CHAPTER 9 – HEALTH RECORDS AND INFORMATION

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MENTAL HEALTH CLINICAL DOCUMENTATION (PD2010_018)


PURPOSE

This Policy Directive requires that all public mental health services use standardised Mental Health Clinical Documentation modules to document care. The modules aim to support the recording, retrieval and sharing of medical record information at all points of care from triage through to discharge. The goal is to improve consumer outcomes by enhancing the clinical information available to inform care.

MANDATORY REQUIREMENTS

The use of the following modules is mandatory for their respective key points of care, for all settings and age groups: Triage, Assessment, Review, Care Plan and Transfer/Discharge Summary.

Additional modules provide support for specific information domains and are available to be used as appropriate to the clinical situation: Physical Examination, Physical Appearance, Risk Assessment, Substance Use Assessment, Family Focused Assessment (COPMI), Functional Assessment, Screening for Domestic Violence, Transcultural Assessment, Cognitive Assessment (RUDAS), Cognitive Assessment (3MS/MMS). In the case of the Risk Assessment module, clinicians are expected to complete the module where clinically appropriate and/or when the screening questions contained in the Triage, Assessment or Review modules indicate the presence of risk.

The modules should be used as tools to record information, with clinical judgement to guide how information is gathered and the appropriate detail to be recorded. Where there are clinical reasons to use alternative documentation, the clinician should ensure that:

(a) the documentation reflects the content of the modules, and
(b) that the format of their documentation is legible and locatable by other clinicians involved in care.

Progress notes can be used to supplement information documented in the modules as appropriate.

IMPLEMENTATION

The implementation of the Mental Health Clinical Documentation modules is supported by Mental Health Clinical Documentation Guidelines (GL2014_002), with the Physical Examination module also supported by Provision of Physical Health Care with Mental Health Services Policy (PD2009_027) and the Screening for Domestic Violence supported by Domestic Violence - Identifying and Responding policy (PD2006_084).

Health services are expected to have local guidelines and/or procedures to help clinicians embed the documentation within local clinical practice and business processes, particularly those addressing the sharing of medical records information between services involved in the consumer’s care.

The modules are ordered as per the usual procedure for NSW Health forms, refer to State Health Forms PD2009_072 and Redesigned Mental Health Clinical Documentation: Notification of Availability IB2008_047.
9. HEALTH RECORDS AND INFORMATION

Area Mental Health Services are required to monitor the use of the modules. NSW Health will develop a file audit framework to aid Areas to undertake this process. Audit findings will be addressed within a governance process overseen by NSW Health’s Mental Health Clinical Advisory Council and Mental Health Program Council.

Any queries concerning the clinical modules should be directed to Ms Neda Dusevic, Project Manager MH-OAT, on (02) 8877 5120 or ndusevic@nsccahealth.health.nsw.gov.au
9. HEALTH RECORDS AND INFORMATION

PRIVACY MANAGEMENT PLAN (PD2015_036)

PD2015_036 rescinds PD2005_554

1 BACKGROUND

NSW Health is responsible for managing and funding health services in a wide range of settings, from multi-purpose health centres in remote communities to large metropolitan teaching hospitals.

There are more than 220 public hospitals and health services in NSW which provide free health care to Australian citizens and permanent residents. Services provided at public hospitals may include emergency care, elective and emergency surgery, medical treatment, maternity services, and rehabilitation programs.

More detailed information about the structure of NSW Health is available on the NSW Health Website.

1.1 NSW MINISTRY OF HEALTH

The NSW Ministry of Health supports the executive and statutory roles of the Health Cluster and Portfolio Ministers.

The NSW Ministry of Health also has the role of ‘system manager’ in relation to the NSW public health system, which operates more than 225 public hospitals, as well as providing community health and other public health services, for the NSW community through a network of local health districts, specialty networks and non-government affiliated health organisations, known collectively as NSW Health.

1.2 HEALTH ORGANISATIONS

NSW Health comprises:

- A number of state-wide or specialist health services including NSW Ambulance, Health Infrastructure, HealthShare NSW, NSW Health Pathology, eHealth, Health Protection

- Fifteen NSW Local Health Districts providing health services across NSW (eight Local Health Districts covering Sydney metropolitan regions and seven covering rural and regional areas) and 2 Specialty networks (Justice Health and Forensic Mental Health Network and the Sydney Children’s Hospital network)

- Pillar organisations (Agency for Clinical Innovation, Bureau of Health Information, Cancer Institute NSW, Clinical Excellence Commission, Health Education and Training Institute and NSW Kids and Families)

- Affiliated Health Organisations (St Vincent’s Hospital, the Sacred Heart Hospice at Darlinghurst and St Joseph’s Hospital at Auburn).
9. HEALTH RECORDS AND INFORMATION

2 PRIVACY MANAGEMENT PLAN FRAMEWORK

2.1 PURPOSE OF PRIVACY MANAGEMENT PLAN

This Privacy Management Plan (the plan) is intended to provide information about how personal information is managed within NSW Health in accordance with the Privacy and Personal Information Protection Act 1998 (NSW) (PPIP Act). The plan provides information about how a person can access and amend their personal information and how possible breaches of privacy in relation to personal information will be managed by NSW Health.

This plan explains how personal information is managed by NSW Health in accordance with the PPIP Act. It must be read in conjunction with the Privacy Manual for Health Information which comprehensively sets out how NSW Health manages health information under the Health Records and Information Privacy Act 2002 (NSW) (HRIP Act).

The plan aims to:

- Meet the requirements of s33 of the PPIP Act
- Demonstrate to members of the public how we meet our obligations under the PPIP Act
- Provide staff information to enable them to manage personal information appropriately and in accordance with the law
- Illustrate our commitment to respecting the privacy rights of staff and members of the public.

2.2 KEY DEFINITIONS

**Chief Executive** – the Chief Executive of a Local Health District, Specialty Network, statutory health corporation, unit of the Health Administration Corporation, or the person responsible to the governing body of an affiliated health organisation for management of its recognised establishment and services.

**Collection** (of personal information) - the way the information is acquired by NSW Health. This can include a written form, a verbal conversation, an online form or a photographic image.

**Disclosure** (of personal information) - means providing personal information to an individual or entity outside of NSW Health.

**Health information** – personal information or an opinion about a person’s physical or mental health or disability, or a person’s express wishes about the future provision of health services for themselves or a health service provided, or to be provided to a person. Any personal information collected for the purposes of the provision of health care will generally be ‘health information, and will also include personal information that is not itself health-related but is collected in connection with providing health services.

**Investigative agency** – any of the following: the NSW Ombudsman’s office, the Independent Commission against Corruption (ICAC) or the ICAC inspector, the Police Integrity Commission (PIC) or the PIC Inspector, the Health Care Complaints Commission, the Office of the Legal Services Commissioner.
9. HEALTH RECORDS AND INFORMATION

Law enforcement agency – the NSW Police Force, the NSW Crime Commission, the Australian Federal Police, the Australian Crime Commission, the Director of Public Prosecutions, Department of Corrective Services, Department of Juvenile Justice, Office of the Sherriff of NSW.

NSW Health – refers collectively to NSW health organisations.

NSW Health organisation – For the purposes of this policy directive, a public health organisation as defined under the Health Services Act 1997, NSW Ambulance, Health Infrastructure, HealthShare NSW, eHealth NSW, NSW Health Pathology, any other administrative unit of the Health Administration Corporation and all organisations under the control and direction of the Minister for Health or the Minister for Mental Health or the Secretary, NSW Health.

Personal Information - information or an opinion (including information or an opinion forming part of a database and whether or not recorded in a material form) about an individual whose identity is apparent or can reasonably be ascertained from the information or opinion. This includes such things as an individual’s fingerprints, retina prints, body samples or genetic characteristics. Exclusions to the definition of personal information are contained in s4 (3) of the PPIP Act and includes Health Information.

Public register – a register of personal information that is required by law to be, or is made, publicly available or open to public inspection (whether or not on payment of a fee).

Privacy obligations – the information privacy principles and any exemptions to those principles that apply to NSW Health.

Staff - any person working in a casual, temporary or permanent capacity in NSW Health, including volunteers, consultants, contractors, board members and any person performing a public official function whose conduct could be investigated by an investigating authority.

* Additional relevant definitions may be found in the Privacy Manual for Health (s1)

2.3 LEGISLATIVE AND POLICY FRAMEWORK

2.3.1 RELEVANT LEGISLATION

Privacy Legislation

- Privacy and Personal Information Protection Act 1998 NSW (PPIP Act)
- Privacy and Personal Information Protection Regulation 1998
- Health Records and Information Privacy Act 2002 NSW (HRIP Act)
- Health Records and Information Privacy Regulation 2006. Other

Legislation

Other legislation that may also affect the application of the privacy principles includes, but is not limited to:

- Criminal Records Act 1991 (NSW)
- Government Information (Public Access) Act 2009 (NSW)
9. HEALTH RECORDS AND INFORMATION

- State Records Act 1998 (NSW)
- Workplace Surveillance Act 2005 (NSW)
- Surveillance Devices Act 2007 (NSW)
- Ombudsman Act 1974 (NSW)
- Public Interest Disclosures Act 1994 (NSW)
- Telecommunications Act 1997

2.3.2 RELEVANT POLICY DOCUMENTS NSW HEALTH INTERNAL REVIEW GUIDELINES

The NSW Health Internal Review Guidelines (GL2006_007) provides guidance and information about the internal review process at NSW Health organisations.

Privacy Manual for Health Information

The Privacy Manual for Health Information is a comprehensive policy document, which governs the management of health information (as opposed to general personal information), as required by the Health Records and Information Privacy Act 2002. The Privacy Manual for Health Information is the primary privacy policy for NSW Health, given that the core business of NSW Health involves managing a large volume of health information.

3 WHAT THIS PLAN COVERS

S33 (2) of the PPIP Act sets out the requirements of a privacy management plan. The plan must include:

- Information about NSW Health policies and practice to ensure compliance with the PPIP Act
- How staff are made aware of these policies and practices
- Internal review procedures for NSW Health
- Anything else we consider relevant to the plan.

For most organisations, the plan includes information about compliance with the HRIP Act, however for NSW Health, this information is covered in the Privacy Manual for Health.

3.1 PERSONAL INFORMATION

Personal information is defined in s4 of the PPIP Act. Essentially, personal information is information or an opinion that identifies, or could reasonably identify, an individual. Examples of personal information include a person’s name, bank account details, a photograph or a video. Personal information also includes such things as an individual’s fingerprints, retina prints, voice recordings, body samples or genetic characteristics.
A person’s identity may be apparent where neither the name nor a photograph is involved, but the information about the person is such that it could not be referring to anyone else.

Section 4(3) excludes certain types of information from the definition. The most significant exceptions are:

- Information contained in a publicly available publication
- Information about an individual’s suitability for public sector employment
- Information about people who have been dead for more than 30 years
- Information about an individual contained in a public interest disclosure
- A number of exceptions relating to law enforcement investigations.

Section 4A excludes health information from the definition of personal information.

Some examples of information which is NOT personal information include: recruitment records and referee reports, as well as information that is published or available on the internet. The PPIP Act also excludes certain information that may be held in connection with some activities authorised under different legislation.

For detailed information about information excluded from the definition of personal information, consult ss 4(3) and 4A of PPIPA or contact the Privacy Contact Officer for your NSW Health organisation.

### 3.2 HEALTH INFORMATION

For guidance on the management of health information in NSW Health, refer to the Privacy Manual for Health Information.

Health information is excluded from the PPIP Act, and instead governed by the Health Records and Information Privacy (HRIP) Act 2002. It is defined in section 6 of the HRIP Act to include personal information or an opinion about:

- A person’s physical or mental health or disability
- A person’s express wishes about the future provision of health services for themselves
- A health service provided, or to be provided, to a person.

There are 15 Health Privacy Principles set out in Schedule 1 of the HRIP Act which govern health information.

### 4 PERSONAL INFORMATION HELD BY NSW HEALTH

The functions of NSW Health are established primarily under the Health Services Act 1997 and the Health Administration Act 1982. Given the diversity of functions across NSW Health organisations, the range of personal information held is wide-ranging. Some of the types of personal information held by NSW Health are discussed below.
9. HEALTH RECORDS AND INFORMATION

4.1 PERSONAL INFORMATION PROVIDED DURING ENQUIRIES

Across NSW Health, staff receive many different types of enquiries about issues in NSW Health. Enquiries are made by phone, email, in writing and in person.

People may provide NSW Health staff with personal information when they contact a NSW Health organisation with an inquiry. This could include names, contact details, opinions, health conditions and illnesses, family relationships, housing or tenancy information, work history, education and criminal history.

NSW Health decides what level of personal information is appropriate to be collected during enquiries on a case-by-case basis. Sufficient information will be collected to accurately record the management of the matter. In the majority of cases, the information will be health information, which is governed by the HRIP Act and the Privacy Manual for Health. Personal information will be collected, used and stored in compliance with the PPIP Act.

4.2 EMPLOYEE RECORDS

For various reasons, such as leave management, workplace health and safety and operational requirements, NSW Health keeps staff records including:

- Documents related to the recruitment process
- Payroll, attendance and leave records
- Banking details and tax file numbers
- Training records
- Workers compensation records
- Workplace health and safety records
- Records of gender, ethnicity and disability of employees for equal opportunity reporting purposes
- Medical conditions and illnesses
- Next of kin
- Secondary employment
- Conflicts of interests.

This information is collected directly from employees and will be managed in accordance with the provisions of the PPIP Act.

4.3 BUSINESS RECORDS

NSW Health maintains business records which contain personal information including contact details for public officials in other government entities, as well as other third party organisations. Contracts with other government and third party entities and individuals may include personal information. This information is managed in accordance with the provisions of the PPIP
9. HEALTH RECORDS AND INFORMATION

4.4 INFORMATION MANAGEMENT SYSTEMS

NSW Health organisations use a variety of information management systems including paper based filing systems and electronic records forming part of a secure computerised database.

We follow strict rules in storing personal information in all its formats in order to protect personal information from unauthorised access, loss or other misuse.

5 HOW TO ACCESS AND AMEND PERSONAL INFORMATION

Individuals have the right to access personal information held by NSW Health. This can be accomplished in a number of ways.

5.1 INFORMAL REQUEST

A person wanting to access or amend their own personal or health information can make an informal request to the staff member or team managing their information. This request does not need to be made in writing, but a formal application may be required. If a person is unhappy with the outcome of their informal request, they can make a formal application.

5.2 FORMAL APPLICATION

Each NSW Health organisation has a privacy contact officer. A person can make a formal application to the manager or unit holding the information. More complex requests relating to personal information may be made directly to the privacy contact officer for the relevant NSW Health organisation by email, fax or post. The application should:

- Include the person’s name and contact details
- State whether the person is making the application under the PPIP Act or the HRIP Act
- Explain what personal or health information the person wants to access or amend
- Explain how the person wants to access or amend it.

The person managing the request will aim to respond to the formal application within 20 working days. They will contact the applicant to advise how long the request is likely to take, particularly if it may take longer than expected.

If the applicant thinks NSW Health is taking too long to deal with the request, we encourage them to contact the privacy contact officer and request an update and time frame for the matter to be dealt with. If they remain unsatisfied, they have the right to seek an internal review or make a complaint directly to the information and privacy commissioner.

