PATIENT/CLIENT TREATMENT AND CARE - Hospital and emergency care	1.1.0	Scope expanded to include ambulance and patient transport care
	1.1.4	New class to cover ambulance, emergency and non-emergency transport patients
PATIENT/CLIENT TREATMENT AND CARE - Community based health care	1.2.1	Entries 1.2.1, 1.2.2, 1.2.4 and 1.2.6 combined All records relating to minors retained until the age of 25 Inclusion of specific requirement to retain records of TB Chest Clinic patients/clients for 15 years after last attendance or official contact by or on behalf of the patient or until patient attains or would have attained the age of 25 years, whichever is longer
PATIENT/CLIENT TREATMENT AND CARE - Oral (dental) health care	1.3.1	Scope widened to include consent forms where treatment is required Increase in retention period for consent forms where treatment is required to 7 years after last attendance etc or until age of 25 is reached Scope narrowed to cases where treatment is required
	1.3.2	Increase in retention period for consent forms where no intervention is required from 2 to 7 years Widening of scope to include screening where no further treatment, care or intervention is required Reduction in retention period where no further treatment, care or intervention is required to 7 years after action completed.
PATIENT/CLIENT TREATMENT AND CARE - Obstetric/maternal health care	1.4.1	Reduction in retention period to 50 years after date of birthing episode, or 15 years after action completed (for Group A Hospitals) or 10 years after action completed (for Group B-F Hospitals), whichever is longer Description amended to provide more specific detail of scope of records covered.

PATIENT/CLIENT TREATMENT AND CARE - Psychiatric and mental health care	1.5.2	Increase in retention period to 45 years after last attendance or official contact or access by or on behalf of the patient.
PATIENT/CLIENT TREATMENT AND CARE - Assisted Reproductive Technology (ART)	1.7.1	1.7.1 and 1.7.2 combined. Disposal action amended to allow for retention of prescribed information in accordance with legislative requirements, with non-prescribed information to be retained for 15 years after last attendance etc
PATIENT/CLIENT TREATMENT AND CARE - Sexual assault, physical abuse and neglect patients	1.8.0	Scope widened to include sexual assault, physical abuse and neglect patients
	1.8.1	1.8.1 and 1.9.1 combined. Increase in retention period for minors to 45 years after completion of any legal action or after last contact for legal access
PATIENT/CLIENT TREATMENT AND CARE - Radiotherapy treatment	1.10.1	Increase in retention period to 15 years after age of 70, date of death or last attendance
CORRESPONDENCE	1.13.3	Copies of service requests or referrals not recorded elsewhere moved to 2.3.1 and increased from 3 to 7 years
PATIENT/CLIENT TREATMENT AND CARE - Complaints and incident management	1.14.3	Increase of retention period for records relating to the complaints involving minors until age of 25 reached and records relating to allegations of sexual assault involving minors for a minimum of 45 years
PATIENT/CLIENT TREATMENT AND CARE - Sterilisation of equipment	1.17.1	Trigger for calculating retention period changed to action completed
PATIENT/CLIENT REGISTRATION AND ADMINISTRATION - Patient/client registers	2.1.3	Additional requirement to retain records for cases involving minors until the age of 25 years
	2.1.9	Scope extended to encompass ambulance and emergency transport patient/clients.
	2.1.11	Reduction in retention period to 75 years after implantation of the device or prosthesis
PATIENT/CLIENT REGISTRATION AND	2.2.1	1.13.3 (referrals, requests for service where patient did not attend), 2.2.1,

ADMINISTRATION - Patient/client administration		2.2.2, 2.2.3, 2.2.4, 2.2.5, 2.2.6, 2.4.1 and 2.4.3 combined with minor increases and decreases in retention periods.
DIAGNOSTIC IMAGING AND RECORDING SERVICES	3.3.1	3.3.1, 3.3.2 and 3.3.3 combined Removal of requirement to retain records of minors until the age of 25 is reached Additional requirement to retain TB Chest x-rays for life of patient or 85 years from date of birth if date of death unknown, then destroy Where no abnormality detected increase to 7 years after last attendance etc.
PATHOLOGY AND LABORATORY SERVICES	4.1.1	4.1.1, 4.2.1, 4.2.2, 4.2.3, 4.2.4, 4.2.5, 4.2.6, 4.3.5, 4.4.1 combined. Disposal action changed to retain in accordance with the relevant legislative requirements and/or national standards and guidelines (for example standards and guidelines issued by the National Pathology Accreditation Advisory Council or its successor agency/ies)
PATHOLOGY AND LABORATORY SERVICES	4.3.2	4.3.2, 4.3.3 and 4.3.4 combined with minor changes to disposal action
PATHOLOGY AND LABORATORY SERVICES	4.4.2	4.4.2, 4.4.3, 4.4.4, 4.5.1 combined. Disposal action changed to retain in accordance with the relevant legislative requirements and/or national standards and guidelines (for example standards and guidelines issued by the National Pathology Accreditation Advisory Council or its successor agency/ies)
PATHOLOGY AND LABORATORY SERVICES	4.6.1	4.6.1, 4.71, 4.8.1 combined. Disposal action changed to retain in accordance with the relevant legislative requirements and/or national standards and guidelines (for example standards and guidelines issued by the National Pathology Accreditation Advisory Council or its successor agency/ies)
PATIENT/CLIENT FINANCE AND PROPERTY MANAGEMENT	7.1.1	7.1.1, 7.1.2, 7.1.4, 7.2.2, 7.2.3 combined. Increase in minimum retention period from 6 to 7 years
PATIENT/CLIENT FINANCE AND PROPERTY MANAGEMENT	7.1.3	7.1.3, 7.2.1, 7.3.1 combined. Increase in minimum retention period from 1 to 2 years

Schedule of amendments 2019

Entries removed

Function - Activity	No. Ref.	Remarks
Electronic health records	1.11.0	See relevant patient record or the Normal Administrative Practice (NAP) provisions of the State Records Act for extracts of data where source records still exist
Correspondence	1.13.1	see relevant patient file or NAP where appropriate
	1.13.2	See GA28 INFORMATION MANAGEMENT - Control 12.0.0
Legal Matters and Incident Management	1.14.1, 1.14.2, 1.14.4 & 1.14.5	See GA28 LEGAL SERVICES - Litigation
PATIENT/CLIENT REGISTRATION AND ADMINISTRATION	2.1.13	Copies are covered by the Normal Administrative Practice (NAP) provisions of the State Records Act
	2.3.2	Diaries and appointment books covered by GA28 STRATEGIC MANAGEMENT - Meetings 19.13.3
	2.4.2	Data collections forms are covered by the Normal Administrative Practice (NAP) provisions of the State Records Act
	2.7.1	See GA28 STRATEGIC MANAGEMENT - Reporting or GA28 GOVERNMENT RELATIONS – Reporting
PATHOLOGY AND LABORATORY SERVICES	4.3.1	Specimens, slides etc not State records
NOTIFICATIONS	6.1.2	covered by the Normal Administrative Practice (NAP) provisions of the State Records Act
RECORDS IMAGING	9.0.0	See GA45, relevant patient record or Normal Administrative Practice (NAP) provisions of the State Records Act

Part 2: Understanding and using the authority

Purpose of the authority

The purpose of this general retention and disposal authority is to identify those records created and maintained by NSW public offices providing health care which are required as State archives, and to provide approval for the destruction of certain other records after minimum retention periods have been met.

The approval for disposal given by this authority is given under the provisions of the *State Records Act 1998* only and does not override any other obligations of an organisation to retain records.

The retention and disposal of State records

The records retention and disposal practices outlined in this authority are approved under section 21(2)(c) of the *State Records Act 1998 (NSW).* Part 3 (Protection of State Records) of the Act provides that records are not to be disposed of without the consent of the State Archives and Records Authority of New South Wales (NSW State Archives and Records) with certain defined exceptions. These exceptions include an action of disposal which is positively required by law, or which takes place in accordance with a normal administrative practice (NAP) of which NSW State Archives and Records does not disapprove. Advice on the State Records Act can be obtained from NSW State Archives and Records.

The authority sets out how long the different classes of records generated by an organisation must be kept to meet its legal, operational and other requirements, and whether the records are to be kept as State archives.

