Government of **Western Australia**
Department of **Health**

Patient Information Retention and Disposal Requirements

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Contents

Introduction

The additional mandatory information below is to be read in conjunction with the Patient Information Retention and Disposal Schedule (2019-008).

1. Formats of patient information

Patient records regardless of format must be sentenced in accordance with the Patient Information Retention and Disposal Schedule (2019-008). Patient records can be in the following formats:

Physical

Physical records are patient records that can be touched and take up physical space, for example:

- Paper based medical records
- Non-digital photographs, videotapes, films and audiotapes
- Microforms (microfilm and microfiche)
- Non-digital diagnostics information.

Digital

Digital records are patient records that are either born digital or have been digitised from a physical format. Examples are:

- Born digital records such as photographs, videos, audios, information contained within databases.
- Patient records that have been scanned into a digital format such as the various medical information contained in the paper-based record.

Biological

Biological records are specimens taken from a patient. Biological records must be identifiable and held in appropriate storage conditions for the life of that record. Examples are:

- cell and tissues samples
- blood samples
- genetic samples
- biobank samples.

2. Specific records

There are some patient records that require different retention periods due to the nature of the record and/or the patient's medical history.

2.1 Aboriginal records

Children of Australian Aboriginal and Torres Strait Islander descent who were removed from their families between the 1900's and the 1960's are known as the Stolen Generation. A National Inquiry (Bringing Them Home) into the Stolen Generation was undertaken in the late 1990's. In response, WA Government agencies were to cease the destruction of Aboriginal records. The WA health system continues to maintain this requirement for certain categories of records relating to Aboriginal people.

For the WA health system, Aboriginal patient records with a date of birth prior to and including 1970. In addition to this, Aboriginal patient records created by remote clinics in the Kimberley, Pilbara, Goldfields and Midwest health regions must be retained indefinitely, regardless of date of birth, with the exemption of Case Management Program records.

The following considerations will assist in the identification and preservation of Aboriginal patient records:

- Aboriginal status is recorded within the health information systems such as webPAS
- The patient record has a recognised Aboriginal family name including aliases
- Clinical records have care delivered by a health service including Mission, Station and itinerant health workers
- Relates to a health program that provided care to the Aboriginal population
- Record exists in an area with a high proportion of Aboriginal population such as the Kimberley region
- Record contains evidence of adoption, fostering or an informal arrangement of care for a child.

2.2 Child records

Recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse have placed recordkeeping responsibilities on relevant government agencies.

For further information refer to the State Records Office's General Retention and Disposal Authority for Incidents and Allegations of Child Abuse or Neglect.

2.3 COVID-19 Records

Records of patients with a confirmed diagnosis of with COVID-19 are considered 'significant', as outlined in the Patient Information Retention and Disposal Schedule (DA2019-008) and must be retained as State archives. This includes the restricted access of 100 years from date of last documentation.

2.4 Voluntary Assisted Dying

Records of patients that have received voluntary assisted dying as an admitted patient are considered 'significant', as outlined in the Patient Information Retention and Disposal Schedule (2019-008) and must be retained as State archives. This includes the restricted access of 100 years from date of last documentation.

3. Recordkeeping practices

3.1 Sentencing records

Determining the appropriate minimum retention period of a patient record is a process that is required at the commencement of record creation. Health care facilities must:

- adopt a concurrent record sentencing process
- configure their electronic recordkeeping systems to sentence electronic records and digitised patient records at the time of creation or capture.

Where it is known or there is a reasonable expectation that a record or series of records may later be subject to legal proceedings and FOI requests or other investigations/inquires, health care facilities must retain these records for future reference. Records that are currently the

subject of legal proceedings, must be retained until the action and any subsequent actions are completed.

3.2 Date of last documentation

Date of last documentation refers to the last document of directly related health care of the patient. For example:

- Freedom of Information application, subpoena, or medico-legal request
- Clinical review
- Post-discharge completion
- Copies of patient record documentation
- Provision of a report to another health care worker or agency
- Education of health professionals
- Research
- Notifications to patient's or deceased's next of kin.