5.3 LIMITS AND REASONS FOR REFUSAL

We cannot charge people to lodge their request for access. But we can charge reasonable fees for copying or inspection, if we tell people what the fees are up-front.
9. HEALTH RECORDS AND INFORMATION

If there is personal information about other individuals or confidential information about third parties in any records identified by our searches, then the request will be more complex to manage. Requests of this nature ought to be referred to the privacy contact officer. This will ensure that the privacy and confidentiality of other people/third parties can also be properly considered.

6 Request for An Internal Review

6.1 Internal Review by NSW Health

If a person considers that NSW Health has breached the PPIP act or HRIP act relating to their personal or health information, they may request an internal review under the provisions of the PPIP Act. A person may not request an internal review in relation to a breach of another person’s privacy unless they are an authorised representative of the person whose privacy is alleged to have been breached.

Under s53 (3) of the PPIP Act, an application for an internal review must:

- Be in writing
- Be addressed to the appropriate NSW Health Organisation
- Specify an address within Australia to which a notice can be sent
- Be lodged within 6 months from when the applicant became aware of the conduct the subject of the application (however, NSW Health may consider a late application for internal review).

6.2 Internal Review Process

An application for an internal review will be dealt with in accordance with the Internal Review Guidelines. (GL 2006_007). The review will be dealt with by the privacy contact officer for the NSW Health Organisation.

The review will be completed as soon as is reasonably practical, and within 60 days from the date the application is received.

Internal reviews follow the process set out in the Office of the Privacy Commissioner NSW’s internal review checklist.

When the internal review is completed, the Privacy Contact Officer will notify the applicant in writing (within 14 days) of:

- The findings of the review
- The reasons for the finding, described in terms of the IPPs and / or HPPs
- Any action we propose to take
- The reasons for the proposed action (or no action), and
- The applicant’s entitlement to have the findings and the reasons for the findings reviewed by the NSW Civil and Administrative Tribunal.
9. HEALTH RECORDS AND INFORMATION

We will also send a copy of that letter to the Privacy Commissioner. Statistical information about the number of internal reviews conducted must be maintained for the Department’s Annual Report.

6.3 EXTERNAL REVIEW BY THE NSW CIVIL AND ADMINISTRATIVE TRIBUNAL

People may apply to the NSW Civil and Administrative Tribunal (NCAT) for an external review of the conduct which was the subject of their earlier internal review application. A person must seek an internal review before they have the right to seek an external review. Generally, a person has 28 days from completion of the internal review to seek an external review.

The NCAT has the power to make binding decisions on an external review. For more information on how to request an external review please contact the NCAT. The NCAT does not provide legal advice, however their website has general information about the process of seeking an external review.

7 HOW THE INFORMATION PRIVACY PRINCIPLES APPLY

The Privacy and Information Protection Act 1998 sets out 12 Information Protection Principles (IPPs). NSW Health must follow these principles for collecting, storing, using and disclosing personal information. Information about the application of Health Privacy Principles (HPPs) in relation to personal health information can be found in the Privacy Manual for Health Information.

This section sets out the NSW Health approach to these principles. Specific applications of these principles should be built into NSW Health policies and procedures relating to collection, storage, use or disclosure of personal or health information.

There are a number of exemptions to these IPPs, which are discussed in below at s8

COLLECTION

7.1 LAWFUL

NSW Health organisations will only collect personal information for a lawful purpose, which is directly related to our functions or activities and necessary for that purpose.

7.2 DIRECT

NSW Health organisation will only collect personal information directly from the person concerned, unless they have authorised collection from someone else or the person is under the age of 16 and the information has been provided by a parent or guardian.

7.3 OPEN

NSW Health organisations inform people why their personal information is being collected, what it will be used for, and to whom it will be disclosed. We tell people how they can access and amend their personal information and the consequences if they decide not to give their personal information to us.
9. HEALTH RECORDS AND INFORMATION

7.4 RELEVANT

NSW Health organisations ensure that personal information is relevant, accurate, is not excessive and does not unreasonably intrude into the personal affairs of people.

STORAGE

7.5 SECURE

NSW Health organisations store personal information securely, keep it no longer than necessary and destroy it appropriately. We protect personal information from unauthorised access, use or disclosure.

ACCESS AND ACCURACY

7.6 TRANSPLANT

NSW Health organisations are transparent about the personal information we store about people, why we use the information and about the right to access and amend it.

7.7 ACCESSIBLE

NSW Health organisations allow people to access their own personal information without unreasonable delay or expense.

7.8 CORRECT

NSW Health organisations allow people to update, correct or amend their personal information where necessary.

USE

7.9 ACCURATE

NSW Health organisations make sure that personal information is relevant, accurate and up to date before using it.

7.10 LIMITED

NSW Health organisations only use personal information for the purpose we collected it for, unless the person consents to us using it for an unrelated purpose.
9. HEALTH RECORDS AND INFORMATION

DISCLOSURE

7.11 RESTRICTED

NSW Health organisations only disclose personal information with a person’s consent, unless they were already informed that the information would be disclosed, if disclosure is directly related to the purpose for which the information was collected and there is no reason to believe the person would object, or the person has been made aware that information of that kind is usually disclosed, or if disclosure is necessary to prevent a serious and imminent threat to any persons health and safety.

7.12 SAFEGUARDED

NSW Health organisations will take particular care not to disclose sensitive personal information without a person’s consent. For example, information about ethnic or racial origin, political opinions, religious or philosophical beliefs, sexual activities or trade union membership. We will only disclose sensitive information without consent in order to deal with a serious or imminent threat to any person’s health and safety.

8 EXEMPTIONS

Some of the exemptions to the IPPs are discussed below. Different exemptions may apply between an IPP and its equivalent HPP.

When considering whether an exemption applies, it is therefore important to determine if the information is simply personal or includes health information. If the information is health information, it is necessary to refer to the Privacy Manual for Health Information for further guidance.

When considering whether an exemption may apply to a particular situation, the wording of the exemptions contained within PPIP Act should be consulted, and guidance sought from the Privacy Contact Officer. Ss 22 – 28 of the PPIP Act detail specific exemptions to the IPPs. Common exemptions include unsolicited information (which contains personal information), personal information collected before 1 July 2000, health information collected before 1 September 2004, personal information used for law enforcement or investigative purposes, or to lessen or prevent a serious threat to public health or safety.

Under s25 of the PPIP Act, NSW Health may not be required to comply with IPP’s if lawfully authorised or required to do so.

Some relevant exemptions where compliance with the IPPs may not be required include:

COLLECTION:

• When collecting information in connection with proceedings (whether or not actually commenced) before any court or tribunal

• When collecting information during investigation or management of a complaint or a matter that could be made or referred to an investigative agency, or which has been referred to NSW Health by an investigative agency

• When compliance with the IPPs in relation to collection would prejudice the interests of the individual to whom the information relates.
9. HEALTH RECORDS AND INFORMATION

USE:

- When the use of the information for a purpose other than the purpose for which it was collected is reasonably necessary for law enforcement purposes

- When the use of the information is reasonably necessary to enable investigation or management of a complaint which could be made or referred to an investigative agency, or which has been referred to NSW Health by an investigative agency

DISCLOSURE:

- When the individual to whom the information relates has expressly consented to the agency not complying with the IPPs in relation to disclosure

- When the information is disclosed by a NSW Health organisation to another public sector agency under the administration of the Minister for Health if the disclosure is for the purposes of informing that Minister about any matter within that administration

- When the information is disclosed by NSW Health to any public sector agency under the administration of the Premier if the disclosure is for the purposes of informing the Premier about any matter.

- When the disclosure is made in connection with proceedings for an offence, or for law enforcement purposes

- When the disclosure is made to a law enforcement agency for the purposes of ascertaining the whereabouts of a person who has been reported missing.

- Where sensitive information is required to be disclosed for law enforcement purposes where there are grounds to believe an offence may have been, or may be committed

- When the disclosure is to an investigative agency.

8.1 PUBLIC REGISTERS

The PPIP Act governs how NSW Health manages personal information in public registers (Part 6 – Public Registers).

Under the legislation, an agency responsible for keeping a public register must not disclose any personal information kept in the register unless satisfied that it is to be used for a purpose relating to the purpose of the register, or the Act under which the register is kept. A person applying to inspect information in the public register may be required to provide a statutory declaration as to the intended use of any information obtained.

A person whose information is contained in a public register, may request the agency responsible for the register to have their information removed from public availability on the register and not disclosed to the public.
In most cases, personal information held by NSW Health is not publicly available. However, there are some circumstances where personal information may be held on registers by NSW Health which are available to the public. For example, the Tobacco Retailer Notification Scheme, which requires Tobacco retailers to provide information including their trading name and business address and the name and address of the owners and directors of the business.

A person who wishes to access personal information contained in a public register managed by NSW Health should contact the relevant business unit responsible for the register to discuss their request.

8.2 PUBLIC INTEREST DIRECTIONS

Under section 41 of the PPIP Act, the Privacy Commissioner has made Public interest directions to waive or modify the requirement for a public sector agency to comply with an IPP. Details about Public interest directions can be found at the Information and Privacy Commission website (www.ipc.nsw.gov.au).

Public interest directions may permit NSW Health:

- To be exempt from some principles in relation to the conduct of investigations
- To be exempt from some principles when transferring enquiries to another NSW public sector agency
- To disclose personal information collected for research purposes.

Public interest directions which may be relevant to NSW health organisations include:

**Direction on Information Transfers between Public Sector Agencies**

This Direction covers most NSW state agencies. It was originally made on 30 June 2000. On 19 June 2015 the Privacy Commissioner renewed this Direction to commence from 1 July 2015 to 31 December 2015, or until legislative amendments are made to incorporate this Direction, whichever is earlier.

**Direction on the Collection of Personal Information about Third parties by NSW Public Sector (Human Services) Agencies from their clients**

This Direction replaced the Direction on the Better Service Delivery Program. It commenced on 1 July 2003 and affects some health, education, welfare, housing, juvenile justice and Aboriginal affairs agencies. On 19 June 2015 the Privacy Commissioner renewed this Direction to commence from 1 July 2015 to 31 December 2015, or until legislative amendments are made to incorporate this Direction, whichever is earlier.

**Direction on Disclosures of Information by Public Sector Agencies for Research Purposes**

This Direction affects most NSW state agencies. It was originally made on 28 September 2000. On 19 June 2015 the Privacy Commissioner renewed this Direction to commence from 1 July 2015 to 31 December 2015, or until legislative amendments are made to incorporate this Direction, whichever is earlier.
9. HEALTH RECORDS AND INFORMATION

Direction on Processing of Personal Information by Public Sector Agencies in relation to their Investigative Functions

This Direction covers most NSW state agencies. It was originally made on 30 June 2000. On 19 June 2015 the Privacy Commissioner renewed this Direction to commence from 1 July 2015 to 31 December 2015, or until legislative amendments are made to incorporate this Direction, whichever is earlier.

Direction on Disclosures of Information by the New South Wales Public Sector to the National Coronial Information System (NCIS)

This Direction affects some health and justice agencies. On 19 June 2015 the Privacy Commissioner renewed this Direction to commence from 1 July 2015 to 31 December 2015, or until legislative amendments are made to incorporate this Direction, whichever is earlier.

9 STRATEGIES FOR IMPLEMENTATION OF PRIVACY MANAGEMENT PLAN

Effective privacy governance can improve business productivity and help to develop more efficient business processes. Effective privacy governance assists NSW Health to manage both the risk of a privacy breach and our response should one occur.

Each NSW Health Organisation will develop tailored strategies suited to the organisation to assist compliance by the Health Organisation with the requirements of the PPIP Act.

NSW Health develops policies and procedure documents to assist NSW Health Organisations to comply with the IPPs and this plan.

When staff have a role that requires access to personal information, managers have a responsibility to ensure that these staff are aware of their privacy obligations in conducting their work.

9.1 STAFF AWARENESS

Strategies adopted by NSW Health organisations to promote general privacy awareness within NSW Health organisations may include:

- Staff are provided with access to this Privacy Management Plan and relevant resources to assists with education on privacy obligations.
- New staff members receive privacy training as part of their orientation process (this mandatory training requirement is set out in the Privacy Manual for Health Information)
- Privacy issues are reported annually in the Annual report.
- Privacy issues are identified and addressed during development and implementation of new systems
- Privacy notices are prepared as a standard inclusion in all projects where personal information will be collected
- Provision of regular privacy training and highlighting of privacy obligations (for example during Privacy Awareness Week)
9. HEALTH RECORDS AND INFORMATION

- Liaison with Privacy Contact officers at their organisation or the NSW Ministry of Health where issues or queries arise that cannot be resolved locally
- Prompt referral of requests for privacy internal review (and complaints) to the privacy contact officer at the organisation
- Proactive reporting of any identified privacy breaches or risks to the privacy contact officer.

9.2 PUBLIC AWARENESS

Strategies adopted by NSW Health organisations to promote public awareness may include:

- Including links to the privacy management plan and other resources on NSW Health organisation websites
- Providing copies of the plan to members of the public on request.
- Referring to the privacy management plan in privacy notices
- Telling people about the plan when answering queries about personal information
- Referring enquiries to the privacy contact officer for the NSW Health organisation where appropriate.

10 LIST OF ATTACHMENTS

1. Implementation Checklist
2. Template Confidentiality Undertaking
3. Privacy Information Sheet for Personal Information
## 9. HEALTH RECORDS AND INFORMATION

### Attachment 1: Implementation checklist

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Attachment 2: Template Confidentiality Undertaking

I, ................................................................. (name), understand that while I am employed by the ................................................................. (name of health organisation) I will have access to personal health information collected from patients / clients that is protected by privacy law. I undertake not to knowingly access any personal information, (such as information contained in a patient’s health record, including in an electronic health record/ XXXX data collection(s)/ XXXX data warehouse) unless such information is essential for me to properly and efficiently perform my duties.

I recognise and accept that my access to, holding and use of this information is subject to the Information privacy Principles contained in the Privacy and Personal Information Protection Act 1998 (NSW) Health Privacy Principles contained in the NSW Health Records and Information Privacy Act 2002 (NSW) (copy of Information and Health Privacy Principles attached). In order to fulfil this undertaking, I will not divulge any personal information regarding individual persons, except as allowed by the legislation.

I undertake to comply with other information privacy and security procedures as stipulated by NSW Health policies* in relation to any personal information that I access in the course of my duties. In order to fulfil this undertaking I will ensure that, so far as is within my control, such information, whether in the form of paper documents, computerised data or in any other form, cannot be viewed by unauthorised persons, and that the information is stored in a secure and orderly manner that prevents unauthorised access.

I further undertake to inform (my supervisor/ title of relevant officer) immediately if I become aware of any breach of privacy or security relating to the information that I, or other staff, access in the course of my duties.

Signed Witnessed

.................................................................  .................................................................
(name) (name)

.................................................................  .................................................................
(signature) (signature)

.................................................................  .................................................................
(position) (position)

.................................................................  .................................................................
Date Date

* Relevant NSW Health policy directives include:
- NSW Health Privacy Manual for Health Information
- Privacy Management Plan for NSW Health
- Data Collections - Process for Approval of New or Modified
- Electronic Information Security Policy – NSW Health
- NSW State Digital Information Security Policy

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Attachment 3: Privacy Information Sheet for Personal Information

NSW Health

NSW Health is committed to treating your personal information in accordance with privacy law.

This leaflet explains how and why we collect personal information about you, how you can access your information and how your information may be used within the NSW public health service or disclosed to other parties.