NSW State Archives and Records' decisions take into account both the administrative requirements of public offices in discharging their functional responsibilities and the potential research use of the records by the NSW Government and the public. One of NSW State Archives and Records' functions is to identify and preserve records as State archives. These are records which document the authority and functions of Government, its decision-making processes and the implementation and outcomes of those decisions, including the nature of their influence and effect on communities and individual lives. Criteria for the identification of State archives are listed in *Building the Archives: Policy on records appraisal and the identification of State archives*. The Policy also explains the roles and responsibilities of NSW State Archives and Records and of public offices in undertaking appraisal processes and disposal activities.

Public offices authorised to use this authority

This general retention and disposal authority applies to:

- any organisation, facility or service which is part of the New South Wales public health system, including the local health districts and the NSW Ambulance Service.
- NSW public offices who provide health care services to clients, such as NSW universities.

What records does the authority cover?

This Authority authorises the disposal of:

- records relating to the treatment and care of individual patients and clients within the NSW public health system, including records relating to the provision of allied health care and to research participants

- records relating to the treatment and care of individual patients and clients by other relevant NSW public offices, such as universities, including records relating to the provision of allied health care and to research participants
- patient/client administration registers, systems and databases used to record summary information about patients and clients
- records relating to diagnostic imaging and pathology and laboratory services, with the inclusion of permission to destroy certain records as per relevant legislative requirements and/or national standards and guidelines (for example standards and guidelines issued by the National Pathology Accreditation Advisory Council or its successor agency/ies)
- records relating to the supply and administration of pharmaceuticals, encompassing drugs, poisons and other substances
- records of notifications to prescribed bodies concerning patient medical conditions
- records relating to the management of patient/client finances and property during the period of their admission to a facility or service
- records relating to the management of clinical and non-clinical research, trials or studies, etc.

Date range of records covered

Patient/client records listed in this authority created wholly or in part prior to 1930 are required as State archives (see entry 10.1.0). For records created wholly after 1930 the minimum retention periods and disposal actions identified in this authority apply to the various classes of records listed.

What records are not covered

This Authority does not cover:

- records relating to the management and administration of public health organisations. See the *General retention and disposal authority: Public health services administrative records* (GDA21)
- records relating to general administration (ie not health sector specific), financial management and personnel are covered by the *General retention and disposal authority: administrative records* (GA28)
- records relating to the provision of State wide health services such as those provided by the Clinical Excellence Commission, the Bureau of Health Information, The Health Education Training Institute and the Agency for clinical innovation. See *Health Services: statewide health services, quality assurance, reporting, education and training* (GA44).

Records of **private hospitals, services, nursing homes, centres** etc. are not State records and are not covered in this disposal authority. They should be retained and disposed of in accordance with any requirements of the Act or regulations under which the establishment is licensed.

How long is this authority in force?

This authority will remain in force until it is superseded by a new authority or it is withdrawn from use by NSW State Archives and Records.

Previous disposal authorisations superseded

This disposal authority supersedes previous disposal authorisation in the following authority:

- certain parts of the *General retention and disposal authority: public health services patient records,* 2004 version. See tables above for advice about changes to disposal actions.
- The *General retention and disposal authority: university records*, with respect to health services (GDA23, entries 14.0.0.).

Records covered by normal administrative practice (NAP)

Certain records of a facilitative, ephemeral or duplicate nature can, in prescribed circumstances, be disposed of in accordance with the normal administrative practice (NAP) provisions of the State Records Act without the need of formal approval from NSW State Archives and Records.

See Schedule 2 of the *State Records Regulation 2015* for further information on what constitutes normal administrative practice in a public office.

Public offices should develop internal policies and procedures, based on Schedule 2 of the Regulation, to define and authorise what is meant by normal administrative practice for their organisation and to identify and document the types of records that are disposed of under this provision of the Act as part of the routinely implemented practices of the organisation.

Providing feedback

To suggest amendments or alterations to this authority please contact us via email at: govrec@records.nsw.gov.au or phone (02) 9673 1788.

Further assistance

NSW State Archives and Records provides guidance and training in the development and use of retention and disposal authorities as well as other aspects of records management. More information is available on our website at www.records.nsw.gov.au/recordkeeping.

To obtain assistance in the interpretation or implementation of this authority, or any of our general retention and disposal authorities, contact us at:

govrec@records.nsw.gov.au or phone (02) 9673 1788.

Part 3: Implementing the authority

This general retention and disposal authority covers records controlled by the public office and applies only to the records or classes of records described in the authority. The authority should be implemented as part of the records management program of the organisation. Two primary objectives of this program are to ensure that records are kept for as long as they are of value to the organisation and its stakeholders and to enable the destruction or other disposal of records once they are no longer required for business or operational purposes.

The implementation process entails use of the authority to sentence records. Sentencing is the examination of records in order to identify the disposal class in the authority to which they belong. This process enables the organisation to determine the appropriate retention period and disposal action for the records. For further advice see *Implementing a retention and disposal authority*.

Where the format of records has changed (for example, from paper-based to electronic) this does not prevent the disposal decisions in the authority from being applied to records which perform the same function. The information contained in non paper-based or technology dependant records must be accessible for the periods prescribed in the classes. Where a record is copied, either onto microform or digitally imaged, the original should not be disposed of without authorisation (see the *General Retention and Disposal Authority – Original or source records that have been copied*). Public offices will need to ensure that any software, hardware or documentation required to gain continuing access to technology dependent records is available for the periods prescribed.

Minimum retention periods

The authority specifies minimum retention periods for all records not required as State archives. A public office must not destroy or otherwise dispose of records before the minimum retention period has expired. If a public office desires to reduce the minimum retention period it must seek specific written approval from NSW State Archives and Records. Public offices may retain records for longer periods of time, subject to organisational need, without further reference to NSW State Archives and Records.

Records required as State archives

Records which are to be retained as State archives are identified with the disposal action 'Required as State archives'. Records that are identified as being required as State archives should be stored in controlled environmental conditions and control of these records should be transferred to NSW State Archives and Records when they are no longer in use for official purposes.

Transferring records identified as State archives and no longer in use for official purposes to NSW State Archives and Records should be a routine and systematic part of a public office's records management program. If the records are more than 25 years old and are still in use for official purposes, then a 'still in use determination' should be made.

To obtain assistance regarding transferring material as State archives, contact the Senior Archivist, Transfer/Custody at: transfer@records.nsw.gov.au or (02) 9673 1788.

Records approved for destruction

Records that have been identified as being approved for destruction may only be destroyed once a public office has ensured that all other requirements for retaining the records are met. Retention periods set down in this authority are *minimum* periods only and a public office should keep records for a longer period if necessary. Reasons for longer retention can include legal requirements, administrative need, government directives and changing social or community expectations. A public office ***must not*** dispose of any records where the public office is aware of possible legal action (including

legal discovery, court cases, formal applications for access) where the records may be required as evidence.

Once all requirements for retention have been met, destruction of records should be carried out in a secure and environmentally sound way. Relevant details of the destruction should be recorded. See *Destruction of records.*

Regardless of whether a record has been approved for destruction or is required as a State archive, a public office or an officer of a public office ***must not*** permanently transfer possession or ownership of a State record to any person or organisation without the explicit approval of NSW State Archives and Records.

Records required to be retained in agency

There are a number of entries where the disposal action is retain in agency. There is no authorisation for destruction of these records – they must be maintained on an ongoing basis.

Transfer of ownership must be approved

Regardless of whether a record has been approved for destruction or is required as a State archive, a public office must not transfer ownership of a State record to any person or organisation without the explicit authorisation of NSW State Archives and Records. This does not apply to transfers to other NSW public offices such as another local health district or the Ministry of Health.

Retention of digital records

Digital records must be protected and readily accessible for the specified minimum retention period.

Imaged records

Many public offices routinely image records. This may be the scanning of incoming correspondence or bulk digitisation of existing hard copy records such as patient files. Most hard copy originals are authorised for destruction after imaging, provided a number of conditions are met. Public offices should check *General retention and disposal authority: original or source records that have been copied* for more information.