3.3 Digitisation of patient records

A digitised patient record is a record that has been transformed into a digital format by scanning a paper-based patient record (source record). The source record is the systematic documentation of a single patient's medical history and includes, but not limited to, notes captured at examination, treatment plans, medication charts, correspondence between treating clinicians and diagnostic reports.

Health Service Providers must have local policies, procedures or processes for digitising patient records based on the following State Records Office documents:

- Standard 8 – Managing Digital Information
- Digitization Specification
- General Disposal Authority for Source Records

These local policies, procedures or processes are to be kept on the Health Service Provider's records management webpage(s):

- CAHS Records Management
- EMHS Records Management
- NMHS Records Management
- SMHS Records Management
- WACHS Records Management.

Exceptions

The State Records Office's Specification for Digitisation of State Records (section 5.8) outlines a process for documenting exceptions to specification requirements.

Health Service Providers can be exempt from the requirements of the State Records Office's Digitisation Specifications providing the following minimum specification are met when digitising patient medical records only:

- Resolution - 8 dots per millimetre (200 dpi)
- Type of image - colour
- Bit-depth - 24 bits
- Colour management - embedded ICC colour profile
- Lossless compression - lossy compression is acceptable if this is the only representation available from the digitization device.

This exception also allows the destruction of original source records including specific records under Section 2 of this document, where such records have been reproduced through scanning or digitisation, providing the minimum requirements listed above have been met and can be evidenced. Source documents must be retained for a minimum of six months after digitisation.

The State Records Office must be advised regarding these exceptions where the affected records are to be retained as State archives.

Approval and risk assessment

To enable Health Service Providers to scan paper medical records as per the exception, each Health Service Provider must complete the Exceptions Authorisation and Risk Assessment Forms (section 5, Appendix).

The Chief Executive of the Health Service Provider approves the Exceptions Authorisation and Risk Assessment Forms, and both are sent to the State Records Office for review and approval.

The Exceptions Authorisation and Risk Assessment Forms are a once only process, but the risk assessment must be reviewed on a regular basis to ensure currency and lists the compliance requirements of the:

- General Disposal Authority for Source Records
- Standard 8 – Managing Digital Information.

4. Disposal of records

Before any patient records are destroyed, a review of their significance value must be undertaken. This significance value is the potential business or historical value to the type or series of records. For example:

- diagnoses that are controversial, new or rare
- current environment of Government at the time of the review, for example, Royal Commissions.

The employee that is assigned to this duty requires the suitable knowledge and experience to undertake this role.

Temporary records can be destroyed by an external contractor who is under the Common Use Agreement. Where destruction is performed by external contractor, a certificate confirming the secure, confidential and complete destruction of the records must be provided by the external contractor. Secure transport and storage pending the destruction is also required.

4.1 Methods of destruction

Patient records that have been reviewed as outlined above and approved by the relevant delegated authority must be destroyed via the applicable method outlined below.

Physical records

Method	Description
Shredding	Mechanical cutting into a multitude of narrow strips (strip-shred) or particles (cross-shred). Ensure all information is incapable of reconstruction.
Pulping	Chemical and/or mechanical methods.

Method	Description
Incineration	Is not recommended as a reliable and environmentally means of destruction.
Burial	Must never be used as a disposal method.

Digital

Digital media can be re-used or destroyed. The below outlines both methods.

Methods for enabling the re-use of the digital media

Method	Description
Magnetic media overwrite	Enables digital storage media to be overwritten many times with random characters. This process is a form of sanitisation and renders the underlying, previously stored data beyond easy recovery. The media may be subsequently reused for other purposes.
Reformatting	Results in the loss of previously stored data on the media. Reformatting is a basic form of sanitisation and can only be used when the media will continue to store patient records and remains in its existing environment.
Sanitisation	For digital media before disposal. Involves erasing or overwriting data stored on digital storage media but does not involve the physical destruction of the media.

Methods for the disposal of the digital media.

Method	Description
Degaussing	Reduces the magnetic flux density to zero by applying a reverse magnetising field to the digital storage media. Degaussing renders any previously stored data on the storage media unreadable.
Physical Destruction	Involves physically damaging the digital storage media with the objective of making the data stored on it inaccessible.

Biological

Method	Description
Incineration	Burns biological waste at high temperatures within biological waste incinerators.