The Privacy and Personal Information Protection Act 1998

The Privacy and Personal Information Protection Act (PPIP Act) explains how NSW State and local government agencies should manage personal information.

The PPIP Act offers the people of NSW enforceable privacy rights. It gives you the opportunity to make a complaint about a public sector agency if you feel it has misused your personal information.

What do ‘Privacy’ and ‘Personal Information’ mean?

There is no simple definition of privacy. It can mean the right to a sense of personal freedom, the right to have information about oneself used fairly, and a ‘right to be left alone’. Many people confuse privacy with secrecy or confidentiality, but privacy is broader than both of these.

The fair use of ‘personal information’ is just one aspect of this broader concept of ‘privacy’.

*Personal information is any information or opinion about an identifiable person. This includes records containing your name, address, sex, etc., or physical information like fingerprints, body samples or your DNA.*

The 12 Rules of Personal Information Protection

The Information Protection Principles (IPPs) are the backbone of the Act, and all NSW government agencies must adhere to them unless they have a lawful exemption. They are summarised here:

Collection

1. **Lawful**
   When NSW Health collects your personal information, the information must be collected for a lawful purpose. It must also be directly related to the agency’s activities and necessary for that purpose.

2. **Direct**
   Your information must be collected directly from you, unless you have given your consent otherwise.

3. **Open**
   You must be informed that the information is being collected, why it is being collected and who will be storing and using it. We should also tell you how you can see and correct this information.

4. **Relevant**
   NSW Health must ensure that the information is relevant, accurate, up-to-date and not excessive. The collection should not unreasonably intrude into your personal affairs.
9. HEALTH RECORDS AND INFORMATION

Storage

5. Secure
Your information must be stored securely, not kept any longer than necessary, and disposed of appropriately. It should be protected from unauthorised access, use or disclosure.

Access

6. Transparent
The agency must provide you with enough details about what personal information they are storing, why they are storing it and what rights you have to access it.

7. Accessible
The agency must allow you to access your personal information without unreasonable delay and expense.

8. Correct
The agency must allow you to update, correct or amend your personal information where necessary.

Use

9. Accurate
NSW Health must make sure that your information is accurate before using it.

10. Limited
NSW Health can only use your information for the purpose for which it was collected, for a directly related purpose, or for a purpose to which you have given your consent. It can also be used in order to deal with a serious and imminent threat to any person’s health or safety.

Disclosure

11. Restricted
NSW Health can only disclose your information with your consent or if you were told at the time we collected it from you that we would do so, or if it is for a related purpose and we don’t think that you would object. Your information can also be used without your consent in order to deal with a serious and imminent threat to any person’s health or safety.

12. Safeguarded
NSW Health can only disclose your sensitive personal information without your consent in order to deal with a serious and imminent threat to any person’s health or safety. Sensitive information may be about your ethnic or racial origin, political opinions, religious or philosophical beliefs, health or sexual activities or trade union membership.

What to do if you think your privacy has been breached

If your complaint is about your personal information, and a NSW Health organisation you should normally seek an Internal Review.

An Internal Review is an internal investigation that NSW Health is required to conduct when you make a privacy complaint.

Contact us

If you have questions or a complaint about the privacy of your personal information, please contact the Privacy Contact Officer for the relevant NSW Health Organisation.

The following link provides the names of the Privacy Contact Officers for NSW Health:

PHOTO AND VIDEO IMAGING IN CASES OF SUSPECTED CHILD SEXUAL ABUSE, PHYSICAL ABUSE AND NEGLECT (PD2015_047)

PURPOSE

The purpose of this Policy Directive is to:

- Define the NSW Health requirements and minimum standards for the use and management of photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect
- Guide NSW Health staff when capturing, storing and managing images for the purpose of documenting health and clinical features and informing possible future judicial proceedings that require medical opinion.

MANDATORY REQUIREMENTS

This policy requires that:

- The immediate and longer-term physical and emotional needs of the child and their parent(s) / guardian(s) are identified and taken into account when considering photo and video imaging.
- Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and limited other relevant purposes, and is not excessive or unreasonably intrusive.
- Imaging is only captured where informed consent is sought and obtained for each purpose for which it may be used.
- Capture, recording and storage of images is limited to LHD / SCHN owned memory devices.
- Images are stored securely and are stored separately from the principal health care record, to maintain patient privacy.
- Limited access is provided to images, to maintain patient privacy.
- Capture, use and management of photo and video images in cases of suspected child abuse is conducted in accordance this Policy Directive, in conjunction with:  
  Child Wellbeing and Child protection Policies and Procedures for NSW Health (PD_2013_007)
  Current Standards and Practice Guidelines for NSW Health Sexual Assault Services

IMPLEMENTATION

Chief Executives are responsible and accountable for:

- Establishing mechanisms to ensure the directives and requirements of this policy are applied, achieved and sustained
- Ensuring that NSW Health staff understand and are aware of their obligations in relation to this policy and related policies and procedures
- Ensuring resources are available to deliver and meet the directives and requirements of this policy
- Ensuring that NSW Health staff are trained to operationalise and implement this Policy
- Ensuring NSW Health staff are advised that compliance with this policy is part of their patient / client care responsibilities
- Ensuring that procedures for capture, storage, access and security are subject to risk analysis reassessment over time.

Facility managers are responsible for:

- Ensuring the requirements of this policy directive are disseminated and implemented in their service / department / hospital
- Establishing local validated processes for image preparation, capture, processing, storage, transmission, archiving, retention and disposal
- Monitoring implementation and compliance with this policy.

NSW Health workers are responsible for:

- Implementing and complying with the directives and requirements of this policy
- Ensuring that their knowledge of consent, privacy and documentation management processes is maintained, consistent with the requirements of this policy directive.

1 INTRODUCTION

1.1 Rationale

Clinical evaluation of a child or young person who is suspected of having been abused or neglected involves a holistic assessment of their physical needs, psychosocial needs, medical history, and any social or familial risk factors. NSW Health practitioners are required to document and report suspicion of harm and may use clinical photo and video imaging to supplement and enhance the detail in written notes and diagrams. Imaging can assist the physician to review the facts associated with clinical examination and history as part of their clinical diagnosis: in an attempt to ensure the accuracy of a diagnosis this may include professional peer review. Diagnoses in cases of suspected child abuse have an impact on the safety, welfare and wellbeing of a child or young person. Clinical photo and video imaging is an important tool in the achievement of accurate clinical conclusions to support the needs of children and young people.

This policy defines the NSW Health requirements and minimum standards for the use and management of photo and video imaging in cases of suspected child sexual abuse, physical abuse and neglect. It will guide NSW Health workers to know what actions to take when capturing, storing and managing images for the purpose of documenting health and clinical features, and informing possible future judicial proceedings that require medical opinion. A development group was convened to inform the development of this policy. Details of membership appear at Appendix 5.5.

1.2 Who this policy applies to

This policy applies to NSW Health workers in Local Health Districts (LHDs) and the Sydney Children’s Hospitals Network (SCHN) who are employed or contracted to capture or manage imaging in cases of suspected child abuse, including:
Medical practitioners or other specialist staff undertaking medical and forensic examinations of children and young people aged under 18 who are suspected of having been sexually abused, physically abused or neglected

Psychosocial, sexual assault and child protection practitioners, coordinators and managers

Medical photographers, Joint Investigation Response Teams (JIRTs), Aboriginal health services and other clinical and allied health staff

Managers or officers who support the capture, viewing, accessibility, transmission or management of photo and video imaging. This includes data custodians, IT technical and support staff, health information managers and staff in medical records departments.

The policy may also be of interest to:

- NSW Health interagency child protection partners
- Those who work in the wider criminal justice setting and child health and advocacy settings
- Networks that support children and young people who have experienced sexual abuse, physical abuse or neglect and their non-offending family members
- Those who work in private health settings who wish to adopt minimum standards for the use and management of photo and video imaging in cases of suspected child abuse.

1.2.1 Exclusions

This policy does not apply to:

- Sexual abuse examinations utilising clinical colposcopic equipment without capture of imaging
- Photo and video imaging taken in other types of medical examinations (i.e. those that do not relate to suspected child abuse)
- Medical imaging such as Magnetic Resonance Images (MRI), Computerised Tomography (CT) scans, skeletal surveys, radioisotope scans or post-mortem imaging.

1.3 Service users

Children or young people who use NSW Health services in relation to suspected sexual abuse, physical abuse and/or neglect and, depending on the age of a young person, this may include parent(s), carer(s) or guardian(s).

1.4 Context for practice

1.4.1 Interagency context

Medical and forensic examinations and associated photo and video imaging take place in the context of an interagency response to child protection. Interagency roles and responsibilities are outlined in the Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013, current standards and guidelines for NSW Health Sexual Assault Services and NSW Interagency Guidelines.

1.4.2 NSW Health context

The psychosocial and medical needs of a child or young person are a priority and need to be responded to appropriately. NSW Health’s role is to provide an integrated psychosocial and medical response to all suspected child abuse presentations including assessment, crisis intervention and counselling. The medical response will potentially include a medical and forensic examination.
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Medical and forensic examinations are critical to the crisis response required on presentation of: a child victim of sexual abuse to a Sexual Assault Service or Emergency Department; or a child with suspected physical abuse or neglect to a medical practitioner, Emergency Department, or other health service.

Related child protection and violence prevention, privacy, security and document management policies are listed in Appendices 5.1 to 5.4.

1.4.3 Clinical context

Clinical photography has assisted in the development of medical knowledge and skills within the NSW Health workforce over the last two decades, and aided the interpretation and evaluation of injuries, for the benefit of examiners and their patients. Medical and forensic assessment of children suspected of having been abused occurs within a framework that responds to the immediate psychosocial and medical needs of a child and their family – who are often traumatised and distressed.

This context includes:

- Identification of children at risk who require a medical and forensic assessment
- Recording of medical history and examination findings complemented by appropriate clinical photo or video imaging
- Forensic specimen collection where relevant (as in recent sexual abuse)
- Medical treatment of injuries or other sequelae of the abuse, such as the risk of exposure to sexually transmitted diseases or pregnancy
- Interpretation of clinical findings, with a reference to any allegation of abuse.

Anatomical diagrams are useful for recording certain features of an injury, such as the number of injuries, the type of injuries, their overall size and shape and the general location of the injuries on the body. It is difficult for a doctor to record adequately sufficient information for detailed medical and forensic assessment of many injuries with diagrams and words alone. Medical illustration is a specialised career. It takes both skill and time to produce an accurate and useful medical drawing. The extra detail provided by a photo or video record is of particular relevance when a medical and forensic examiner is asked to comment, sometime after the medical examination, on whether a particular account of accidental injury, provided by a caregiver, might reasonably account for the clinical findings.

Several advantages of photography can be summarised as below:

- Photo and video images allow review of injuries or other clinical findings, such as evidence of dermatological conditions or malnutrition, in a more comprehensive manner. Indeed there are many reasons why a child’s injuries may need to be reviewed. The original examining doctor may review photos when preparing an expert certificate and/or prior to appearing in court. Photo and video imaging can assist the examining doctor when they review the patient for ongoing clinical care, or if the police provide additional information and ask for a clinical opinion, in regards injury causation. Photo and video imaging is useful for gaining a second opinion by a senior colleague as to the significance of the injury and also helps determine if specialist referral is necessary. It may also prevent the need for a child to travel long distances to a specialist centre

- Imaging can overcome the difficulties presented by children and young people having to lie still for extended periods of time. Children can naturally wriggle and not want to lie still – especially if they have experienced sexual abuse or if there is injury or recent assault. This is particularly relevant to examining the ano-genital regions, especially in pre-pubertal females where there is a need to assess in detail the significance of small anatomical structures which may be a normal variant or an indicator of recent or earlier injury
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- Sexual abuse assessment in pre-pubertal children is complex. Paediatric genital anatomy is variable and accurate observation and interpretation is difficult. Forensic colposcopic imaging allows the examination to proceed with the knowledge that a child or young person can benefit from subsequent specialist review of the imaging as a record of the complex clinical findings.

- Photo and video imaging may enable the medical examiner to capture a clear picture of an area that was only exposed for a few seconds. The use of photo and video imaging can in many cases prevent the need for a child or young person to return for a repeat examination, or undergo examination under anaesthesia.

It is best practice in Forensic Medicine to rigorously separate the observation and recording of findings from the interpretation of those findings. Photo and video imaging enables the examiner to concentrate on observation, which is demanding, and then to later consider all possible causes.

1.4.4 Intimate images, sensitive evidence and retention

Photo and video imaging captured as part of a medical and/or forensic assessment may include intimate images.

Intimate images are defined as depicting the genitalia, anus or post-pubertal female breast (Faculty of Forensic & Legal Medicine, 2014) and may also include other parts of the body, such as the buttocks or chest of a pre-pubertal child.

These images are considered as 'sensitive evidence' under the Criminal Procedure Act 1986 (Section 281B). Where they are held by the NSW Police Force and Office of the Director of Public Prosecutions (ODPP) access to them is restricted. These restrictions do not extend to images held by NSW Health. Where a subpoena has been validly lodged, the court is not obliged to restrict access to intimate images held by NSW Health.

In accordance with health care record retention policies, once an image is captured as a medical record it can be subpoenaed, shown in court and remains on a medical record file for at least 30 years (NSW Government General Retention and Disposal Authority policy, 2004, revised 2011).

2 NSW HEALTH MINIMUM STANDARDS

When use of photo and video imaging is being considered during medical and forensic examinations in cases of suspected child sexual abuse, physical abuse and neglect, NSW Health will ensure that:

1. The immediate and longer-term physical and emotional needs of the child and their parent(s)/guardian(s) are identified and taken into account. (Section 2.1)

2. Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and other directly related purposes, and is not excessive or unreasonably intrusive. (Section 2.2)

3. Imaging is only captured where informed consent is sought and obtained for the specific purposes for which it may be used. (Section 2.3)

4. There are standardised procedures for capturing and documenting images to reduce variation across statewide services. (Section 2.4)

5. Capture, recording and storage of images is limited to LHD/SCHN owned memory devices. (Section 2.5)

6. Images are stored securely and separately from the principal health care record, to maintain patient privacy. (Section 2.6)

7. Restricted access is provided to images, to maintain patient privacy. (Section 2.7)

8. The integrity of images is maintained in the longer-term. (Section 2.8)
9. HEALTH RECORDS AND INFORMATION

2.1 Physical and emotional needs of the child or young person

Standard: The immediate and longer-term physical and emotional needs of the child and their parent(s)/guardian(s) are identified and taken into account when considering photo and video imaging.

In accordance with the Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013 and current standards and guidelines for NSW Health Sexual Assault Services:

- In cases of suspected physical abuse and neglect, optimally, assessment should be conducted by the medical officer with a social worker or other health professional colleague, e.g. a nurse, present to facilitate a holistic assessment (Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014).

- In cases of suspected sexual assault a joint response by the medical practitioner and counsellor from the Sexual Assault Service or Child Protection Unit provides the professional response required in these circumstances (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).

When deciding whether and how to capture images in this context, NSW Health workers must:

- Identify and take into account:
  - Factors arising from the life circumstances of the child or young person, their psychosocial development, vulnerability to particular risks and their linguistic, cultural and religious needs
  - The circumstances in which the child or young person was alleged to have been assaulted, abused or neglected
  - The need for an appreciation and understanding of Aboriginal people and communities’ inter-generational trauma legacies, the impact of power dynamics, the importance for understanding an Indigenous world-view, including cultural practices and protocols, the multiple and inter-related factors that contribute to the poorer health status of Aboriginal people, and the limitations of Western approaches in the assessment and treatment of trauma (see http://www.health.nsw.gov.au/aboriginal/pages/default.aspx).