Interpretation of disposal triggers in this authority

It is very important that triggers are appropriately interpreted and understood by those implementing the authority. Sometimes they rely on information from elsewhere in the organisation. Where possible, the organisation should build the recording of the dates or required information into standard records procedures so staff will know, for example, when a file should be marked as inactive or closed. Without this information being recorded, sentencing cannot take place in a streamlined or efficient manner.

After last attendance or official contact or access by or on behalf of the patient

Access by or on behalf of the patient refers to any use made of the record or access to the records for any purpose directly concerning the patient, such as attendance by the patient, provision of a report to another health care worker or agency, access under subpoena, inspection by the patient or their legal representative. Access for research, quality assurance, audit or educational purposes or by next of kin checking medical history does not constitute access by or on behalf of the patient.

Until patient attains or would have attained the age of 25 years

This requires patient/client records to be retained until the patient attains, or would have attained (in cases where the date of birth of not known or the patient dies), until the age of 25 is reached.

In accordance with the relevant legislative requirements and/or national standards and guidelines

In some cases the retention of records is mandated by legislation or standards, for example, the National Pathology Accreditation Advisory Council standards or the *Assisted Reproductive Technology Act 2007.* Where specified in the disposal authority these instruments should for the disposal of records.

After action completed:

This is the most common disposal trigger in the authority. 'Action completed' refers to the final transaction of business, i.e. the final document is attached to the file and the file is closed. An action does not include a file movement or audit (unless the organisation determines an audit is an action).

In the case of paper-based registers the date of the last entry in the register may be a suitable trigger for when action is completed (providing all actions associated with the matters recorded in the register have been completed). In the case of electronic registers, however, it may be more appropriate to apply the disposal action to individual entries in the register rather than the register as a whole (as the last action on the register as a whole may be indefinite). In this case the trigger can be calculated from the last time an individual entry in the register was updated or amended, or from when the data has become obsolete (i.e. when all the business for which the record was maintained has been completed).

Until ceases to be of administrative or reference use:

This trigger usually applies where ongoing use of the records is likely to be short term, or where ongoing reference use of the records is linked to the conduct of business processes and the determination of appropriate periods for retention relies on an organisation's assessment of its own business needs and uses. This can vary from one organisation to another depending on the nature of its business.

For the purposes of implementing the authority and facilitating the production of reports or triggers for the review of these records as part of a regular disposal program the organisation may wish to define a standard retention period for these types of records. Suitable standard retention periods can be defined through discussions with business units or action officers who use the records.

Managing the calculation of triggers and disposal processes

Public offices need to consider and plan how they are to manage the implementation of triggers. For some it may be possible to automate the process. For example, a date of birth may be entered into the public office's system and automatically applied as a 'after date of birth' trigger in the records management system.

If automation is not possible, the development of business rules or procedures may be required to ensure that information is communicated by the relevant business unit to the records management unit so that the trigger is applied.

When disposal dates have been reached, procedures should also be in place to ensure the circulation of lists or details of records proposed for destruction to relevant action officers for internal authorisation and approval before any disposal action takes place. These officers can identify if circumstances have changed, e.g. extensions of contracts or legal cases, which will affect the implementation of disposal decisions and may warrant the retention of records for longer periods as appropriate.

Contact Information

NSW State Archives and Records
PO Box 516
Kingswood NSW 2747
Telephone: (02) 9673 1788
E-mail: govrec@records.nsw.gov.au

General Retention and Disposal Authority
Public health services: patient/client records

Authority number: GDA17 **Dates of coverage: Open**

List of Functions and Activities covered

Public health services: patient/client records

Authority number: GDA17 **Dates of coverage: Open**

List of Functions and Activities covered

Authority number: GDA17 **Dates of coverage: Open**

No.	Description of records	Disposal action

1.0.0 PATIENT/CLIENT TREATMENT AND CARE

The provision of health assessment, diagnosis, management, treatment and care services and/or advice to individual patients/clients.

Note: records of private hospitals, services, nursing homes, centres etc. are not State records and should be retained and disposed of in accordance with any requirements of the Act or regulations under which the establishment is licensed.

See **PRE-1930 PATIENT/CLIENT RECORDS** for records created prior to 1930.

See **PATIENT/CLIENT REGISTRATION AND ADMINISTRATION - Patient/client administration** for records documenting booking of non-emergency transport services.

See General Retention and Disposal Authority *Administrative records* **PERSONNEL - Misconduct** for records relating to allegations of misconduct against staff, volunteers, work placement students, including allegations of assault against minors.

See General Retention and Disposal Authority *Administrative records* **PERSONNEL - Reporting** for records relating to the statutory reporting of incidents or referral of other matters to external bodies such as the Police, Independent Commission Against Corruption, the Ombudsman or child protection agencies e.g. Community Services.

See General Retention and Disposal Authority *Administrative records* **STRATEGIC MANAGEMENT - Compliance** for records relating to the management of allegations of assault against minors from visitors, other patients etc.

1.1.0 Hospital and emergency care

The provision of treatment, care and services to hospital inpatients, outpatients and accident and emergency patients. Includes the provision of treatment, care and services by ambulance and other transport services.

1.1.1	Records documenting the treatment and care of admitted patients of Group A hospitals, e.g. principal referral hospitals providing specialist, acute care, research and teaching services. **Note**: if the patient record contains the only record of a surgically implanted device then it needs to be retained as per entry 2.1.11.	Retain minimum of 15 years after last attendance or official contact or access by or on behalf of the patient[1] or until patient attains or would have attained the age of 25 years, whichever is longer, then destroy

[1]'access by or on behalf of the patient' refers to any use made of the record or access to the records for any purpose directly concerning the patient, such as attendance by the patient, provision of a report to another health care worker or agency, access under subpoena, inspection by the patient or their legal representative. Access for research, quality assurance, audit or educational purposes or by next of kin checking medical history does not constitute access by or on behalf of the patient

Public health services: patient/client records

Authority number: GDA17 **Dates of coverage: Open**

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Hospital and emergency care

Justification/Remarks: Confirms 2004 disposal action. 15 years is based on based on the nature of care provided and clinical research needs as principal referral hospitals often provide specialist, research and teaching services (the Australian Code for the Responsible Conduct of Research recommends clinical research data be kept for 15 years). The retention period for minors is based on the pre-2002 statute of limitations for personal injury claims (age of 24 but rolled up to 25 to manage disposal of records on a yearly basis). In 2002 the requirement to retain records of minors until the age of 24 was removed from the Limitations Act in NSW but was retained in the disposal authority as it had been in place for many years and was seen as less risky than destroying the patient records of children receiving acute care after 12 years.		
1.1.2	Records documenting the treatment and care of admitted patients of Group B to F hospitals and services, e.g. nursing homes, rehabilitation facilities, hospices and hospitals that are not principal referral, paediatric specialist or acute hospitals.	Retain minimum of 10 years after last attendance or official contact or access by or on behalf of the patient[2] or until patient attains or would have attained the age of 25 years, whichever is longer, then destroy
Justification/Remarks: Confirms 2004 disposal action. The retention period is based on based on the nature of care provided, which is less complex than that covered by entry 1.1.1. Although the limitation period for personal injury is 12 years, given the type of facility and nature of care provided the risk of legal action for personal injuries is low and 10 years is appropriate.		
1.1.3	Records documenting the treatment and care of patients attending or presenting at emergency and/or out-patient clinics that are not admitted as patients, including patients who are dead on arrival.	Retain minimum of 7 years after last attendance or official contact or access by or on behalf of the patient[2] or until patient attains or would have attained the age of 25 years, whichever is longer,

[2] 'access by or on behalf of the patient' refers to any use made of the record or access to the records for any purpose directly concerning the patient, such as provision of a report to another health care worker or agency, access under subpoena, inspection by the patient or their legal representative. Access for research, quality assurance, audit or educational purposes or by next of kin checking medical history does not constitute access by or on behalf of the patient.