4.2 Destruction registers

A destruction register must be in place to ensure a record of destruction is maintained for future reference and accountability. The destruction register must list each individual record that is destroyed. Minimum requirements are outlined in the below table.

Information	Description
Disposal authority number	Indicates the retention and disposal schedule that authorises the destruction of records. For example, RD 2007079
Index number	Refers to the types or class of record.

Information	Description
Description	Provides a description of the individual record item being destroyed. For individual patient records, the Unique Medical Record Number (UMRN), patient surname and given names may be collected.
Date range	Indicates the inclusive dates of records being destroyed (e.g. 1950 – 1955)
Date of destruction	Refers to the date records are destroyed.
Company	Refers to the name of the contractor providing destruction services and the location of the service (if applicable).
Method of destruction	Specifies how the records are destroyed. For example, shredding.
Certification	Indicates that records have been destroyed in accordance with methods outlined in the WA health system's approved retention and disposal schedule. The delegated officer with the authority to destroy records and who witness the destruction of records by the contractor may sign this part of the register as certification or cross-reference to other certification document.

5. Appendix

5.1 Exceptions Authorisation Form

Additional information and examples are in grey font, delete when completing that section of the form.

Agency (Government Organisation at Authorisation date)	Name of Health Service Provider
Record Owner	Delegated person responsible for management of the records in accordance with the Health Service Provider's record keeping plan
Class of Records	Patient Medical Records under the Patient Information and Retention Schedules, both past and present versions.
Type of Exception	Digitisation of patient medical records to the following minimum specifications: • Resolution - 8 dots per millimetre (200 dpi) • Type of image - colour • Bit-depth - 24 bits • Colour management - embedded ICC colour profile • Lossless compression - lossy compression is acceptable if this is the only representation available from the digitization device. All other quality and validation requirements of the Digitisation Specification will be met.
Reason	The large volume of patient medical records within the **<insert HSP name>** makes digitisation to 300dpi unworkable. This is due to: **<insert reasons>** Examples: • The amount of storage required for 200dpi scanned documents is less than for 300dpi • Cost of storing 200dpi scanned documents within a DMR is less than for 300dpi scan documents • Cost of replacing digitisation machines that currently digitise at 200dpi.
Risk Assessed/Accepted	Yes - Refer to attached risk assessment
Approval	The digitised patient medical records are authentic, reliable and usable for their intended purpose. Name: Position: Chief Executive, **<insert HSP name>** Date:

5.2 Risk Assessment Form

Risk Assessment Form

The following table lists compliance requirements of the GDA Source that require consideration when assessing the risk of implementing it, along with associated requirements under State Records Office *Standard 8 – Managing Digital Information*.

Additional information and examples are in grey font, delete when completing that section of the form.

Compliance Requirement	**Standard**	**Controls in place** **(are all areas of compliance met?)**	**Notes**
Comprehensive digitization procedures in accordance with best practice, such as AS/NZS ISO 13028:2012 *Information and documentation - Implementation guidelines for digitization of records*	***GDA Source* Section 2.4** ***Specification for Digitisation of State Records*** **AS/NZS ISO 13028:2012 *Information and documentation - Implementation guidelines for digitization of records* – available for purchase via SAI Global - https://infostore.saiglobal.com/en-au/standards/as-nzs-iso-13028-2012-1520846/**	Yes/No	Are such procedures in place, do they cover all requirements? Are all procedures signed off by the CE?
Staff training in digitization procedures	***GDA Source* Section 2.4**	Yes/No	Who is responsible for scanning? Is training and support provided to all staff undertaking scanning?
Procedures for the creation and management of digital files	***GDA Source* Section 2.4**	Yes/No	Are procedures outlined to manage creation and management of digital files within the

Compliance Requirement	Standard	Controls in place (are all areas of compliance met?)	Notes
	Specification for Digitisation of State Records		Recordkeeping system or business information system?
Quality assurance checks to ensure that source records have been completely digitized – that is, all pages or parts of a record have been scanned;	***GDA Source* Section 2.4** ***Specification for Digitisation of State Records***	Yes/No	What are the QA processes? *Refer to section 5.7 “Digitization Processes” in the *Specification for Digitisation of State Records*.
The registration of the reproductions in an electronic document and records management system (EDRMS) or business information system;	***GDA Source* Section 2.4** ***Specification for Digitisation of State Records***	Yes/No	
The process is such that the reproduction can be certified as having the same evidential value as the source record.	***GDA Source* Section 2.4** ***Specification for Digitisation of State Records***	Yes/No	Can the Health Service Provider prove from the processes in place that the records digitised are authentic true versions of the original? *Refer to section 5 “Digitization Processes” in the *Specification for Digitisation of State Records*.