- Ensure that children, young people and their parent(s)/guardian(s) have:
  - Access to health information relative to their wellbeing
  - The opportunity to participate in decision making
  - Access to an interpreter if required (see Interpreters – Standard procedures for working with Health Care Interpreters)
  - Access to an Aboriginal Health worker if desired. It is important to determine at the beginning the most appropriate person or people to communicate with in relation to the patient.

2.2 Purpose of imaging

Standard: Imaging is captured for the primary purpose of documenting a clinical finding for the health care record and other directly related purposes, and is not excessive or unreasonably intrusive.

In accordance with the NSW Health Privacy Manual for Health Information, 2015:

- The primary purpose for collecting photo and video imaging is to document a clinical finding for the medical record
- Imaging must be relevant to the purpose, not excessive, accurate, up to date, complete and must not be unreasonably intrusive
- Collection of photo and video imaging must supplement, not replace, other methods of documenting findings

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- Other directly related purposes for collecting photo and video imaging may include:
  - Peer review to assist diagnosis
  - Providing an aide-memoire for potential future legal proceedings
  - Teaching, research and quality improvement activities (sections 2.3.3, 2.7.1, 2.8 and 2.9).

LHDs/SCHN must ensure that images are only captured and used for relevant purposes in accordance with the NSW Health Privacy Manual for Health Information, 2015.

2.3 Seeking consent

Standard: Imaging is only captured where informed consent is sought and obtained for the specific purposes for which it may be used

LHDs/SCHN must ensure that NSW Health workers act in accordance with the NSW Health Consent to Medical Treatment - Patient Information policy, 2005 and the NSW Health Privacy Manual for Health Information, 2015 and comply with 2.3.1 to 2.3.3 below. Additional advice may be sought from NSW Health Legal and Regulatory Services.

2.3.1 Who should seek consent

An examiner must ensure that valid consent has been obtained. An examiner may ask another health care practitioner to seek consent, however the examiner maintains responsibility and may be held responsible in some circumstances if consent is not sought correctly (NSW Health Privacy Manual for Health Information, 2015).

2.3.2 Who can provide consent

Where a child or young person is less than 14 years of age, consent given by a parent or legal guardian is generally necessary. In some circumstances, consent can be given by the young person if he or she is considered by the treating health care practitioner to be mature enough, and if this would be appropriate in the circumstances. See ‘Gillick competence’ in the ‘Glossary’.

Where a young person is aged 14 or 15 they are generally able to consent, however an assessment of their maturity and understanding will still need to be made. Effort should be made to seek the consent of a parent or legal guardian unless the young person indicates a strong objection, and this is reasonable in the circumstances. Alternatively a parent or legal guardian can provide consent, however it would be exceptional to proceed on the basis of parent or guardian consent without the acquiescence of the young person aged 14 or 15.

Where the young person is 16 years of age or over they should generally be capable of consenting themselves (NSW Health Consent to Medical Treatment - Patient Information policy, 2005; NSW Heath Privacy Manual for Health Information, 2015).

For guidance on capacity to consent see the NSW Health Consent to Medical Treatment - Patient Information policy, 2005 and the NSW Heath Privacy Manual for Health Information, 2015.

Occasionally, a parent delegates their responsibility for consenting to medical treatment on behalf of their minor child, to another adult. This may occur in certain cultures, for example, in relation to Aboriginal children, where an extended family member, rather than the child’s mother or father, might be responsible for giving consent on their behalf. Where NSW Health workers require advice about who is able to provide consent for imaging they should consider the following options:
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- Refer to policy relating to:
  - The broader context of consent for the examination (NSW Health Consent to Medical Treatment - Patient Information policy, 2005; NSW Heath Privacy Manual for Health Information, 2015)
  - Child Wellbeing and Child protection Policies and Procedures for NSW Health, 2013 and current standards and guidelines for NSW Health Sexual Assault Services
- Contact NSW Health Legal and Regulatory Branch or NSW Kids and Families during business hours
- Contact the Guardianship Division of the NSW Civil and Administrative Tribunal.

2.3.3 The consent process

Where child sexual abuse, physical abuse or neglect is suspected and the capture and use of photo and video imaging is considered as part of a medical and forensic examination, informed consent must:

- Be sought in accordance with the NSW Health Consent to Medical Treatment - Patient Information policy, 2005 and the NSW Health Privacy Manual for Health Information, 2015 and
- Address consent for the capture of the image(s) and the separate specific purposes for which image(s) may be used.

The consent process must include:

- Patient/parent/guardian access to culturally appropriate information
- Seeking written informed consent for the capture of photos to document a clinical finding
- An explanation to the child or young person and/or their parent(s)/guardian(s)
  - What the procedure for capturing imaging will involve
  - That imaging may include ano-genital and breast/chest areas of the body and that they may opt to exclude imaging of these or other specific body areas
  - That any records of examinations, findings, photos, videos, samples/specimens taken in accordance with the consent/s given
    - Will be stored in accordance with NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Government General Retention and Disposal Authority policy, 2004 (revised 2011) for a minimum of 30 years
    - May be referred to another clinician for a second opinion and peer review
    - May be forwarded to the NSW Police Force, ODPP, and by the court under subpoena, including the judge, the jury, the defendant, counsel for both prosecution and defence and any other people whom the judge considers relevant
    - May be produced to comply with a request to a NSW Health organisation under the legislation set out in the Children and Young Persons (Care and Protection) Act 1998
    - May be forwarded to parties in Family Court proceedings under subpoena

For the purpose of this policy the consent process must also include:

- Seeking separate informed consent for the use of copies of photo and video imaging for a) teaching and/or b) approved research. All such copies must be de-identified, the teaching and research activities must be compliant with the NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies and research must be approved by a Research Ethics Committee (for example, see https://hrep.nhmrc.gov.au/certification/hrecs, http://www.ahmrc.org.au/ethics2.php and www.ipc.nsw.gov.au/statutory-guidelines-research-purposes-pdf).
9. **HEALTH RECORDS AND INFORMATION**

**Human Research Ethics Committees – Quality Improvement & Ethical Review: A Practice Guide for NSW** can help to determine whether an activity constitutes a research or quality improvement activity.

- An explanation that consent for the future use of images for a) teaching and/or b) approved research activities may be withdrawn by the person who provided consent or the person depicted in the image(s) once they are Gillick competent.

An interim NSW Health consent form is located in Appendix 5.6.

### 2.4 Procedures for capturing and documenting imaging

**Standard:** There are standardised procedures for capturing and documenting images to reduce variation across statewide services

LHDs/SCHN must support NSW Health workers to comply with 2.4.1 and 2.4.2 below.

#### 2.4.1 Capturing imaging

Capture of imaging in cases of suspected child abuse must be conducted in accordance with the **NSW Health Privacy Manual for Health Information, 2015,** and must be restricted to NSW Health workers with suitable training and experience in the procedures required to comply with this photo and video imaging policy.

At a minimum, NSW Health workers must:

- Carefully explain to the child or young person, and where appropriate their parent(s)/guardian(s), what the procedure is going to involve in advance of the examination

- Provide the opportunity for the child or young person, and/or parent(s)/guardian(s) to ask questions and receive answers in a way that takes into consideration the person’s level of development and understanding as described in section 2.1 of this policy

- Seek informed consent as described in section 2.3 of this policy directive via a process that:
  - Explains what consent means in relation to the separate specific purposes for which images may be used (as described in section 2.3 of this policy directive) and the implications that may arise for the child, young person or their parent/guardian providing consent
  - Provides options for providing or refusing consent at any time during the course of the examination for:
    - The capture of images of specific areas of the body
    - The specific purposes for which images may be used.

- Consider whether the child or young person and their parent(s)/guardian(s) would find it helpful if the practitioner or other NSW Health worker demonstrated the use of the video colposcope and observation monitor. This could be achieved by displaying real time magnified images of objects and/or non ano-genital body parts on a monitor placed in a location easily seen by the child or young person and examiner

- Ensure that images of a child or young person’s face are not captured, unless it is required to document a clinical finding

- Capture the minimum number of images required to adequately document a clinical finding

- Adopt the following good practice techniques:
  - Use a RAW (digital negative that requires processing), TIFF or JPEG format for capturing still images
  - Use a procedure that will allow reliable identification of the recording(s) in relation to the particular child or young person and the time that the image(s) was taken. For example, include the child’s hospital ID label for identification purposes
9. HEALTH RECORDS AND INFORMATION

9.31 Include some form of further visual identification on the first and last image, including the child’s name or initials, Medical Record Number (MRN) and/or Area Unique Identifier (AUID) and the date. Include a scale in the image, where possible. Consider anterior, posterior and lateral images of the patient and document the anatomical location of each image (an example 'Request for medical photography services' form is located in Appendix 5.7).

When conducting telehealth NSW Health workers must:

- Consider the professional capacity of the host and remote site examiners as either the supervising or the supervised clinician based on their relevant and appropriate training and experience.
- Act in accordance with the requirements of this policy directive.
- Consider using the good practice techniques set out in the Agency for Clinical Innovation Guidelines for the use of telehealth for clinical and non-clinical settings in NSW, 2015.

NSW Health does not support recording of an entire telehealth consultation with a patient or any audio recording.

2.4.2 Documenting imaging

NSW Health workers must:

- Reference images using an individual health care patient identification system including a child or young person’s name or initials, Medical Record Number (MRN) and/or Area Unique Identifier (AUID), date of birth (DOB), the date the images were captured and the name of the treating physician.
- Document consent and the existence of images in the patient’s medical records. For physical abuse and neglect the Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014 may be used, unless this is being assessed in conjunction with suspected sexual abuse when the Child Sexual Assault Medical Protocol in the Sexual Assault Investigation Kit (SAIK) may be used. Details must include:
  - Any refusal of consent for capturing photo and video imaging.
  - Any withdrawal of consent for the capture or use of photo and video imaging before and during the examination.
  - The name of the photographer, the date and time, and the location of where the images were taken to maintain integrity in the event of legal action or issuing of a subpoena.
  - The number and type of images that were taken.
- Note that child abuse and neglect images must be stored securely and separately from a child or young person’s principal health care record (see section 2.6.2) and a reference placed on the health care record where the images are located to identify the existence of any principal health care record or other relevant health related documents. Index or patient administration systems must reference the existence of satellite/decentralised health care records that address a specific issue and that are kept separate from the principal health care record.
- Document authorised permission for release/transmission in the patient's medical records (see section 2.6.3 of this policy directive).

Where telehealth is used, document at both sites that the consultation has occurred and ensure that this documentation concurs.

It is good practice to disclose the existence of images to NSW Police Force on the Expert Certificate.
2.5 Devices used to capture, record, store and transmit images

Standard: Capture, recording and storage of images is limited to LHD/SCHN owned memory devices. LHDs/SCHN must ensure that:

- In cases of suspected child abuse, medical and forensic imaging is captured on dedicated LHD/SCHN owned:
  - Clinical camera imaging devices used for the sole purpose of documenting suspected sexual abuse, physical abuse, and neglect;
    - or where the sole purpose of a clinical camera is not restricted to documenting abuse or neglect, such as in an Emergency Department, the clinical camera must accommodate an LHD/SCHN owned removable memory device and images must be captured onto the removable device and not the camera, using one removable device per patient
  - Clinical colposcope imaging equipment, preferably used for the sole purpose of documenting sexual abuse
  - Portable or removable memory devices, such as DVDs, memory sticks and external hard drives
- Single Lens Reflex (SLR) clinical camera equipment is the preferred option and:
  - Includes a flash
  - Includes a lens with a close up facility
  - Has at least six megapixels.
A 'stand-alone' personal camera (i.e. one that is not part of a mobile telephone or ipad) may be used in exceptional circumstances and only where:
  - No LHD/SCHN owned equipment is available and
  - The personal camera can accommodate an LHD/SCHN owned removable memory device and use is restricted to capturing images onto the removable device and not the personal camera, using one removable device per patient.
- All equipment complies with NSW Health Electronic Information Security Policy, 2013 and NSW Health Privacy Manual for Health Information, 2015
- Imaging equipment is:
  - Capable of producing an accurate representation of any evidential clinical finding being recorded
  - Appropriately maintained and managed, such as updating date and time settings, recharging/replacing batteries
  - Strictly governed and controlled and adequately secured using lockable facilities
  - Monitored in respect of who accesses and uses it.
- Any equipment or devices used for remote access to NSW Health networks from an external location must be authenticated and authorised by the LHD/SCHN and connectivity must be protected by approved controls. This includes mobile devices, smartphones, tablets, netbooks, notebooks, palmtops, handheld personal organisers, laptops, modems, PDAs, wireless access points, portable or removable storage devices, CD/DVD burners and printers
9. HEALTH RECORDS AND INFORMATION

NSW Health does not support:

- The use of any other personal equipment or devices for the purpose of capturing or storing images in relation to suspected child abuse. Examples include cell phones, smartphones, tablet devices, netbooks, notebooks, palmtop, handheld personal organisers, laptops, USB drives, DVDs and removable memory cards and sticks.
- Use of Skype or other insecure software/platforms in NSW Health care settings.

2.6 Security and storage of images

Standard: Images are stored securely and separately from the principal health care record, to maintain patient privacy.

LHDs/SCHN must support NSW Health workers to comply with 2.6.1 to 2.6.6 below.

2.6.1 Transfer of images from the capture equipment to secure storage

NSW Health workers who capture and/or support the management of medical and forensic photo and video imaging in cases of suspected child abuse must:

- Check the original images on the camera equipment/LHD removable memory device and:
  - Consider deleting those where at the time the examiner first views the image(s), in the opinion of the practitioner, it is not usable. For example, the image depicts surrounding context rather than the patient or the lighting or exposure impedes what is depicted. Caution must be exercised and where the practitioner is unsure the image must be retained.
  - Delete those where the person that provided consent for imaging withdraws consent before completion of the examination.
  - Where images are deleted, document the number of images that were deleted and for each image, the reason why it was deleted.
- Transfer the retained original image/s from the capture equipment/LHD removable memory device to LHD/SCHN secure network storage facilities as soon as possible and usually within one working day (see Figure 1).
- Archive retained original image/s. A 'read only' format or the equivalent facility is preferred to ensure the integrity of the original image/s and restrict the potential for editing.
- Use a separate working copy of an original image for any editing that might be required.
- Check images have successfully transferred to LHD/SCHN secure network storage facilities and then delete images that are left on the camera equipment/LHD removable memory device.
- Periodically format capture camera equipment/LHD removable memory devices to ensure data recovery processes cannot be used to recover deleted images: Where a removable memory device per patient is used, such as in personal or non-dedicated cameras, formatting must occur as soon as possible after transfer to LHD/SCHN secure network storage facilities and usually within one working day.

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9. HEALTH RECORDS AND INFORMATION

2.6.2 Storage of images


Photo and video imaging in cases of suspected child abuse, together with the medical records associated with the imaging, must be stored securely and separately from a child or young person’s principal health care record.

LHD/SCHN secure storage facilities may be within a Child Protection Unit, Sexual Assault Service, an Emergency Department or other LHD/SCHN facility offering medical and forensic examinations.