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Hospital and emergency care

		then destroy
Justification/Remarks: Confirms 2004 disposal action. This class relates to patients/clients who are not admitted to hospital. The retention period complies with the recommended retention periods for medical practitioners issued by the Medical Board of NSW. The minimum retention periods of 7 years (with additional requirements for records of minors) has also been in place since 1989, when the Department of Health published Circular 89/13.		
1.1.4	Records documenting the treatment and care of ambulance, emergency and non-emergency transport service patients/clients. **Note**: this entry covers records created by ambulance and patient transport services.	Retain minimum of 7 years after provision of service or after last official contact or access by or on behalf of the patient[3] or until patient attains or would have attained the age of 25 years, whichever is longer, then destroy
Justification/Remarks: This is a new entry to cover records created and maintained by ambulance and patient transport services. The retention period is consistent with that for the ambulance service in Victoria. For admitted patients a copy of this record is provided to the hospital and incorporated into the patient record which will be retained for 10 or 15 years as per entries 1.1.1 or 1.1.2.		

[3] 'access by or on behalf of the patient' refers to any use made of the record or access to the records for any purpose directly concerning the patient, such as provision of a report to another health care worker or agency, access under subpoena, inspection by the patient or their legal representative. Access for research, quality assurance, audit or educational purposes or by next of kin checking medical history does not constitute access by or on behalf of the patient.

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Community based health care

1.2.0 Community based health care

The provision of treatment and care to patients/clients through community based health care facilities, centres or services, including services provided at patient's place of residence. This includes unregistered clients, clients who are screened without follow up, potential clients or clients who are referred elsewhere.

1.2.1	Records documenting the provision of treatment, care, assessment, screening and other services to community clients. Includes: • immunisations • audiology and eyesight screenings • breast screening and other imaging services • child, family health and school screening.	Retain minimum of 7 years after last attendance or official contact or access by or on behalf of the client[4] or until patient attains or would have attained the age of 25 years, whichever is longer, then destroy **TB (tuberculosis) service/Chest Clinic patients:** Retain minimum of 15 years after last attendance or official contact by or on behalf of the patient[4] or until patient attains or would have attained the age of 25 years, whichever is longer, then destroy
Justification/Remarks: Confirms 2004 disposal action. 7 years encompasses expected requirements for clinical care for patients that are not admitted to hospital, and complies with the recommended retention periods for medical practitioners issued by the Medical Board of NSW. Extended retention period for TB patients allows for extended care and contact screening. To simplify the management of children's records, all immunisation and screening records retained until the age of 25 is reached.		

[4] 'access by or on behalf of the patient' refers to any use made of the record or access to the records for any purpose directly concerning the patient, such as provision of a report to another health care worker or agency, access under subpoena, inspection by the patient or their legal representative. Access for research, quality assurance, audit or educational purposes or by next of kin checking medical history does not constitute access by or on behalf of the patient.

Public health services: patient/client records

Authority number: GDA17 **Dates of coverage: Open**

No.	Description of records	Disposal action
PATIENT/CLIENT TREATMENT AND CARE- Community based health care		
1.2.2-1.2.7	See entry 1.2.1.	
1.2.8	Criminal histories of clients referred by Courts under rehabilitation or treatment programs e.g. Magistrates Early Referral into Treatment (MERIT) Program, Adult Drug Court etc.	Retain until conclusion of client's active involvement in program, then destroy
Justification/Remarks: Confirms 2004 disposal action. Complies with the Memoranda of Understanding between NSW Health and NSW Police.		

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Oral (dental) health care

1.3.0 Oral (dental) health care

The provision of treatment, care and services to clients of oral (dental) health care services.

1.3.1	Records documenting the examination, assessment and treatment of dental patients/clients. Includes dental charts, consent forms, x-rays etc.	Retain minimum of 7 years after last attendance or official contact or access by or on behalf of the client[5] or until patient attains or would have attained the age of 25 years, whichever is longer, then destroy
Justification/Remarks: 7 years meets expected requirements for clinical care for dental patients that were not admitted to hospital, and is consistent with guidelines published by the Dental Board of Australia. The minimum retention period for consent forms where treatment has been provided has been increased to the same period of time as the patient record so there is evidence consent was given.		
1.3.2	Records documenting consent for non-interventional school screening activities and school screening results that do not indicate need for further treatment, care or interventional action (i.e. no abnormality detected).	Retain minimum of 7 years after action completed, then destroy
Justification/Remarks: Previously consent forms were only retained for 2 years. Where no further treatment is required, it is proposed to retain them for 7 years after action completed to meet the Dental Board guidelines. Widening of scope to include screening where no further treatment, care or intervention is required, with reduction in retention period to 7 years after action completed.		

[5] 'access by or on behalf of the patient' refers to any use made of the record or access to the records for any purpose directly concerning the patient, such as provision of a report to another health care worker or agency, access under subpoena, inspection by the patient or their legal representative. Access for research, quality assurance, audit or educational purposes or by next of kin checking medical history does not constitute access by or on behalf of the patient.

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Obstetric/maternal health care

1.4.0 Obstetric/maternal health care

The management of births, including adoption processes. Includes any pregnancy that results in the birth of a baby where birth registration is required under the *Births, Deaths and Marriages Act,* including live and still births.

See **PATIENT/CLIENT TREATMENT AND CARE - Hospital and emergency care and Community based health care** for records relating to the care and treatment of mother and child.

1.4.1	Records documenting birth episodes. Includes: • the mother's antenatal records, including any antenatal screening results • records of the labour, including CTG traces • medical records relating to the neonatal period and following. **Note**: Services need to assess patterns of use and frequency of access requests prior to proceeding to destruction of collections of obstetric records. Services may also want to consider if the collection is of exemplary or other significance warranting retention as State archives under entry 1.12.1.	Retain a minimum of 50 years after date of birthing episode, or 15 years after action completed (for Group A Hospitals) or 10 years after action completed (for Group B-F Hospitals), whichever is longer, then destroy
Justification/Remarks: Previously these records were required to be retained indefinitely. 50 years after date of birthing episode, or 10 to 15 years after action completed, whichever is longer: • accommodates the needs of patients up to the age of 50 who are having babies and want access to their mother's records • provides an extended period of time to allow obstetric negligence claims to be commenced • assists people attempting to locate their birth parents. Obstetric records are used by people searching for information about their birth parents, and the adoption records held by government agencies and private adoption agencies are not always extant for older cases.		
1.4.2	Records documenting arrangements for adoptions that proceed. Includes associated social work, counselling or support records.	Retain in agency
Justification/Remarks: Confirms 2004 disposal action. The *Adoption Act 2000* provides a right to access information held by public hospitals.		

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Psychiatric and mental health care

1.5.0 Psychiatric and mental health care

The provision of treatment, care and services to patients under mental health legislation e.g. the *Mental Health Act.*

See **PATIENT/CLIENT REGISTRATION AND ADMINISTRATION - Patient/client registers** for registers or summary records documenting the administration of electro-convulsive therapy or sedation or seclusion of mental health patients.

See **PATIENT/CLIENT TREATMENT AND CARE - Hospital and emergency care or Community based health care** for records relating to the treatment and care of patients not covered by the Mental Health Act who have mental health conditions.

1.5.1	Records of patients/clients of former Crown operated/5th Schedule psychiatric hospitals where the records were wholly or partly created prior to 1960.	Required as State archives
Justification/Remarks: Confirms 2004 disposal action. The introduction of the *Mental Health Act 1958* represented a significant shift in public perceptions of mental illness and medical approaches to the treatment and care of psychiatric patients. From the late 1950's onwards there was a general movement away from in-patient care in large institutions, where patient admissions tended to be involuntary and the services performed a custodial as well as a therapeutic role, towards the provision of care by community based services or voluntary admission to psychiatric units within general hospitals. The records identified for retention as State archives are reflective of the provision of services to persons affected by mental illness at a time when they differed significantly to those currently prevailing.		
1.5.2	Records documenting the treatment and care of patients/clients under mental health legislation e.g. the *Mental Health Act.*	Retain minimum of 45 years after last attendance or official contact or access by or on behalf[6] of the patient, then destroy
Justification/Remarks: Minimum retention period for mental health patients increased to 45 years. This will assist in the provision of care to patients who may receive mental health care across their lifespan, and complies with the recommendations of the Royal Commission into Institutional Responses to Allegations of Child Sexual Assault, as some of the institutions that provide mental health services may be subject to future claims for compensation as a result of sexual assault allegations.		