Compliance Requirement	Standard	Controls in place (are all areas of compliance met?)	Notes
The organization's digitization program / processes is approved by the organization's CEO (or authorized delegate) and is included in the organization's Recordkeeping Plan	***GDA Source* Section 3.1 (Destruction of source records is permitted ONLY IF ALL these conditions are met)**	Yes/No	
The digitization program / processes meet the minimum compliance requirements of Principle 5 of *SRC Standard 8: Managing Digital Information*	***GDA Source* Section 3.1 (Destruction of source records is permitted ONLY IF ALL these conditions are met)**	Yes/No	(See Principle 5 under SRC Standard 8)
The file formats of the reproductions meet the requirements of the *Digitization Specification*	***GDA Source* Section 3.1 (Destruction of source records is permitted ONLY IF ALL these conditions are met)**	Yes/No	Records with a retention period of 10 years or more **must** meet the Long-term file format requirements in section 6 "Sustainable Digital Formats' within the *Specification for Digitisation of State Records.*
The reproductions are registered or captured in an EDRMS or incorporated into an official corporate business information system at the time of digitization	***GDA Source* Section 3.1 (Destruction of source records is permitted ONLY IF ALL these conditions are met)**	Yes/No	
The reproductions have the required degree of authenticity, integrity, reliability and usability necessary to substitute for the source records for the purpose for which the source records were created or kept	***GDA Source* Section 3.1 (Destruction of source records is permitted ONLY IF ALL these conditions are met)**	Yes/No	What Quality Control was undertaken as at earliest date of implementation?

Compliance Requirement	Standard	Controls in place (are all areas of compliance met?)	Notes
The source records are identified in, or covered by, an approved disposal authority	***GDA Source* Section 3.1 (Destruction of source records is permitted ONLY IF ALL these conditions are met)**	Yes/No	Patient's paper medical record will have a variety of source records including State archives. Each patient's medical record may not be reviewed thoroughly due to the volume of records each patient has within each paper medical file and the volume of patients that go through each site within **<insert name of HSP>**. This risk will be mitigated by ensuring digitisation specifications and exceptions, such as COVID-19 or VAD, are adhered to.
The reproductions will be kept and be accessible for as long as required under the relevant approved disposal authority.	***GDA Source* Section 3.1 (Destruction of source records is permitted ONLY IF ALL these conditions are met)**	Yes/No	
Determine the conditions under which source records **<u>may not</u>** to be destroyed	***GDA Source* - 3.2 Destruction of source records is NOT PERMITTED IF ANY of the conditions under 3.2 are met:**	Yes/No Exception's chart needed and how to manage exceptions?	Policy and procedures will need to be in place to ensure staff are aware of exceptions under 3.2 of the GDA Source.
Determine which source records are transactional records and which must be retained for a minimum period of six (6) months following digitisation	***GDA Source – 3.4.1 and 3.4.2***	Yes/No QA processes?	3.4.1 - Transactional, low value source records only need to be retained until accuracy and integrity of the reproduction has been verified – only then may the source

Compliance Requirement	Standard	Controls in place (are all areas of compliance met?)	Notes
			records be destroyed. *SRO Specification for Digitisation of State Records* updated regarding receipts/proof of purchase records. All other source records must be retained for a minimum period of 6 months following digitisation before they are destroyed.
Security of Digital Information	***SRC Standard 8 – Managing Digital Information***	Yes/No Meeting SRC Standard 6 if storage is outsourced?	Are procedures in place to ensure digital information is secure including back-ups with any offsite Data/cloud Service? Does Contract with them require compliance with RKP requirements of SRC Standard 6? Have security risks of storage of data in the cloud been assessed? ****

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