All original photo and video images and any separate working copies used for editing must be stored on LHD/SCHN owned restricted secure network drives. Such restriction(s) to be determined by the Chief Executive Officer, or officer delegated responsibility for the security of LHD/SCHN medical records relating to cases of suspected child abuse.

Where LHD/SCHN owned restricted, secure network drives are not immediately available, in some remote areas for example, electronic/digital photo and video imaging must be:

- Transferred from the camera equipment/removable memory device to an LHD/SCHN owned laptop using appropriate safeguards, such as password or PIN codes, together with encryption technology (see Figure 1)
- Kept in lockable facilities with restricted access.

It is preferred that original images are stored using a 'read only' format, or equivalent, and images must be maintained in an original state and not subject to processes that cause permanent alteration.

All hard copy images must be stored securely in LHD/SCHN owned lockable facilities with restricted access. Such restriction(s) to be determined by the Chief Executive Officer, or officer delegated responsibility for the security of LHD/SCHN medical records relating to cases of suspected child abuse.

To maintain the integrity of the images in the event of legal action, images must be stored with:

- A copy of the consent form and documentation that includes the name of the photographer, the date and time the image/s were taken, and the location where the images were taken (see section 2.4.2)
- Accompanying documentation that includes a child or young person’s initials, Medical Record Number (MRN) and/or Area Unique Identifier (AUID), date of birth (DOB), the date the images were captured and the name of the treating physician
- A reference that identifies the existence of any other relevant health related records or documents that are kept separately from the images, such as the location of the principal health care record. The images can be linked to the principal health care record via a notation on the principal record that a 'confidential health record exists'.

The restricted access electronic and hard copy storage facilities must have an auditing or tracking procedure that documents:

- Who, other than restricted access workers, views an image
- When an image leaves the location where it is stored and its destination
- When an image is copied and by whom.
2.6.3 Transmission of images

For the purpose of security and patient privacy, NSW Health workers involved in the transmission of medical and forensic photo and video imaging in cases of suspected child abuse must act in accordance with the NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, NSW Health: Health Care Records – Documentation and Management policy, 2012 and the NSW Health Privacy Manual for Health Information, 2015 and:

- Restrict access to images as described in section 2.7 of this policy directive
- Obtain authorised written permission to release/transmit a copy of an image from a senior member of NSW Health staff, such as the attending medical and forensic practitioner, health information manager or a senior medical records officer/manager. Archived original image(s) should be retained as described in section 2.6.1 of this policy
- Document the authorised permission for release/transmission in the patient's medical record and:
  - The details of the request for release, including the reason for release
  - The number and type of images released
  - The date
  - The person/recipient to whom the image/s have been released
  - Full details of the address/location that the image/s were sent to.

**Within NSW Health**

- Consideration must first be given to restricted party viewing of the images at the NSW Health source site.
- Where this is not possible and electronic transmission occurs, it must occur:
  - Within NSW Health email
  - From NSW Health email accounts to another recognised NSW Health address
  - Using appropriate safeguards such as encryption technology, password or PIN codes and delivery/receipt confirmations, where available
  - From LHD/SCHN owned computers, equipment or devices or those that are authenticated and authorised by the LHD/SCHN with connectivity protected by approved controls or, through NSW Health Secure File Transfer solutions.

In all cases consider whether it is feasible to remove or abbreviate patient identifiers on the image and in any subject lines whilst the image is in transit in liaison with the recipient.

**External to NSW Health**

Where it is necessary to release images to restricted parties outside NSW Health, such as the court or under rigorously restricted information sharing practices relating to Chapter 16A and Section 248 of the Children and Young Persons (Care and Protection) Act 1998 (see section 2.7.1 to 2.7.4 for details of permitted access):

- Consideration must first be given to restricted party viewing of the images at the NSW Health source site
- Where this is not possible:
  - Electronic copy/copies on a removable memory device under strict governance and control using appropriate security safeguards such as encryption technology, password or PIN codes, or where this is not possible
  - Hard copy/copies
9. Health records and information

9.37 should be transported sealed in an appropriately robust sealed envelope (or similar package) with a unique number allocated from a register held by the NSW Health source site.

The envelope/package should be delivered by hand by an employee of NSW Health, registered post or courier and a receipt should be obtained.

At no time must a portable or removable device be used if it is not securely encrypted and released using these safeguards.

- Where this is not possible it should be noted that electronic transmission of personal health information to destinations external to NSW Health are not considered secure (NSW Health Privacy Manual for Health Information, 2015) and where electronic transmission is necessary, the following must occur:
  - Appropriate safeguards must be used such as encryption technology, password or PIN codes and where available, delivery/receipt confirmations
  - LHD/SCHN owned computers, equipment or devices or those that are authenticated and authorised by the LHD/SCHN with connectivity protected by approved controls must be used.

In all cases consider whether it is feasible to remove or abbreviate patient identifiers on the image and in any subject lines whilst the image is in transit in liaison with the recipient. Images must never be emailed or uploaded via the internet to cloud services. Personal email accounts must never be used to transmit patient information.

- Communication using File Transfer Protocol (FTP), telnet, Mobile SMS, instant messaging and web traffic (HTTP) is not permitted by NSW Health as a secure process for sharing photo and video imaging (NSW Health Electronic Information Security Policy, 2013).

2.6.4 Ownership and copyright

Images, recordings and documentation produced by NSW Health workers in a NSW Health service facility remain the property of the health service, including those taken by visiting medical officers.

Copyright of all recordings is owned by the State of New South Wales through the Local Health District/Speciality Network.

2.6.5 Destruction of images and medical record information

An original image on the camera equipment/device may be deleted in accordance with section 2.6.1 of this policy directive.

In all other cases, NSW Health workers must act in accordance with the NSW Government General Retention and Disposal Authority policy, 2004 (revised, 2011) and retain images for a minimum of 30 years after legal action is completed and resolved (where known), or after last contact for legal access or 30 years after the individual attains or would have attained the age of 18 years, whichever is the longer.

2.6.6 Images received from external sources

With the exception of formal, professional clinical peer group requests, review of an image sent to a practitioner from any other source, for example, a family member, in the context of investigating allegations of child abuse needs to be carefully managed. Offering an opinion on such images needs to be done with caution because the practitioner may be exposed to various risks, including difficulties arising from the quality of the image, uncertainties about the date and time it was captured, the identity of the person depicted in the image(s) and an inability to document a clear chain of evidence. In these circumstances:

- Where a person depicted in an image has not been examined by an appropriate practitioner, a NSW Health practitioner that receives the image must not provide advice based solely on the image
- The image should be retained as a record of a request for review, stored separately from images that the examiner has captured and include a notation with full details of the request (for example, the source and date) and any response.
2.7 Access to images for relevant purposes

Standard: Restricted access is provided to images, to maintain patient privacy

LHDs/SCHN must ensure that NSW Health workers comply with 2.7.1 to 2.7.5 below.

2.7.1 Permitted access

NSW Health workers who capture and/or support the management of medical and forensic photo and video imaging in cases of suspected child abuse must ensure that access is restricted to:

- Designated NSW Health workers providing treatment to children or young people or involved in their safety who have unique user identification, individual password authentication and permission controls

- Circumstances where:
  - It is reasonably necessary, and directly associated with the primary purpose/s of collection and
  - The patient/their parent(s)/guardian(s) would reasonably expect the information to be used for that purpose, or
  - Separate informed consent has been obtained for the purpose of a) teaching and/or b) research activities

- The patient or their parent(s)/guardian(s), unless release would affect the personal affairs of any person, including a request by a parent or guardian where such access may lead to child abuse or prejudice a child’s physical or mental health. Caution must be exercised and an interpretation and explanation of the clinical findings is preferable to the provision of access to images

- Approved teaching and/or research activities (section 2.8) where:
  - the young person and/or their parent/guardian has provided separate informed consent, and
  - images are de-identified and anonymity of patients is maintained, and
  - the teaching and/or research activities are compliant with the NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies and the research has received ethical approval (for example, see https://hrep.nhmrc.gov.au/certification/hreces, http://www.ahmrc.org.au/ethics.php and www.ipc.nsw.gov.au/statutory-guidelines-research-purposes-pdf), and

- Quality improvement activities (section 2.9) where:
  - images are de-identified and anonymity of patients is maintained, and
  - Human Research Ethics Committees – Quality Improvement & Ethical Review: A Practice Guide for NSW is used to help to determine the activity, and
  - the quality improvement activities are compliant with NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies.

- Information sharing under Chapter 16A and Section 248 of the Children and Young Persons (Care and Protection) Act 1998 (sections 2.72 and 2.7.3)

- Requests under a court subpoena (see section 2.7.4)

- The requirements of the Health Privacy Principles NSW Health Privacy Manual for Health Information, 2015.

Where access to images is deemed necessary, consideration must be given to viewing the images at the NSW Health source site.
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Where release is deemed necessary it should be restricted to the above circumstances and integrity of security must be maintained in accordance with section 2.6.3 of this policy directive and NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, the NSW Health Privacy Manual for Health Information, 2015 and NSW Health: Health Care Records – Documentation and Management policy, 2012.

2.7.2 Information sharing under Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998

Chapter 16A establishes a scheme for sharing information relating to the safety, welfare or wellbeing of children and young persons between prescribed bodies.

All applications and requests for access to photo and video imaging under Chapter 16A must be forwarded to an appropriate Health worker, medical and forensic examiner involved in the case, manager of the relevant service that authorised the images to be taken (e.g. Sexual Assault Service, Child Protection Unit, Emergency Department or Paediatric Unit), or LHD/SCHN Central Contact Point, regardless of the author of the recording.

The LHD/SCHN will provide a medical report or Expert Certificate to summarise findings to support investigation, assessment, decision making and coordination of services. Access to images of ano-genital, breast/chest and other sensitive areas of the body must be rigorously restricted and considered in the context that such images can only be interpreted by qualified medical and forensic examiners.

Consideration must be given to the relevance of access to or release of photo and video imaging relating to suspected physical abuse and neglect to prescribed bodies for the purpose of the safety, welfare or wellbeing of the child or young person. Where a request is granted, accompanying interpretation or explanation of clinical findings must also be provided.

- Where a medical examination has taken place in accordance with Section 173 of the Children and Young Persons (Care and Protection) Act 1998 a medical report is provided for the Secretary of Family and Community Services (FACS). An existing Expert Certificate could also be provided.

2.7.3 Information sharing under Section 248 of the Children and Young Persons (Care and Protection) Act 1998

Section 248 governs the exchange of information relating to the safety, welfare and wellbeing of children and young people between the Department of Family and Community Services and prescribed bodies.

Requests under Section 248 should be directed to the LHD/SCHN Central Contact Point and come from the Secretary, Family and Community Services (or delegate).

Under Section 248 FACS can request access to a child or young person's medical record, which includes the Child Sexual Assault Medical Protocol/SAIK and Suspected Child Abuse and Neglect (SCAN) Medical Protocol, 2014. The LHD/SCHN will provide a medical report or Expert Certificate to summarise findings to support investigation, assessment, decision making and coordination of services. Access to images of ano-genital, breast/chest and other sensitive areas of the body must be rigorously restricted and considered in the context that such images can only be interpreted by qualified medical and forensic examiners.

Consideration must be given to the relevance of access or release of photo and video imaging relating to suspected physical abuse and neglect to the Secretary of the Department of Family and Community Services and prescribed bodies for the purpose of the safety, wellbeing and welfare of the child or young person. Where a request is granted, accompanying interpretation or explanation of clinical findings must also be provided.

Where a medical examination has taken place in accordance with Section 173 of the Children and Young Persons (Care and Protection) Act 1998 a medical report is provided for the Secretary of FACS. An existing Expert Certificate could also be provided.
LHDs/SCHN must act in accordance with the NSW Health Subpoenas policy, 2010, and ensure that the LHD/SCHN designated officer (e.g. medical records health information manager or medico-legal officer or risk manager) is informed about the subpoena, as well as, where possible, the senior health care provider and treating health care provider.

NSW Health workers who manage subpoenas must:

- Be aware of whether any claim for privilege over the images can be applied and take appropriate action
- Follow the precautions for 'sensitive records' (see section 6.4: NSW Health Subpoenas policy, 2010)
- Where images are produced, provide only those that are captured under the schedule of the subpoena
- Retain a copy of the subpoena and the images that the Health service provided under the subpoena.

Where the patient whose records are subpoenaed are not a party to the proceedings before the court, the LHD/SCHN must notify the patient:

- That the subpoena has been received
- The date that the photo/video imaging must be provided to the court, so that the patient can arrange to attend court if they so wish.

2.7.5 Sexual assault communications privilege

Records relating to the counselling of victims of sexual abuse may be protected from production to the court. Photo and video imaging is not covered under this privilege (see Chapter 6 of the Criminal Procedure Act 1986).

2.8 Use of imaging for teaching and research

LHDs/SCHN must ensure that NSW Health workers comply with the following:

- Specific informed consent must be obtained from the young person or their parent(s)/guardian(s) for de-identified photo and video imaging to be used for a) teaching and/or b) approved research activities. This must include an explanation that consent for future teaching and/or approved research activities may be withdrawn by the person who provided consent or the person depicted in the image(s) once they are Gillick competent
  
  For this purpose, where consent is provided for de-identified images to be used for the purposes of teaching and/or approved research activities there must be a process to ensure that withdrawal of consent may be withdrawn. An example of good practice is described in Appendix 5.8

- Anonymity of patients must be maintained during case presentations, demonstrations, teaching, research and at seminars and conferences. Where possible, fictitious data must be used and identification of individuals must not occur. Use of images that would identify the child or young person must not occur. Images of the face must be de-identified and use of blocked sections or cropping, for example, could be used for this purpose


- Act in accordance with the NSW Health Privacy Manual for Health Information, 2015.
9. HEALTH RECORDS AND INFORMATION

2.9 Use of imaging for quality improvement activities

LHDs/SCHN must ensure that NSW Health workers comply with the following:

- Quality improvement activities must:
  - use de-identified images and maintain anonymity of patients, and
  - be determined by reference to Human Research Ethics Committees – Quality Improvement & Ethical Review: A Practice Guide for NSW, and
  - comply with NSW Health Privacy Manual for Health Information, 2015 and other relevant NSW Health policies.

2.10 Maintaining the integrity of images in the longer-term

Standard: The integrity of images is maintained in the longer-term

The extent and range of digital image capturing devices, communication technologies and storage systems create a complex environment and significant challenges and opportunities for those that provide forensic science services and their patients (Australia New Zealand Policing Advisory Agency, 2013).

- LHDs/SCHN must use risk analysis and management techniques to reassess the procedures used for capture, storage, access and security for the purpose of maintaining the integrity of images in the longer term. (See, for example, NSW Health Electronic Information Security Policy, 2013, NSW Government Digital Information Security Policy, 2015, and NSW Health: Health Care Records – Documentation and Management policy, 2012.)