[6] 'access by or on behalf of the patient' refers to any use made of the record or access to the records for any purpose directly concerning the patient, such as attendance by the patient, provision of a report to another health care worker or agency, access under subpoena, inspection by the patient or their legal representative. Access for research, quality assurance, audit or educational purposes or by next of kin checking medical history does not constitute access by or on behalf of the patient.

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Genetic or inherited disorders

1.6.0 Genetic or inherited disorders

The diagnosis of genetic or inherited disorders.

See **PATIENT/CLIENT TREATMENT AND CARE - Hospital and emergency care or Community based health care** for records relating to the treatment and care of patients with a genetic or inherited disorder.

1.6.1	Records held by specialist genetic units documenting the diagnosis of patients with genetic or inherited disorders.	Retain in agency
Justification/Remarks: Confirms 2004 disposal action. The NPAAC requires reports of genetic testing to be retained for 100 years (effectively indefinite).		
1.6.2	See relevant entry under PATIENT/CLIENT TREATMENT AND CARE for records relating to the management of patients with genetic or inherited disorders.	

1.7.0 Assisted Reproductive Technology (ART)

The provision of assisted reproductive technology services.

See **PATIENT/CLIENT TREATMENT AND CARE - Obstetric/maternal health care** for records documenting birth episodes.

1.7.1	Records documenting the treatment and care of assisted reproductive technology (ART) patient/clients.	Retain prescribed information in accordance with legislative requirements, all other records retain for minimum of 15 years after last access by or on behalf of the patient, then destroy
Justification/Remarks: To avoid potential inconsistency between retention requirements identified by legislation regulating ART procedures and the requirements of the State Records Act, this disposal action has been amended to allow for the retention and disposal of prescribed records in accordance with current applicable legislative requirements, and other records for a minimum of 15 years after last access by or on behalf of the patient.		
1.7.2	See 1.7.1.	

Authority number: GDA17 **Dates of coverage: Open**

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Sexual assault, physical abuse and neglect patients

1.8.0 Sexual assault, physical abuse and neglect patients

The provision of treatment and care to victims of sexual assault, physical abuse and neglect. Includes children, young people, and mandatory reporting cases.

1.8.1	Records documenting the treatment and care of victims of: • sexual assault or abuse • physical abuse and neglect subject to mandatory reporting. This includes instances of the abuse and neglect of children, young people and other vulnerable persons such as the elderly, disabled or persons in care subject to mandatory reporting. **Note**: includes records created by: • sexual assault services (including Sexual Assault Assessment Centres which are a Level 1 Sexual Assault Service according to NSW Health Role Delineation Guidelines) • child protection units/teams • violence, abuse and neglect services • child protection counselling services • JIRT Health workforce • street services and domestic violence services.	**Adult victims:** Retain minimum of 30 years after date of last contact with the service, or request for access or legal event, then destroy **Where victims are minors:** Retain minimum of 45 years after date of last contact with the service, or request for access or legal event, then destroy
Justification/Remarks: Confirms 2004 disposal action for adult patients 30 year minimum retention period for adult victims meets extended care needs of patients, requirements to provide evidence to Courts, and equates to the ultimate bar in the statute of limitations for personal injury. The minimum retention period for child victims has been increased from 30 to 45 years to meet the recommendation of the Royal Commission into Institutional Responses to Allegations of Child Sexual Abuse. Scope for physical abuse patients extended to apply more broadly e.g. elderly, disabled or persons in care where instances of suspected abuse and neglect are subject to mandatory reporting.		

1.9.0 Physical abuse and neglect

1.9.1	See entry 1.8.1	

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Radiotherapy treatment

1.10.0 Radiotherapy treatment

The delivery of radiation treatment to radiotherapy patients.

1.10.1	Records documenting radiation dose delivery to patients undergoing radiotherapy treatment. Includes external radiotherapy, as well as internal radiotherapy (such as radioisotope and brachytherapy).	**Where date of death is known:** Retain minimum of 15 years after date of death, then destroy **Where date of death is not known:** Retain a minimum of 15 years after patient would have attained the age of 70 years or after last attendance, whichever is longer, then destroy
Justification/Remarks: Minimum retention period of 15 years after death of patient to assist with oncology research meets the recommendations of the Australian Code for the Responsible Conduct of Research. Retention of records up to the age of 85 years where the date of death is not known, ensures records of treatment will be available if patient relapses.		

1.11.0 Electronic health records

Superseded - see relevant patient record or the Normal Administrative Practice provisions of the State Records Act.

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Collections or samples of patient significance

1.12.0 Collections or samples of patient significance

See **PRE-1930 PATIENT/CLIENT RECORDS** for records created prior to 1930.

1.12.1	Collections or samples of patient records identified as being of continuing value for medical or social research purposes. **Note**: this could include cases where the service has taken a leading role in the development and delivery of new or specialised treatments or because the records: • illustrate or provide comparative insight into the provision of services to particular community groups • illustrate or provide comparative insight into aspects of treatment, care and the delivery of services over time • document significant achievements or break throughs in research or relate to research of major national or international significance, interest or controversy • document significant outbreaks of disease that represented major public health risks and their impact • document critical points of change or developments in the treatment or management of a particular type of condition, illness or disease • relate to the diagnosis, management, treatment of or research into particularly rare diseases or conditions and would significantly enhance and contribute to the existing body of knowledge of these diseases or conditions.	Required as State archives
Justification/Remarks: Confirms 2004 disposal action. Under GDA17, summary records of patients are required as State archives, but not patient files. This entry gives NSW State Archives and Records flexibility to accept patient records that have been identified as being of continuing value for medical or social research purposes.		

1.13.0 Correspondence

Superseded

See **PATIENT/CLIENT REGISTRATION AND ADMINISTRATION - Patient/client administration** for records documenting patient/client contact not recorded elsewhere e.g. copies of service requests or referrals.

See **PATIENT/CLIENT TREATMENT AND CARE** for correspondence with patients/clients or others on behalf of patients/clients.

See General Retention and Disposal Authority *Administrative records* **INFORMATION MANAGEMENT - Control** for records relating to correspondence logs or registers.

Authority number: GDA17 **Dates of coverage: Open**

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Complaints and incident management

1.14.0 Complaints and incident management

The activities relating to the management of complaints from or incidents involving patients/clients.

See General Retention and Disposal Authority *Administrative records* **GOVERNMENT RELATIONS - Advice** for records relating to the reporting of critical incidents

See General Retention and Disposal Authority *Administrative records* **LEGAL SERVICES - Litigation** for records relating to complaints, incidents or claims that result in legal action and for the handling of subpoenas and discovery orders.

See General Retention and Disposal Authority *Administrative records* **PERSONNEL - Misconduct** for records relating to allegations of misconduct against staff, volunteers, work placement students, including allegations of assault against minors.

See General Retention and Disposal Authority *Administrative records* **PERSONNEL - Reporting** for records relating to the statutory reporting of incidents or referral of other matters to external bodies such as the Police, Independent Commission Against Corruption, the Ombudsman or child protection agencies e.g. Community Services.

See General Retention and Disposal Authority *Public health Services: Administrative records* **CLINICAL SERVICES - Incident management** for records relating to rectification action taken in response to an incident or complaint or the monitoring of complaints and occurrence of incidents

1.14.1-1.14.2	See the *General retention and disposal authority: administrative records* LEGAL SERVICES - Litigation.	
1.14.3	Records relating to the handling of complaints and investigation of incidents concerning the provision of patient/client treatment or care not involving legal action. This includes associated reports of and records of investigations into an incident or complaint.	Retain minimum of 7 years after action completed or until the patient/client attains or would have attained the age of 25, whichever is longer, then destroy **For records relating to allegations or cases of child sexual abuse:** Retain minimum of 45 years after action completed, then destroy.
Justification/Remarks: Minimum retention period for complaints involving children has been increased to age of 25 (for consistency with other records involving children), or 45 years if they relate to allegations of sexual abuse to comply with the recommendations of the Royal Commission into Institutional Responses to Allegations of Child Sexual Abuse .		
1.14.4-	See the *General retention and disposal authority:*	

Authority number: GDA17 **Dates of coverage: Open**

No.	Description of records	Disposal action
PATIENT/CLIENT TREATMENT AND CARE- Complaints and incident management		
1.14.5	*administrative records* LEGAL SERVICES - Litigation.	
1.14.6	Summary records of patient/client complaints, injuries or incidents.	Retain minimum of 30 years after action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. 30 year minimum retention period equates to the ultimate bar in the statute of limitations for personal injury.		

1.15.0 Clinical audits

The activities associated with the conduct of clinical audits.

1.15.1	Records relating to the conduct of clinical audits for the purpose of evidence based quality management e.g. an audit of the outcome of pain management treatment.	Retain minimum of 5 years after audit completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets reference and accountability needs.		

1.16.0 Medical certificates

Superseded - see entry 2.3.1 for copies of medical certificates issued to patients detailing dates of attendance not maintained as part of the main patient file.

1.17.0 Sterilisation of equipment

The sterilisation of instruments, items and equipment used in surgical and medical procedures.

1.17.1	Records relating to the sterilisation of surgical instruments and equipment, e.g. log books, registers.	Retain minimum of 15 years after action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. Sterilisation registers record details of item sterilised as well as details of the temperatures, times, gas mix etc. This information may be vital in responding to legal inquiries or litigation about patient care. 15 years equates to the retention of patient records in Group A Hospitals and meets (and exceeds by 3 years) the statute of limitations for personal injury claims.		
1.17.2	Superseded - see 1.17.1.	

Authority number: GDA17 **Dates of coverage: Open**

No.	Description of records	Disposal action

PATIENT/CLIENT TREATMENT AND CARE- Surgical procedures

1.18.0 Surgical procedures

The management of accountable items used in surgical and medical procedures.

See **PATIENT/CLIENT REGISTRATION AND MANAGEMENT - Patient/client registers** for registers of surgically implanted devices or prostheses.

See **PATIENT/CLIENT TREATMENT AND CARE - Hospital and emergency care** for accountable item and sterile instrument tracking forms which are maintained as part of the patient file.

1.18.1	Copies of records of accountable items used in operating theatres e.g. instruments and swab counts. **Note:** original records are to be maintained as part of the patient file.	Retain minimum of 1 year after action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action . Retention period meets short-term accountability requirements. Originals are retained on the patient file for at least 7 years.		

No.	Description of records	Disposal action

PATIENT/CLIENT REGISTRATION AND ADMINISTRATION- Patient/client registers and indexes

2.0.0 PATIENT/CLIENT REGISTRATION AND ADMINISTRATION

The function of managing the identification, registration, admission, transfer and discharge of patients/clients.

See **PRE-1930 RECORDS** for records created prior to 1930.

2.1.0 Patient/client registers and indexes

The management of registers and summary information relating to patient/client admission, identification, transfer, discharge and treatment.

Note: *registers etc. of private hospitals, services, nursing homes, centres etc. are not State records and should be retained and disposed of in accordance with any requirements of the Act or regulations under which the establishment is licensed.*

See **PATIENT/CLIENT TREATMENT AND CARE - Complaints and incident management** for registers of patient injuries, complaints or incidents

See **PHARMACEUTICAL SUPPLY AND ADMINISTRATION** for drug registers maintained on wards.

2.1.1	Patient/client registration information supporting unique identification of patients/clients. This may include patient/client identification or record number and associated patient/client details (name, date of birth, sex, address, etc.) that enables unique identification to support ongoing provision of treatment, care and services. May also include associated patient administration details such as health insurance details, next of kin or guardian, concession eligibility, etc.	Retain until administrative or reference use ceases (i.e. until information would no longer be required to support unique identification and ongoing provision of care to registered patient/client or for potential legal action, research, accountability or other reference purposes associated with the provision of treatment/care to the patient/client), then destroy
Justification/Remarks: Confirms 2004 disposal action. The index or register will be retained for as long as it is required for the purpose of locating individual patient records and, where the index or its equivalent records the details of the disposal of individual records, for an appropriate period thereafter to account for the disposal of individual patient records. Depending on other types of records maintained, the PMI may be retained indefinitely.		
2.1.2	Hospital and emergency department patient registration or administration information providing summary details of births, deaths (including mortuary	Required as State archives

No.	Description of records	Disposal action

PATIENT/CLIENT REGISTRATION AND ADMINISTRATION- Patient/client registers and indexes

	admissions), patients admitted, presenting, treated and discharged, length of stay and the nature of treatment and care provided (e.g. admission and discharge diagnosis, surgical procedures and operations performed).	
Basis for determination: Confirms 2004 disposal action. These records provide an overview of the delivery of public health care services and health outcomes within particular areas and a resource for insight into the health status, treatment and care of the population of NSW over time.		
2.1.3	Registers or indexes documenting physicians and medical practitioners with admitting rights and details of patients attended.	Retain until patient attains or would have attained the age of 25 years, or minimum of 15 years after date of last entry, whichever is longer, then destroy
Justification/Remarks: Confirms 2004 disposal action for indexes of physicians and medical practitioners, with an additional requirement to retain records for cases involving minors until the age of 25 years for consistency with other records relating to children.		
2.1.4-2.1.8	See entry 2.1.2.	
2.1.9	Registers or summary presenting/treatment data for community health patient/clients and Ambulance and emergency transport patient/clients. **Note**: see entry 2.1.1 above for patient/client identification information.	Retain until patient attains or would have attained the age of 25 years or minimum of 15 years after action completed, whichever is longer, then destroy
Justification/Remarks: Scope extended to encompass ambulance and emergency transport patient/clients. A minimum retention period of 15 years ensures the registers will retain details of treatment provided even though the patient records are only retained for 7 years to assist with enquiries and potential legal action.		
2.1.10	Registers, summary records, reports, report books and other ward records documenting the reception, admission, management, treatment and care of patient/clients into/on a ward.	Retain minimum of 7 years after last entry or action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action . Retention period meets local reference needs for staff on wards. The admission registers of patients admitted to hospital are retained as State archives (see entry 2.1.2).		

Public health services: patient/client records

Authority number: GDA17 **Dates of coverage: Open**

No.	Description of records	Disposal action
PATIENT/CLIENT REGISTRATION AND ADMINISTRATION- Patient/client registers and indexes		
2.1.11	Register of surgically implanted devices or prostheses.	Retain minimum of 75 years after implantation of the device or prosthesis, then destroy
Justification/Remarks: Records documenting registers of surgically implanted devices or prostheses were previously required to be retained indefinitely. Minimum retention period of 75 years after implantation of device meets the need to trace recipients of devices in instances of product recall and equates to the expected lifetime of most recipients. It is not possible to implement a disposal action based on date of birth of patient as registers are arranged by date of implantation.		
2.1.12	Registers or summary records documenting the administration of electro-convulsive therapy or sedation or seclusion of mental health patients.	Retain minimum of 15 years after action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets reference and research needs. A record of the administration of therapy to individual patients is maintained on their patient file and will be retained for a minimum of 45 years.		

No.	Description of records	Disposal action

PATIENT/CLIENT REGISTRATION AND ADMINISTRATION- Patient/client administration

2.2.0 Patient/client administration

Administration of arrangements for the provision of treatment, care or services to patients/clients. Includes the management of patient property, accounts and finances and provision of disability equipment.

See **PATIENT/CLIENT REGISTRATION AND MANAGEMENT - Patient/client registration** for patient registers.

See General Retention and Disposal Authority *Administrative records* **STRATEGIC MANAGEMENT - Meetings** for diaries and appointment books of staff that do not record patient/client contact.