3 REFERENCES

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<td>NSW Health PD2010_065. Subpoenas. NSW Ministry of Health. Sydney, NSW.</td>
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### Glossary

<table>
<thead>
<tr>
<th>Term</th>
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<tr>
<td><strong>Capture</strong></td>
<td>Capture is the process of recording (acquiring) data, such as an image or video sequence (<a href="https://www.anzpolice.com.au">Australia New Zealand Policing Advisory Agency</a>, 2013).</td>
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<tr>
<td><strong>Child Sexual Assault Medical Protocol (the written protocol in the Sexual Assault Investigation Kit (SAIK))</strong></td>
<td>A written record used by forensic examiners in NSW Health Sexual Assault Services to record all types of sexual abuse examinations for children 0-14 years of age and, where appropriate, may be used for young people 14 -17 years, otherwise an adult Medical and Forensic Examination Record (MFER) may be used. It is part of the Child Sexual Assault Investigation Kit (SAIK). The Adult Sexual Assault Medical Protocol may be used where a young person aged 14 or above attends an adult Sexual Assault Service. In young people aged 14 to 17, which Protocol is used is contingent upon consideration of the circumstances of the child or young person and whether a child or adult SAIK represents the most appropriate pathway. The Protocols provide guidance to facilitate the medical and forensic examination of victims of sexual abuse and ensure that laboratory specimens are collected correctly and legal requirements are fulfilled.</td>
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<tr>
<td><strong>Children and young people</strong></td>
<td>Child: A person who is under the age of 16 years. Young person: A person who is aged 16 years or above but who is under the age of 18 years. (Section 3. <a href="https://www.nsw.gov.au">Children and Young Persons (Care and Protection) Act</a> 1998).</td>
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<tr>
<td><strong>Colposcope</strong></td>
<td>A lighted, magnifying medical instrument used to examine the tissues of the genitalia. It allows an examiner to take a closer look at a child or young person’s genitalia and check for abnormal areas. Some devices can be fitted with photographic or video equipment that can capture still (photographic) or moving (video) images.</td>
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<td><strong>Cultural competence</strong></td>
<td>Violence, trauma and neglect occur in culturally diverse contexts. Cultural competence is the ability to identify and challenge one’s own cultural assumptions, values and beliefs. It is about developing empathy and appreciating that there are many different ways of viewing the world, as this is influenced by culture.</td>
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<tr>
<td><strong>FACS</strong></td>
<td>Department of Family and Community Services</td>
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<tr>
<td><strong>Gillick competence</strong></td>
<td>Whilst parents, or those having parental responsibility rights, generally have the legal authority to provide consent for medical procedures for children and young people under the age of 16 years, the Gillick principle (1985 decision of the House of Lords in Gillick v West Norfolk and Wisbech Area Health Authority and anor) provides that a child’s competence to consent to medical procedures increases as they approach maturity, that is a minor under the age of 16 years may be capable of independently consenting to medical treatment when they have achieved a sufficient level of understanding and intelligence to enable them to fully understand what is proposed. Medical practitioners must decide on a case-by-case basis whether a minor has achieved this level of understanding and intelligence.</td>
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<tr>
<td><strong>Guardian</strong></td>
<td>A person with ‘parental responsibility’ as defined in Section 79A of the <a href="https://www.nsw.gov.au">Children and Young Persons (Care and Protection) Act</a> 1998.</td>
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### 9. HEALTH RECORDS AND INFORMATION

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<th>Term</th>
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<tr>
<td>Intimate image</td>
<td>A photo or video image depicting the genitalia, anus or post-pubertal female breast (Faculty of Forensic &amp; Legal Medicine, 2014) and may also include other parts of the body, such as the buttocks or chest of a pre-pubertal child.</td>
</tr>
<tr>
<td>JIRT (Joint Investigation Response Team)</td>
<td>JIRT is a collaborative partnership between the Department of Family and Community Services, the NSW Police Force and NSW Health workers that jointly manages statutory child protection matters that may require a criminal justice response and a health response.</td>
</tr>
<tr>
<td>JRU (JIRT Referral Unit)</td>
<td>JRU is comprised of professionals from the Department of Family and Community Services, the NSW Police Force and NSW Health and ensures that reports of risk of significant harm of children and young people to the Child Protection Helpline that require a child protection response, and may require a health and criminal justice response, are jointly assessed for a response by the three JIRT partner agencies.</td>
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<tr>
<td>LHD</td>
<td>Local Health District.</td>
</tr>
<tr>
<td>Medical and forensic examiner</td>
<td>A trained Medical Officer, Sexual Assault Nurse Examiner (SANE) or Forensic Nurse who has specialised education and clinical experience in the treatment of children and young people who may have experienced child sexual abuse, physical abuse or neglect and the collection of forensic evidence.</td>
</tr>
<tr>
<td>Medical and forensic examination</td>
<td>A medical and forensic examination is an examination of a patient for the purpose of providing medical care and collecting forensic documentation and evidence.</td>
</tr>
<tr>
<td>Neglect</td>
<td>Where a child or young person’s basic needs (e.g. supervision, medical care, nutrition, shelter and education) have not been met, or are at risk of not being met, to such an extent that it can reasonably be expected to have a significant adverse impact on the child or young person’s safety, welfare or well-being. This lack of care could be constituted by a single act or omission or a pattern of acts or omissions such as failing to attend medical appointments or failing to ensure that a school age child attends school. (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).</td>
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<tr>
<td>ODPP</td>
<td>Office of the Director of Public Prosecutions.</td>
</tr>
<tr>
<td>Original image</td>
<td>The first image that is captured onto any media.</td>
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| Peer review | The evaluation of work or performance by colleagues in the same field with the aim of maintaining or enhancing the quality of work or performance in that field (Faculty of Forensic & Legal Medicine, 2014a). It includes:  
- Discussion about clinical decision making and interpretation of examination findings and results of investigations  
- Meetings undertaken by and with peers with the aim of updating knowledge and improving practice through presenting of work to peers for review (Medical Board of Australia, 2014a). |
<p>| Personal device | A personal device is one which is not owned by a NSW Health Public Health Organisation. Examples of a personal mobile device include a phone, camera, ipad or other tablet and laptop computer. |</p>
<table>
<thead>
<tr>
<th><strong>9. HEALTH RECORDS AND INFORMATION</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Photo and video imaging</strong></td>
<td><strong>Photo and video imaging depicts an image that:</strong></td>
</tr>
<tr>
<td></td>
<td>Documents the findings of a medical or forensic examination</td>
</tr>
<tr>
<td></td>
<td>Is captured, recorded and in some cases, transmitted for clinical or forensic purposes</td>
</tr>
<tr>
<td></td>
<td>Exists in live 'real time' or is stored in hard copy or electronic form</td>
</tr>
<tr>
<td></td>
<td>Can be transmitted in real time or stored and transmitted at a later point in time</td>
</tr>
<tr>
<td></td>
<td>May become evidence in a legal proceeding.</td>
</tr>
<tr>
<td></td>
<td>Photo and video imaging can be captured using a camera or video recorder. Both can</td>
</tr>
<tr>
<td></td>
<td>be used in conjunction with a colposcope to enhance magnification and lighting.</td>
</tr>
<tr>
<td></td>
<td>For the purpose of this policy, photo and video imaging constitutes part of a health</td>
</tr>
<tr>
<td></td>
<td>care record.</td>
</tr>
<tr>
<td><strong>Physical abuse</strong></td>
<td>Physical abuse occurs if a child or young person sustains a non-accidental injury or</td>
</tr>
<tr>
<td></td>
<td>is being treated in a way that may have or is likely to cause injury. The injury may</td>
</tr>
<tr>
<td></td>
<td>be inflicted by a parent, carer, guardian, other adult or other child or young person. (Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013).</td>
</tr>
<tr>
<td><strong>Prescribed body</strong></td>
<td>Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 establishes a scheme for sharing information relating to the safety, welfare or wellbeing of children and young persons between prescribed bodies. 'A prescribed body' is any organisation specified in Section 248 (6), Children and Young Persons (Care and Protection) Act 1998 or in clause 7, Children and Young Persons (Care and Protection) Regulation, 2000, or in clause 8, Children and Young Persons (Care and Protection) Regulation, 2012.</td>
</tr>
<tr>
<td><strong>Public Health Organisation</strong></td>
<td>A 'Public Health Organisation' is:</td>
</tr>
<tr>
<td></td>
<td>A local health district, or</td>
</tr>
<tr>
<td></td>
<td>A statutory health corporation, or</td>
</tr>
<tr>
<td></td>
<td>An affiliated health organisation in respect of its recognised establishments and</td>
</tr>
<tr>
<td></td>
<td>recognised services.</td>
</tr>
<tr>
<td><strong>SAIK</strong></td>
<td>Sexual Assault Investigation Kit (see 'Child Sexual Assault Medical Protocol').</td>
</tr>
<tr>
<td><strong>SCHN (Sydney Children’s Hospitals Network)</strong></td>
<td>The Sydney Children's Hospitals Network comprises The Children's Hospital at Westmead, Sydney Children's Hospital, Randwick, Bear Cottage, the Newborn and Paediatric Emergency Transport Service (NETS), the Pregnancy and Newborn Services Network (PSN) and the Children's Court Clinic.</td>
</tr>
<tr>
<td><strong>Sexual abuse</strong></td>
<td>The terms sexual abuse and sexual assault are often used interchangeably.</td>
</tr>
<tr>
<td></td>
<td>For the purposes of this policy directive 'sexual abuse' is used to refer to sexual</td>
</tr>
<tr>
<td></td>
<td>activity or behaviour that is imposed, or is likely to be imposed, on a child or young</td>
</tr>
<tr>
<td></td>
<td>person by another person (Child Wellbeing and Child Protection Policies and</td>
</tr>
<tr>
<td><strong>Sexual assault</strong></td>
<td>See 'sexual abuse'.</td>
</tr>
</tbody>
</table>
9. **HEALTH RECORDS AND INFORMATION**

<table>
<thead>
<tr>
<th>Sexual Assault Communications Privilege (SACP)</th>
<th>As set out in the <a href="#">Criminal Procedure Act</a> 1986, the SACP allows courts to exclude evidence that would disclose confidential communications made in the course of a professional or sexual abuse counselling relationship. See Appendix A of the <a href="#">NSW Health Subpoenas policy</a>, 2010, for further information.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard</strong></td>
<td>A standard is a key principle that must be followed.</td>
</tr>
<tr>
<td><strong>Subpoena</strong></td>
<td>A subpoena is an order from a court or tribunal which directs someone that they must on a given date:</td>
</tr>
<tr>
<td></td>
<td>a) Produce to a court certain (existing) documents for use in legal proceedings</td>
</tr>
<tr>
<td></td>
<td>b) Attend a court on a particular date to be a witness in a hearing and give evidence, or</td>
</tr>
<tr>
<td></td>
<td>c) Do both.</td>
</tr>
<tr>
<td></td>
<td>A subpoena can only be issued if legal proceedings have been commenced.</td>
</tr>
<tr>
<td></td>
<td>For the purposes of a subpoena a ‘document’ includes, ‘an electronic medical record or information contained on a computer file, such as photos and/or video’ (<a href="#">NSW Health Subpoenas policy</a>, 2010).</td>
</tr>
</tbody>
</table>

**References**


5 **APPENDICES**

5.1 *List of relevant policy documents*

| NSW Health PD2013_033 | [Electronic Information Security Policy](#). |
| NSW Health PD2012_069 | [Health Care Records – Documentation and Management policy](#). |
| NSW Health PD2013_007 | [Child Wellbeing and Child Protection Policies and Procedures for NSW Health](#). |
| NSW Health PD2010_065 | [Subpoenas policy](#). |
| NSW Health PD2005_405 | [NSW Health Consent to Medical Treatment - Patient Information policy](#). |
9. HEALTH RECORDS AND INFORMATION

5.2 Related policies and procedures

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Sexual Assault Medical Protocol *(2002).</td>
<td>*(Often referred to as the SAIK (Sexual Assault Investigation Kit)</td>
</tr>
<tr>
<td>for Clinical Innovation.</td>
<td></td>
</tr>
<tr>
<td>JIRT Referral Unit (JRU) + Interim Procedures for NSW Health (2015).</td>
<td></td>
</tr>
<tr>
<td>Joint Investigative Response Teams (JIRT) Local Planning and Response Procedures (2013). NSW</td>
<td></td>
</tr>
<tr>
<td>Health, Human Services – Community Services, and NSW Police Force.</td>
<td></td>
</tr>
<tr>
<td>NSW Department of Community Services, NSW Police Service and NSW Health.</td>
<td></td>
</tr>
<tr>
<td>Sydney Children’s Hospitals Network and Kaleidoscope Greater Newcastle (SCHN KGN) Clinical Guideline on Photography and Video Recording of Children and Young People under 18 years who are Suspected of Having Been Physically Abused, Neglected or Sexually Abused who Present to any of the Children’s Hospitals in NSW (2012).</td>
<td></td>
</tr>
</tbody>
</table>

5.3 Key related policies and procedures to respond to adult sexual assault:

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Date</th>
</tr>
</thead>
</table>

5.4 Key Aboriginal health policies and procedures

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Date</th>
</tr>
</thead>
</table>

5.5 Membership of the Photo and Video Imaging Reference Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organisation</th>
<th>LHD/SCHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Graham Vimpani AM</td>
<td>Chair of the Reference Group Senior Clinical Adviser</td>
<td>Child Protection and Wellbeing</td>
<td>NSW Kids and Families</td>
</tr>
<tr>
<td>Mr David Bennett</td>
<td>JIRT Police Officer</td>
<td>NSW Police Force</td>
<td>N/A</td>
</tr>
<tr>
<td>Ms Sue Burke</td>
<td>District Manager, Sexual Assault Services and JIRT Health</td>
<td>Bloomfield Hospital</td>
<td>Western NSW LHD</td>
</tr>
<tr>
<td>Ms Danielle Clark</td>
<td>Manager</td>
<td>Violence Prevention and Response</td>
<td>NSW Kids and Families</td>
</tr>
</tbody>
</table>
### 9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organisation</th>
<th>LHD/SCHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Lisa Crawford</td>
<td>Senior Analyst</td>
<td>Violence Prevention and Response</td>
<td>NSW Kids and Families</td>
</tr>
<tr>
<td>Mr Paul de Sensi</td>
<td>Medical Photographer</td>
<td>Sydney Children’s Hospital, Randwick</td>
<td>Sydney Children’s Hospitals Network</td>
</tr>
<tr>
<td>Dr Rosemary Isaacs</td>
<td>Medical Director, Sexual Assault</td>
<td>Royal Prince Alfred and Liverpool Hospitals</td>
<td>Sydney and South West Sydney LHDs</td>
</tr>
<tr>
<td>Ms Robyn Lamb</td>
<td>Dept. Head (Allied Health), Child Protection</td>
<td>Sydney Children’s Hospital, Westmead</td>
<td>Sydney Children’s Hospitals Network</td>
</tr>
<tr>
<td>Ms Jenny Marshall</td>
<td>Acting Director</td>
<td>Child Protection and Violence Prevention</td>
<td>NSW Kids and Families</td>
</tr>
<tr>
<td>Ms Julia Martinovich</td>
<td>Telehealth Implementation Officer</td>
<td>NSW Agency for Clinical Innovation</td>
<td>N/A</td>
</tr>
<tr>
<td>Dr David McDonald</td>
<td>Senior Staff Paediatrician</td>
<td>Tamworth Rural Referral Hospital</td>
<td>Hunter New England LHD</td>
</tr>
<tr>
<td>Ms Lorna McNamara</td>
<td>Director Acting Director</td>
<td>Education Centre Against Violence Child Protection and Violence Prevention</td>
<td>NSW Health NSW Kids and Families</td>
</tr>
<tr>
<td>Ms Petra Milnes</td>
<td>Executive Officer</td>
<td>NSW e-health</td>
<td>N/A</td>
</tr>
<tr>
<td>Dr Louise Millward</td>
<td>Senior Analyst</td>
<td>Violence Prevention and Response</td>
<td>NSW Kids and Families</td>
</tr>
<tr>
<td>Ms Elena Mirenzi</td>
<td>Manager</td>
<td>Violence Prevention and Response</td>
<td>NSW Kids and Families</td>
</tr>
<tr>
<td>Ms Lynn Mitchell</td>
<td>Senior Analyst</td>
<td>Violence Prevention and Response</td>
<td>NSW Kids and Families</td>
</tr>
<tr>
<td>Ms Chloe Moddel</td>
<td>Telehealth Implementation Officer</td>
<td>NSW Agency for Clinical Innovation</td>
<td>N/A</td>
</tr>
<tr>
<td>Dr Maria Nittis</td>
<td>Department Head, Forensic Medical Units</td>
<td>Blacktown Hospital</td>
<td>Western Sydney LHD</td>
</tr>
<tr>
<td>Mr Hugh Percival</td>
<td>Legal Officer</td>
<td>Legal and Legislative Services</td>
<td>NSW Ministry of Health</td>
</tr>
<tr>
<td>Dr Anne Piper</td>
<td>Community Paediatrician/Training Adviser, Child Protection</td>
<td>John Hunter Children's Hospital</td>
<td>Hunter New England LHD</td>
</tr>
<tr>
<td>Detective S/Sergeant</td>
<td>Staff Officer, Child Abuse Squad</td>
<td>NSW Police Force</td>
<td>N/A</td>
</tr>
<tr>
<td>Ian Priest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Shanti Raman</td>
<td>Paediatrician/Medical and Forensic Practitioner</td>
<td>Liverpool Hospital</td>
<td>South West Sydney LHD</td>
</tr>
<tr>
<td>Dr Carol Stevenson</td>
<td>General Practitioner in Aboriginal Health, Medical Educator, Medical Coordinator</td>
<td>Lismore Sexual Assault Service</td>
<td>Northern NSW LHD</td>
</tr>
<tr>
<td>Dr Dimitra Tzioumi</td>
<td>Staff Specialist, Child Protection Unit</td>
<td>Sydney Children's Hospital, Westmead</td>
<td>Sydney Children’s Hospitals Network</td>
</tr>
</tbody>
</table>