2.2.1	Records relating to administrative arrangements for the management of patients/clients. Includes: • lists and booking schedules • routine census or data collection reports or returns • referrals, requests for services and recommendations for admission where patient/client did not attend. **Note:** for time periods where admission, discharge, death, operation or theatre registers do not exist, the equivalent admission, discharge, etc., lists may warrant retention as State archives. Contact NSW State Archives & Records to discuss.	Retain minimum of 2 years after action completed, then destroy
Justification/Remarks: Minimum retention period for clinical lists, waiting lists and patient related data collection and census returns/reports/forms increased from 1 to 2 years after action completed. Minimum retention period for waiting list audit reports and requests or referrals for services or recommendation for admission forms where the patient did not attend decreased from 3 to 2 years. Reduced retention period still meets reference, reporting or accountability purposes.		
2.2.2-2.2.6	See entry 2.2.1.	
2.3.1	Records relating to the clinical administration or management of client/patients documenting contact not recorded elsewhere e.g. diaries and appointment books, copies of service requests or referrals, requests for or copies of issued medical certificates, etc.	Retain minimum of 7 years after action completed, then destroy
Justification/Remarks: Minimum retention period for requests or referrals increased from 3 to 7 years after action completed. These records are facilitative in nature. Any record relating to the direct care of a patient will be captured on the patient file.		
2.3.2	Removed see GA28 STRATEGIC MANAGEMENT - Meetings (19.3.3).	
2.4.1	See entry 2.2.1.	

Authority number: GDA17 **Dates of coverage: Open**

No.	Description of records	Disposal action
PATIENT/CLIENT REGISTRATION AND ADMINISTRATION- Patient/client administration		
2.4.2	Entry removed as covered by Normal Administrative Practice guidelines.	
2.4.3	See entry 2.2.1.	
2.5.1	See entry 2.1.10.	
2.6.1	See entry 2.1.1.	
2.7.1	See GA28 STRATEGIC MANAGEMENT - Reporting or GOVERNMENT RELATIONS - Reporting.	

No.	Description of records	Disposal action

DIAGNOSTIC IMAGING AND RECORDING SERVICES

3.0.0 DIAGNOSTIC IMAGING AND RECORDING SERVICES

The conduct of procedures and tests for the purpose of patient/client diagnosis. This includes diagnostic imaging, pathology and laboratory services such as diagnostic radiology, tomography, nuclear medicine, ultrasound, magnetic resonance imaging and related diagnostic digital imaging procedures.

Note: Details of requests for diagnostic procedures or tests should be recorded and retained accordingly as part of the record of patient treatment and care, e.g. as part of the progress notes or a copy of any request is maintained as part of the patient file. The original or a copy of any diagnostic report should also be maintained as part of the patient record and retained accordingly.

See **PATIENT/CLIENT TREATMENT AND CARE** for diagnostic procedure or test requests and reports of diagnostic results which form part of the record of patient treatment and care.

3.1.1	Diagnostic service copies of requests for and reports or findings of diagnostic procedures, tests or services.	Retain minimum of 3 years after provision of service or date of report, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets short –term reference needs of the diagnostic service. Reports of findings are also placed on the patient file and will be retained for at least 7 years.		
3.2.1	Patient record copy - see relevant patient record.	
3.2.2	See entry 3.1.1.	
3.3.1	Recordings of diagnostic and screening procedures. Includes: • radiology (X-Rays) images • recordings of electroencephalograms, electrocardiograms, electromyograms, cardiotocograms etc • ultra-sound images • Computed Tomography (CT) scans • Magnetic Resonance Images (MRI) • photographs, videotapes • measurements, gradings, readings and other data e.g. data from sleep studies. **Note:** reports of the results of tests, including the reporting of abnormalities, are required to be retained as per the patient record. **Note:** images may need to be retained for longer	Release to patient upon request if not required for possible future treatment or other reasons, such as litigation, or retain a minimum of 7 years after last attendance for diagnostic procedure, then destroy **TB (tuberculosis) chest X-Ray:** Retain for life of patient or 85 years from date of birth if date of death unknown, then

No.	Description of records	Disposal action

DIAGNOSTIC IMAGING AND RECORDING SERVICES

	periods where an abnormality is detected, a minor is involved, or where a specific medical condition warrants longer retention.	destroy
Justification/Remarks: Additional requirement to retain tuberculosis chest x-rays for the life of the patient. This allows for extended periods of time between infection and potential reactivation, or relapse, and allows examination of films to avoid unnecessary investigation and or treatment when a person presents at a later date. Requirement to retain recordings for minors until patient attains or would have attained the age of 25 has been removed. A copy of any associated diagnostic reports will be retained until the age of 25 as part of the main patient record. These records are voluminous and infrequently accessed after the patient no longer attends.		
3.3.2 - 3.3.3	See entry 3.3.1.	
3.4.1	Registers or associated control records maintained for the purposes of identifying or locating diagnostic recordings and reports. **Note:** The registers should be retained for as long as they might conceivably be required for the purposes of locating a recording, or, where the records contain the details of the disposal of individual recordings, accounting for the disposal of the recording.	Retain until administrative or reference use ceases, then destroy
Justification/Remarks: Confirms 2004 disposal action. The registers will be retained for as long as required to assist in management of the recordings.		

No.	Description of records	Disposal action

PATHOLOGY AND LABORATORY SERVICES

4.0.0 PATHOLOGY AND LABORATORY SERVICES

Medical pathology and laboratory diagnostic services. This includes anatomical pathology, cytology, haematology, clinical chemistry/clinical pathology, blood banks, immunology, microbiology and genetics.

4.1.1	Diagnostic service copies of requests or referrals for and reports or findings of diagnostic procedures, tests or services. Includes associated declarations, consents, etc.	Retain in accordance with the relevant legislative requirements and/or national standards and guidelines (for example standards and guidelines issued by the National Pathology Accreditation Advisory Council or its successor agency/ies)
Justification/Remarks: the National Pathology Accreditation Advisory Council issues detailed mandatory minimum retention periods for these records. The disposal action has been changed to allow the disposal of these records as per the regulations. The NPAAC retention periods range from 4 years to indefinitely (genetic records).		
4.2.1-4.2.6	See entry 4.1.1.	
4.2.7	See relevant patient record for records documenting diagnostic findings.	
4.3.1	Class removed. Bodily specimens, samples or materials are not considered to be records within the meaning of the State Records Act and are not covered by this authority. They should be managed, retained and disposed of in accordance with relevant legislation or standards and guidelines issued by an appropriate body e.g. National Pathology Accreditation Advisory Council (NPAAC).	
4.3.2	Records relating to the tracking or monitoring of testing completion and the management or control of received or collected bodily parts or specimens. Includes registers and other associated control records maintained for the purposes of identifying or locating specimens. **Note**: Retention periods should be in accordance with the minimum retention periods required for the types of specimens recorded in the register, and where these	Retain until administrative or reference use ceases, then destroy

No.	Description of records	Disposal action
PATHOLOGY AND LABORATORY SERVICES		
	records contain the details of the disposal of individual specimens, the records should be retained for as long as they might conceivably be required for the purposes of accounting for the disposal of the specimen.	
Justification/Remarks: Confirms 2004 disposal action. The records will be retained for as long as required to assist in management of specimens.		
4.3.3-4.3.4	See entry 4.3.2.	
4.3.5, 4.4.1	See entry 4.1.1.	
4.4.2	Records of blood, blood product and semen donation and supply. Includes donor records and consents and records documenting the supply of products.	Retain in accordance with the relevant legislative requirements and/or national standards and guidelines (for example standards and guidelines issued by the National Pathology Accreditation Advisory Council or its successor agency/ies)
Justification/Remarks: the National Pathology Accreditation Advisory Council issues detailed mandatory minimum retention periods for these records. The disposal action has been changed to allow the disposal of these records as per the regulations.		
4.4.3, 4.4.4, 4.5.1	See entry 4.4.2.	
4.6.1	Records relating to: • quality control and assurance (certification, implementation and audit of processes and services) • the maintenance and servicing of equipment used for diagnostic or testing purposes • methodologies and standard procedures for the conduct of diagnostic tests and procedures.	Retain in accordance with the relevant legislative requirements and/or national standards and guidelines (for example standards and guidelines issued by the National Pathology Accreditation Advisory Council or its successor

No.	Description of records	Disposal action

PATHOLOGY AND LABORATORY SERVICES

		agency/ies)
Justification/Remarks: the National Pathology Accreditation Advisory Council issues detailed mandatory minimum retention periods for these records. The disposal action has been changed to allow the local health districts to dispose of these records as per the regulations.		
4.7.1, 4.8.1	See entry 4.6.1.	

No.	Description of records	Disposal action

PHARMACEUTICAL SUPPLY AND ADMINISTRATION

5.0.0 PHARMACEUTICAL SUPPLY AND ADMINISTRATION

Management of the supply, administration, dispensing and use of pharmaceuticals, encompassing drugs, poisons and other chemical substances.

See **PATIENT/CLIENT TREATMENT AND CARE** for patient medication charts, incident reports and consent forms for special access scheme drugs

5.1.1	Records relating to the supply, dispensing and inventory of pharmaceuticals. This includes requisitions and orders for pharmaceutical products or substances, prescriptions (other than for highly specialised drugs), records of medication chart orders, records of supply other than on prescription, and receipts/records of delivery. **Note:** for prescriptions of highly specialised drugs see entry 5.1.3.	Retain minimum of 2 years after action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. The Poisons and Therapeutic Goods Regulation 2008 requires these records to be retained for 2 years.		
5.1.2	See relevant patient record.	
5.1.3	Records relating to the procurement, supply, dispensing, administration, audit of drugs of addiction. Includes: • drug registers required to be maintained by regulation (e.g. schedule 8 medications, drugs of addiction, etc.) and for any other medicines as required by local policy (e.g. Schedule 4 Appendix D medications) held in the pharmacy, ward or other departments • applications to prescribe drugs of addiction as part of a treatment program and associated medical reports, authorities, treatment proposals, correspondence, etc.	Retain minimum of 7 years after date of entry or action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets need to provide evidence that drugs of addiction (amphetamine, cannabis, methadone etc) are properly controlled.		
5.1.4	See entry 5.1.1.	
5.1.5	Records relating to the supply of medications under highly specialised drugs programs. Includes prescriptions and declaration forms signed by the prescriber.	Retain minimum of 7 years after date of receipt, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets accountability		

No.	Description of records	Disposal action
PHARMACEUTICAL SUPPLY AND ADMINISTRATION		
requirements. A record of the drugs taken by patients will be recorded in the patient record.		
5.1.6	See relevant patient record.	
5.1.7	Therapeutic Goods Administration (TGA) application and notification forms (for example, prescribing of Special Access Scheme medications and Clinical Trial drugs).	Retain minimum of 7 years after action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets accountability requirements.		
5.1.8	See entry 5.1.3.	
5.1.9	Records relating to the reporting of lost or stolen drugs or drug registers.	Retain minimum of 10 years after action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets accountability requirements.		

No.	Description of records	Disposal action

NOTIFICATIONS

6.0.0 NOTIFICATIONS

Notification and reporting to prescribed bodies or authorities in accordance with statutory or other requirements regarding patient/client medical conditions, instances, episodes, etc.

See **PATIENT/CLIENT TREATMENT AND CARE** for service provider records of the notification or reporting of patient/client conditions, instances, episodes, etc., e.g. birth and death notifications or certificates, reports of notifiable diseases, mandatory reporting of suspected criminal activity (e.g. abuse), etc.

6.1.1	See relevant patient record.	
6.1.2	Copies of death certificates – see Normal Administrative Practice.	
6.2.1	Records of notifications maintained by hospitals. community health services etc fulfilling obligations to report notifiable diseases.	Retain minimum of 15 years after last attendance or official contact or access by or on behalf of the patient or until patient attains or would have attained the age of 25 years, whichever is longer, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets accountability requirements.		
6.2.2	Reports of an incidence of a notifiable disease received by Public Health Units. **Note:** Duplicate notifications received subsequent to the initial notification can be disposed of when no longer required for administrative or reference purposes	Retain minimum of 7 years after action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets reporting requirements. The Ministry of Health retains the central register of notifiable diseases as State archives.		

No.	Description of records	Disposal action

PATIENT/CLIENT FINANCE AND PROPERTY MANAGEMENT

7.0.0 PATIENT/CLIENT FINANCE AND PROPERTY MANAGEMENT

The management of patient/client finances and property.

7.1.1	Records documenting the management of patient/client property, accounts and finances. Includes records which are the primary record of a patient/client's property, clothing, money and valuables, authorisations for the payment of monies or transfer of property e.g. patient election forms, private patient claim and assignment forms, patient money and valuables register, property and clothing books, accounting records.	Retain minimum of 7 years after action completed, then destroy
Justification/Remarks: Minimum retention period for records relating to the management of patient/client property, accounts and finances increased from 6 to 7 years after action completed for consistency with other financial records in the *General retention and disposal authority: administrative records* FINANCIAL MANAGEMENT - Accounting (7.1.1).		
7.1.2	See entry 7.1.1.	
7.1.3	Records relating to the handling of patient/client's property or finances which are not the primary record or do not authorise the payment of monies or transfer of property.	Retain minimum of 2 years after action completed, then destroy
Justification/Remarks: Minimum retention period for records relating to the management of patient/client property, accounts and finances which are not the primary record increased from 1 to 2 years after action completed for consistency with other financial records in the *General retention and disposal authority: administrative records* FINANCIAL MANAGEMENT - Accounting (7.1.6).		
7.1.4	See entry 7.1.1.	
7.2.1	See entry 7.1.3.	
7.2.2-7.2.3	See entry 7.1.1.	
7.3.1	Records relating to applications for disability appliances, aids and services e.g. the Program of Appliances for Disabled People.	Retain minimum of 3 years after last contact with or use of the service, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets need to retain a record of services provided while the client uses the service.		
7.3.2	Records relating to the provision and maintenance of	Retain minimum of 5 years after action

No.	Description of records	Disposal action
PATIENT/CLIENT FINANCE AND PROPERTY MANAGEMENT		
	appliances for disabled people.	completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets accountability requirements.		

No.	Description of records	Disposal action

RESEARCH MANAGEMENT

8.0.0 RESEARCH MANAGEMENT

Management of clinical and non-clinical research, trials or studies, etc.

Note: This does not apply to records created and maintained by Committees formed to oversight the conduct of research activities (e.g. Research Ethics Committees).

8.1.1	Records relating to the conduct of clinical research. This includes records or documentation relating to the recruitment and consent of research participants, data/records/information access requests and approvals, the collection and analysis of data, preliminary findings, surveys, reporting and results.	Retain minimum of 15 years after date of publication or completion of the research or termination of the study, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period complies with Australian Code for the Responsible Conduct of Research for clinical research.		
8.1.2	Records relating to the conduct of: • non clinical research, or • research not involving humans. This includes records of any associated consents or data/information access requests and approvals, the collection and analysis of data, conduct of surveys, reports of findings or results.	Retain minimum of 5 years after date of publication or completion of the research or termination of the study, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period complies with Australian Code for the Responsible Conduct of Research for non-clinical research.		
8.1.3	See entry 8.1.1.	
8.1.4	See entry 8.1.2.	
8.1.5	Records of requests relating to projects where the research does not proceed.	Retain minimum of 3 years after action completed, then destroy
Justification/Remarks: Confirms 2004 disposal action. Retention period meets short-term reference needs if queries are raised.		

9.0.0 RECORDS IMAGING

See the *General retention and disposal authority: original or source records that have been copied* for the disposal of originals of records that have been copied.

See the relevant patient record where imaged/copied records are the primary record.

Note: affidavits and documentation relating to records authenticity should be retained until the master copy of the records to which they relate is destroyed or superseded.

No.	Description of records	Disposal action

PRE 1930 RECORDS

10.0.0 PRE 1930 RECORDS

10.1.0	Patient/client records created wholly or in part prior to 1930. This includes records identified in the previous sections created wholly or in part prior to 1930.	Required as State archives

Justification/Remarks: Confirms 2004 disposal action. This date corresponds with the introduction of the *Public Hospitals Act 1929*. The Act established the Health Commission and a state wide system for the regulation and quality assurance of hospital services. This will ensure the retention of records documenting early medical practices and services prior to their more effective regulation by government.

From the 1930's onwards there is also, within services, a general movement towards the management of patient health care records as individual case files rather than as bound case books based on disease type. The outcome of State Records' survey of holdings of pre 1950 patient records indicated that, in addition to classes of records already identified as State archives (for example births, deaths and admission registers), the record classes primarily affected by this decision would be early patient case books or small quantities of other classes of patient records (eg ward reports and registers) that are the only extant records of the service for that period.