260(29/10/15)
5.6 Interim NSW Health consent form

Reference should be made to: Child Wellbeing and Child Protection Policies and Procedures for NSW Health, 2013 (PD013_007); current standards and guidelines for NSW Health Sexual Assault Services; NSW Interagency Guidelines; Suspected Child Abuse and Neglect (SCAN) Protocol (GL2014_012) and the Child Sexual Assault Medical Protocol in the child Sexual Assault Investigation Kit (SAIK).

I understand that:
- imaging may include any genital and breast/abdominal areas of the body. I have the option to exclude imaging of these or other specific body areas and can advise the examiner accordingly.
- photo and video imaging will be stored securely and confidentially by the NSW Health organisation. Photo and video imaging must be held by the NSW Health organisation for at least 30 years and cannot be destroyed until that time has passed.
- photo and video imaging may be viewed by another forensic examiner for the purposes of obtaining a second opinion or for peer review or by other authorised health workers.
- photo and video imaging can be subpoenaed by the court system as evidence. Where these images are used as evidence they may be viewed by the Judge, the Jury, the Defendant, Counsel for both Prosecution and Defence and any other person whom the Judge considers relevant.
- access to photos and video imaging can be requested by and may be released to the NSW Police Force and/or NSW Department of Family and Community Services.

I consent to de-identified copies of my photo/video imaging being used in:

- (Please tick as applies)
a) teaching ☐ Yes ☐ No
b) research ☐ Yes ☐ No

NOTES: Forensic examiners will:
- record any discussions and respect any requests made by me to exclude imaging of specific body areas.
- inform me that I have the option of withdrawing consent for the future use of images for teaching and research at any stage, noting that in some cases it may not be possible for images that have already been used for education or publication prior to the withdrawal of consent to be withdrawn from circulation.
- inform me that in order to withdraw consent for teaching and research I must contact the Hospital/Service attended for information on the procedure required.

Forensic examiner to document any special requests made by the patient and/or discussions relating to specific consents for imaging below:

__________________________________________
Signature

__________________________________________
Family Name

__________________________________________
Given Names

For Examiner

I am satisfied the person providing consent has both the capacity and authority to consent to the imaging.

Examiner's name ______________________________  Designation ______________________________
Signature ______________________________  Date _____ / _____ / _____

Interpreters name ______________________________  Designation ______________________________
Signature ______________________________  Date _____ / _____ / _____
5.7 Request for Medical Photography Services

Consent must be sought before sending this form to the medical photographer.

<table>
<thead>
<tr>
<th>Request for Medical Photography Services (to be completed by Health Professional requesting service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requester</td>
</tr>
<tr>
<td>Designation/Department</td>
</tr>
<tr>
<td>Signature (of Requester)</td>
</tr>
<tr>
<td>Type of request</td>
</tr>
<tr>
<td>Case history print</td>
</tr>
<tr>
<td>Digital file</td>
</tr>
<tr>
<td>Colour prints</td>
</tr>
<tr>
<td>Black and white prints</td>
</tr>
<tr>
<td>Video/audio</td>
</tr>
</tbody>
</table>

260(29/10/15)
9. HEALTH RECORDS AND INFORMATION

5.8 Good practice example of a process for complying with a withdrawal of consent for de-identified images to be used for future a) teaching and/or b) research activities

For the purpose of complying with a withdrawal of consent for de-identified images to be used for future a) teaching and/or b) approved research activities:

On receipt of consent
- Each de-identified image should be assigned a reference notation
- The reference notation should be recorded in the patient's file
- A register should be:
  - Kept to document and link the reference notation of the de-identified image with the patient file and
  - Maintained for a minimum of 30 years (NSW Government General Retention and Disposal Authority policy, 2004, revised, 2011)
- A copy of the consent must be stored with the de-identified image(s).

On receipt of a withdrawal of consent, for the purpose of compliance and risk analyses, the de-identified image/s must be deleted from:
- Files that are kept and used for the purposes of future teaching and/or research
- Existing training materials, including Powerpoint files, where they are known to exist.
ADOPTION ACT 2000 – RELEASE OF INFORMATION (PD2016_036)

PD2016_036 rescinds PD2010_050

PURPOSE

This Policy Directive provides:

- Information regarding the rights of adopted persons and their families to access information held by Information Sources under the Adoption Act 2000
- NSW Health Information Sources with direction and guidance as to what information should be disclosed to adopted persons and their families and the circumstances in which it should be disclosed.

MANDATORY REQUIREMENTS

Each NSW Health Information Source must have effective systems and procedures in place to ensure adopted persons and their families can access information in accordance with the Adoption Act 2000 and this Policy Directive.

IMPLEMENTATION

Roles and Responsibilities

Chief Executives must ensure:

- The principles and requirements of this Policy Directive are applied, achieved and sustained
- Their medical record staff are made aware of this Policy Directive.

Medical record staff have responsibility to:

- Be aware of this Policy Directive
- Release information to adopted person and their families in accordance with this Policy Directive and the Adoption Act 2000.

BACKGROUND

About this document

The Adoption Act 2000 is administered by the Department of Family and Community Services and sets out the information to which adoptees and their families are entitled to access and the manner in which a person may access that information.

Under the Adoption Act 2000, adopted persons, adoptive parents and birth parents are entitled to access prescribed information held by an “Information Source”. An Information Source includes:

- The NSW Ministry of Health
- A public hospital under the control of a Local Health District
- A statutory health corporation
- An affiliated health organisation, and
This Policy Directive provides specific information on how information about adoptees and their families held by Information Sources should be disclosed.

### 1.2 Legal and legislative framework

Adoption Act 2000  
Adoption Regulation 2015

### 2 GENERAL MATTERS

#### 2.1 Persons making general enquiries

Telephone enquiries should be directed by switchboard to the medical records department. Persons making enquiries should be informed that the Adoption Information Unit of the Department of Family and Community Services offers services regarding past adoptions, including accessing information.

The Adoption Information Unit can be contacted on 1300 799 023 or via email at adoption.information@facs.nsw.gov.au.

Where an enquirer is seeking information held by the NSW Ministry of Health, a public hospital, a statutory health corporation or an affiliated health organisation, this Policy Directive, in conjunction with the Adoption Act 2000 should be complied with.

#### 2.2 Search fees

An Information Source may charge a fee for disclosing information held by the Information Source. Information Sources should refer to PD2006_050 Health Records and Medical / Clinical Reports - Charging Policy in respect of the fees to be charged.

#### 2.3 Information to be provided

Adopted persons, adoptive parents and birth parents are entitled to a variety of information held by an Information Source. This policy only deals with the release of information most likely to be commonly held by NSW Health Information Sources that is health information. If there are further records relating to the adopted person, adoptive parents or birth parents held by an Information Source, you should contact your legal advisor to determine whether the information should be released.

#### 2.4 Proof of identify

Before any information under the Adoption Act 2000 is released to an individual, that individual should provide proof of their identity and, in cases where the individual is seeking information about another person, the individual should provide proof of their relationship to the other person, such as adoption order and birth certificate(s).
2.5 Birth Parents and presumptive fathers

In this policy, a reference to an adopted person’s birth parent includes a reference to the “presumptive father” of the adopted person. Under the Adoption Act 2000, the presumptive father of an adopted person means a man who claims to be the birth parent of the adopted person and who:

(a) Is shown on the adopted person’s original birth certificate as the adopted person’s father, or
(b) Is a person whom the Information Source is entitled to presume under any law to be the adopted person’s father.

If you are unsure whether a particular person is the presumptive father of an adopted person, you should contact your legal advisor.

In some cases, an individual man will be named as the “father” in the medical records but will not be named as the father on the adopted person’s birth certificate. In these cases, the individual man’s identifying information cannot be disclosed to any person. However, in such cases, the medical records department of the Information Source should consider providing the individual man’s details to the Department of Family and Community Services who can determine whether the man would like to exchange information with the adopted person.

2.6 General guidelines for the release of information

Under s142 of the Adoption Act, an Information Source must comply with any guidelines prescribed by the Adoption Regulation before releasing information under the Act. Under clause 105 of the Adoption Regulation, the guidelines below must be complied with.

2.6.1 Confirmation of identity

The Information Source must make reasonable inquiries to confirm the applicant’s identity and relationship to the person to whom the information relates.

2.6.2 Sensitive information

The Adoption Regulation has special guidelines in relation to “sensitive information”. Sensitive information means:

(a) Information indicating that an adopted person was conceived as a result of incest or the sexual assault of his or her birth mother, and
(b) Information indicating that an adopted person has an hereditary condition seriously affecting the current, or that could seriously affect the future, physical or mental health of the adopted person or any descendant of the adopted person, and
(c) Information that could reasonably be expected to be distressing in nature to the person receiving the information.

Before disclosing sensitive information, the Information Source must:

- Make appropriate counselling and support available to the person, and
- Check whether the birth parent’s name is entered in the Reunion and Information Register. If the birth parent’s name is entered on the Reunion and Information Register, the Information Source must not disclose the sensitive information unless the Information Source has taken reasonable steps to ascertain whether the birth parent wishes to provide the information personally.
9. HEALTH RECORDS AND INFORMATION

2.7 Supply Authority

Information may only be disclosed to an individual if that individual provides the Information Source with a Supply Authority issued by the Department of Family and Community Services if:

- The adoption occurred prior to 1 January 2010, or
- The adoption occurred after 1 January 2010 where the applicant is a birth parent or non-adopted sibling.

In some cases, where a Supply Authority is required before information can be released to an individual, that individual may instead produce to the Information Source an original or amended birth certificate issued under the *Adoption Information Act 1990* prior to October 1998 by the Registrar of Births Deaths and Marriages stamped with the words “Not for Official Use”.

If the Information Source is unclear whether the Supply Authority or birth certificate is valid, the Adoption Information Unit should be contacted.

3 RELEASE OF INFORMATION

3.1 Request to access information regarding adoptions occurring on or after 1 January 2010

If an adoption took place on or after 1 January 2010, an adopted person, their adopted parents and birth parents and non-adopted siblings have rights to access information held by an Information Source, including the NSW Ministry of Health, a public hospital, a statutory health corporation or an affiliated health organisation.

3.1.1 Adopted person’s rights

3.1.1 (a) Rights to access information by an adopted person who is over the age of 18

An adopted person who is over the age of 18, and was adopted on or after 1 January 2010, is entitled to receive:

- Information regarding the adopted person’s birth details (including the time of birth and weight and length at birth) and other medical records about the adopted person, and
- Any non-identifying background information about the adopted person’s birth parents, siblings, grandparents, aunts or uncles that will give the adopted person knowledge of his or her origins.

3.1.1 (b) Rights to access information by an adopted person who is under the age of 18

An adopted person who is under the age of 18, and who was adopted on or after 1 January 2010, is entitled to receive information only with the consent of the person’s adoptive parents or the Secretary of the Department of Family and Community Services.

If the adopted person produces a written consent of their adoptive parents or the Secretary of the Department of Family and Community Services, the following information should be provided to the adopted person who is under the age of 18:

- Information regarding the adopted person’s birth details (including the time of birth and weight and length at birth) and other medical records about the adopted person, and
- Any non-identifying background information about the adopted person’s birth parent, sibling, grandparent, aunt or uncle that will give the adopted person knowledge of his or her origins.
3.1.2 **Adoptive Parents’ rights**

An adoptive parent of an adopted person who was adopted on or after 1 January 2010 is entitled to receive the following information held by an Information Source:

- Information regarding the adopted person’s birth details (including the time of birth and weight and length at birth), and
- Any non-identifying background information about the adopted person’s birth parent, sibling, grandparent, aunt or uncle that will give the adoptive parent knowledge of the adopted person’s origins.

3.1.3 **Birth Parents’ rights**

3.1.3 (a) **Rights to access information by a birth parent where the adopted child is under the age of 18**

A birth parent of a person, under the age of 18, who was adopted on or after 1 January 2010 is entitled to receive information held by an Information Source only if the birth parent produces to the Information Source a Supply Authority issued by the Secretary of the Department of Family and Community Services authorising the disclosure of the information. Where a birth parent provides such a Supply Authority, the birth parent is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Any non-identifying background information about an adopted person or his or her adoptive parents that will give the birth parent knowledge of the adopted child’s life, and
- Birth details of the adopted person (including the time of birth and weight and length at birth).

If the birth parent does not have a Supply Authority, information can be released if the head of the Information Source, that is the Health Secretary or the Chief Executive Officer of the relevant Information Source, is of the opinion that the information cannot be used to identify the adopted person or their adopted parents.

3.1.3 (b) **Rights to access information by a birth parent where the adopted child is over the age of 18**

A birth parent of a person, over the age of 18, who was adopted on or after 1 January 2010 is entitled to receive any of the following information held by an Information Source:

- Any non-identifying background information about an adopted person or his or her adoptive parents that will give the birth parent knowledge of the adopted child’s life, and
- Birth details of the adopted person (including the time of birth and weight and length at birth).

3.1.4 **Non-adopted sibling’s rights**

A non-adopted sibling, of a person adopted on or after 1 January 2010, is able to access any non-identifying background information held by an Information Source about the adopted person or his or her adoptive parents and adoptive family that will give the non-adopted sibling knowledge of the adopted person’s life. However, if the non-adopted sibling is under the age of 18, information can only be released with the written consent of the non-adopted sibling’s parents or the Secretary of Family and Community Services.
3.2 Request to access information regarding adoptions occurring before 1 January 2010

If an adoption took place before 1 January 2010, an adopted person, their adopted parents and birth parents have rights to access information held by an Information Source, including the NSW Ministry of Health, a public hospital, a statutory health corporation or an affiliated health organisation.

3.2.1 Adopted person’s rights

3.2.1 (a) Rights to access prescribed information by an adopted person who is over the age of 18

An adopted person who is over the age of 18, and was adopted before 1 January 2010, is entitled to receive information held by an Information Source only if the adopted person produces to the Information Source a Supply Authority issued by the Secretary of the Department of Family and Community Services authorising the disclosure of the information. Where the adopted person provides such a Supply Authority, the adopted person is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Any relevant non-identifying information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of a birth parent, sibling, grandparent, aunt or uncle of the adopted person and that will give the adopted person knowledge of his or her origins, and
- Copies of medical reports of examinations of the adopted person made before the date of the adoption order.

3.2.1 (b) Rights to access prescribed information by an adopted person who is under the age of 18

An adopted person who is under the age of 18, and who was adopted before 1 January 2010, is entitled to receive information only with the consent of the person’s adoptive parents or the Secretary of the Department of Family and Community Services. If the adopted persons produce a written consent of their adoptive parents or the Secretary of the Department of Family and Community Services, the following information should be provided to the adopted person who is under the age of 18:

- Any relevant non-identifying information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of a birth parent, sibling, grandparent, aunt or uncle of the adopted person and that will give the adopted person knowledge of his or her origins, and
- Copies of medical reports of examinations of the adopted person made before the date of the adoption order.

3.2.2 Adoptive parent’s rights

An adoptive parent of a child, under the age of 18, who was adopted before 1 January 2010 is entitled to receive any relevant non-information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of a birth parent, sibling, grandparent, aunt or uncle of the adopted person and that will give the adoptive parent knowledge of the adopted person’s origins.
3.2.3 **Birth parent’s rights**

### 3.2.3 (a) Where the adopted person is over the age of 18

A birth parent of an adopted person over the age of 18 adopted before 1 January 2010, is only entitled to receive information about the adopted person if the birth parent produces a Supply Authority from the Secretary of the Department of Family and Community Services authorising the disclosure of relevant information. If the birth parent produces such a Supply Authority, the birth parent is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Any relevant information that is held by an Information Source about the physical and intellectual attributes, educational and vocational qualifications, social and cultural background, health and welfare, family and other relationships, religious beliefs, hobbies and interests of an adopted person or his or her adoptive parent and that will give the birth parent knowledge of the adopted child’s life after adoption
- Birth details (including the time of birth and weight and length of the person at birth), and
- Copies of medical reports and examinations of the adopted person made before the date of the adoption order.

### 3.2.3 (b) Where the adopted person is under the age of 18

A birth parent of an adopted person under the age of 18 is only entitled to receive information about the adopted person if the birth parent produces a Supply Authority from the Secretary of the Department of Family and Community Services authorising the disclosure of relevant information. If the birth parent produces such a Supply Authority, the birth parent is entitled to receive the following information, subject to any conditions in the Supply Authority, held by an Information Source:

- Birth details (including the time of birth and weight and length of the person at birth), and
- Copies of medical reports and examinations of the adopted person made before the date of the adoption order.

If the birth parent does not have a Supply Authority, information can be released if the head of the Information Source, such as the Chief Executive Officer of the relevant Information Source, is of the opinion that the information cannot be used to identify the adopted person or their adopted parents.
## 9. HEALTH RECORDS AND INFORMATION

### 4 ATTACHMENT 1: IMPLEMENTATION CHECKLIST

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256(25/8/16)
ELECTRONIC INFORMATION SECURITY POLICY - NSW HEALTH (PD2013_033)

PD2013_033 rescinds PD2008_052.

PURPOSE

NSW Health is committed to the provision of appropriate levels of security across all of its information systems. Health information systems containing personal information are acknowledged as having particular security requirements, and are explicitly addressed in this policy.

This policy is based on a number of key principles. These are:
- NSW Health’s major objective is the provision of health care services underlined by the overall welfare of the people it treats.
- All personal health information will be securely managed and that privacy and confidentiality will be preserved. The community must be confident NSW Health observes this principle.
- All other critical and sensitive information will also be securely managed and privacy and confidentiality maintained.
- Personnel have a responsibility for the security and maintenance of critical and sensitive information including personal health information.
- All other information must be classified for the purposes of determining the level of security required as per Australian Government Security Classification System as represented within NSW Government - Digital Information Security Policy M2012-15.
- Providing information security education and developing awareness for all people dealing with electronic information is an integral part of maintaining adequate protection over that information.
- The release of information will comply with relevant and current state and federal legislation.
- The implementation of information security controls to mitigate the risks to sensitive information without impacting the timely provision of those services.
- It is also the responsibility of all NSW Health personnel and their contractors to be aware of and comply with the requirements of the Privacy Manual for Health Information (March 2015) and the NSW Health Privacy Management Plan (PD2015_036).

Please refer to Sections 2 & 3 of the Electronic Information Security Policy which provide further guidance on the policy.

MANDATORY REQUIREMENTS

The Government’s digital information systems security objectives as stated in the new Ministerial Memorandum (M2012-15) are:
- **Confidentiality** – to uphold authorised restrictions on access to and disclosure of information including personal or proprietary information.
- **Integrity** – to protect information against unauthorised alteration or destruction and prevent successful challenges to its authenticity.
- **Availability** – to provide authorised users with timely and reliable access to information and services.
- **Compliance** – to comply with all applicable legislation, regulations, Cabinet Conventions, policies and contractual obligations requiring information to be available, safeguarded or lawfully used.
- **Assurance** – to provide assurance to Parliament and the people of NSW that information held by the Government is appropriately protected and handled.
9. HEALTH RECORDS AND INFORMATION

To meet the above requirements and provide appropriate assurance, implementation guidance is included as Appendix A of the policy.

IMPLEMENTATION

This policy covers security requirements for NSW Health information including electronic personal health information.

This policy applies to all employees, contractors and other persons who, in the course of their work, have access to information (including electronic personal health information) in or on behalf of the NSW public health system.

Please refer to the Section 4 titled ‘Scope’ of the Electronic Information Security Policy for implementation and scope of policy requirements.

Where access is granted to information held by the public health system for research or other purposes, the person or organisation granted access must, under the conditions of access, also be required to comply with the terms of this policy.

Compliance with this policy and all relevant acts and regulations as they relate to information security is mandatory for management, personnel and all persons handling electronic information, whether directly or indirectly involved in client service delivery.

All personnel and organisations referred to above should be aware of their legislative confidentiality obligations and that the breach of those obligations may result in prosecution and the imposition of a penalty or disciplinary actions.

1. Introduction

This document is Version 3.0 of the “NSW Health Information Security Policy” (PD2005_314).

The first version of this policy was issued on 8 July 2003 as Circular 2003/47 and published as a Policy Directive (PD2005_314) on 27 January 2005. The policy was developed following extensive consultation with a wide range of stakeholders, including significant input from clinicians.

The Second version of this policy was issued on 15 September 2008 as Premiers Memorandum M2007-04 and published as a Policy Directive (PD2008_052).

Publication of New Versions has become necessary for the following reasons:

- The applicable national standards relating to information security have changed (the new standards are AS/NZS ISO/IEC 27001:2006 and AS/NZS ISO/IEC 27002:2006);
- Government policy has been updated accordingly and the actions required of agencies in achieving the Government’s objectives have changed. The updated policy is stated in Ministerial Memorandum M2012-15;
- The relevant NSW Health policies concerning the privacy of personal information have been updated. The Privacy Manual for Health Information (March 2015) and the “NSW Health Privacy Management Plan” (PD2015_036);
- To incorporate the changes in structure and requirement relevant to NSW Government Digital Information Security Policy Version 1.0 Released in Nov 2012 as Premiers Memorandum M2012-15;
- As per scheduled periodic review cycle.
2. Information Security Policy Statement

NSW Health is committed to the provision of appropriate levels of security across all of its information systems. Health information systems containing personal information are acknowledged as having particular security requirements, and are explicitly addressed in this policy.

This policy is based on a number of key principles. These are:

- NSW Health’s major objective is the provision of health care services underlined by the overall welfare of the people it treats.
- All personal health information will be securely managed and that privacy and confidentiality will be preserved. The community must be confident NSW Health observes this principle.
- All other critical and sensitive information will also be securely managed and privacy and confidentiality maintained.
- Personnel have a responsibility for the security and maintenance of critical and sensitive information including personal health information.
- All other information must be classified for the purposes of determining the level of security required as per Australian Government Security Classification System as represented within NSW Government – Digital Information Security Policy M2012-15.
- Providing information security education and developing awareness for all people dealing with electronic information is an integral part of maintaining adequate protection over that information.
- The release of information will comply with relevant and current state and federal legislation.
- The implementation of information security controls to mitigate the risks to sensitive information without impacting the timely provision of those services.

3. Privacy Statement

All public sector agencies in NSW, including the public health sector, are required to comply with the Privacy and Personal Information Protection Act 1998 and the Health Records Information Privacy Act 2002, which set out a series of rules designed to protect the privacy of personal information, including personal health information, in NSW.

It is the responsibility of all NSW Health personnel and their contractors to be aware of and comply with the obligations imposed by the Act.

It is also the responsibility of all NSW Health personnel and their contractors to be aware of and comply with the requirements of the Privacy Manual for Health Information (March 2015) and the NSW Health Privacy Management Plan (PD2015_036).

These documents list the relevant NSW Health Policy Directives, other NSW Health and government policies and the relevant laws. It is the responsibility of all NSW Health personnel and their contractors to be aware of and comply with the obligations imposed by these policies and laws.

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1 In the context of this document the term NSW Health includes all NSW Health organisations. The NSW Health organisations are: Local Health Districts (including public health units, public hospitals and Community Health Centres)/Chief Executive Governed Statutory Health Corporations, Board Governed Statutory Health Corporations, Affiliated Health Organisations – Health Administration Corporation (including HealthShare), Dental Schools and Clinics, NSW Ambulance Service, and the NSW Ministry of Health.

2 All unclassified information should be treated as “For Official Use Only” information.
4. **Scope**

This policy covers security requirements for NSW Health information including electronic personal health information.

“Electronic information” is information that is electronically created, processed, held, maintained and transmitted by NSW Health. It also refers to information held electronically for or on behalf of other government agencies or private entities.

“Personal health information” is personal information which concerns a person/client’s health, medical history or past or future medical treatment. It also includes other personal information collected in the course of providing a health service or information collected in relation to donation of human tissue.

“Personal information” is information or an opinion (including information or an opinion forming part of a database and whether or not recorded in a material form) about an individual whose identity is apparent or can be reasonably be ascertained from the information or opinion.

Any identifiable information is subject to this policy.

This policy applies to all information created, processed, held, maintained or transmitted by the NSW Health information or communication infrastructure. This policy shall apply to all information held for, or on behalf of, other government agencies or private entities.

Information systems refer to any information or communication infrastructure used by NSW Health and all personnel that work with it, including computer hardware and software, to create, process, hold, maintain or transmit electronic information.

For example:
- file, database and communication servers;
- computers and/or devices whether connected to a network or stand-alone (notebooks, terminals, tablets, smart phones, storage devices etc.);
- NSW Health mainframes and mid-range computers;
- devices used to store or transmit electronic data (USB storage, switches, wireless access points, etc.);
- providers of information services for NSW Health, government agencies or private entities that have been granted access rights to NSW Health information systems.

This policy applies to all employees, contractors and other persons who, in the course of their work, have access to information (including electronic personal health information) in or on behalf of the NSW public health system. This includes but is not limited to:
- providers of health services such as doctors, nurses, case managers, visiting medical officers (VMO’s) etc.;
- providers and allied health personnel;
- ambulance officers;
- administrators, clerical and service personnel;
- support staff;
- technical, research, scientific and laboratory personnel;
- auditors;
- interpreters;
9. HEALTH RECORDS AND INFORMATION

- volunteers;
- Students;
- Consultants;
- temporary and contract personnel;
- external custodians of information owned by the department.

The policy applies to:
- NSW Health organisations;
- non-government organisations receiving funding from the department where compliance is included in the terms of their funding agreement;
- private hospitals and day procedures centres treating public patients/clients on a contractual basis, where the contract includes requirements for compliance with NSW Health policies;
- personnel of Health Professional Registration Boards (excluding medical, Dental and Pharmacy boards).

Where access is granted to information held by the public health system for research or other purposes, the person or organisation granted access must, under the conditions of access, also be required to comply with the terms of this policy.

Compliance with this policy and all relevant acts and regulations as they relate to information security is mandatory for management, personnel and all persons handling electronic information, whether directly or indirectly involved in client service delivery.

All personnel and organisations referred to above should be aware of their legislative confidentiality obligations and that the breach of those obligations may result in prosecution and the imposition of a penalty or disciplinary actions.

5. Information Security Requirements

The use of information and information systems is an integral part of most NSW Government activities. Electronic information assets are critical in agencies operations and are key element in delivering trustworthy government services. The security threats to information assets are increasing. The government has a duty to safeguard its large information holdings and must provide credible assurance that it is doing so. In 2001 Cabinet recognised these trends and directed that all agencies were to appropriately protect electronic information. In 2006, the document ‘People First – A new direction for ICT in NSW’ reaffirmed the importance of information security.


The Government’s digital information systems security objectives as stated in the new Ministerial Memorandum (M2012-15) are:
- **Confidentiality** – to uphold authorised restrictions on access to and disclosure of information including personal or proprietary information.
- **Integrity** – to protect information against unauthorised alteration or destruction and prevent successful challenges to its authenticity.
9. HEALTH RECORDS AND INFORMATION

- **Availability** – to provide authorised users with timely and reliable access to information and services.
- **Compliance** – to comply with all applicable legislation, regulations, Cabinet Conventions, policies and contractual obligations requiring information to be available, safeguarded or lawfully used.
- **Assurance** – to provide assurance to Parliament and the people of NSW that information held by the Government is appropriately protected and handled.

Agencies and shared services providers should adopt the following Core Requirements of the Digital Information Security Policy (DIS Policy):

1. Implement an Information Security Management System as set out in the Digital Information Security Policy;
2. Comply with the minimum controls as set out in the Digital Information Security Policy;
3. Certify the ISMS implementation where applicable;
4. Nominate a Senior Responsible Officer to represent the organisation in the Digital Information Security - Community of Practice where applicable; and
5. Provide attestation to compliance with policy if applicable.

To meet the above requirements and provide appropriate assurance, implementation guidance is included as appendix A.

Management must ensure that the implementation of information security is aligned with the organisation’s goals. This will be an important aspect for management to consider as it addresses the requirements specified by the national standards. While these standards specify particular practices to safeguard electronic information, these practices must not be adopted without regard for the organisation’s actual risk profile and business objective(s).

Guidelines should be developed where requirements specified by the standards need to be amended to meet the specific requirements of NSW Health. Not all the controls described in the standard will be relevant to every situation, nor can they take account of local environmental, budgetary or technological constraints, or be present in a form that suits every potential user in an organization.

The risk management approach allows for the tailoring of the controls to the situation. The National Standards AS/NZS ISO 31000 Risk management - Principles and guidelines, (or subsequent versions) should be used in implementing this approach.

6. National Standards

The national standards for an Information Security Management System (ISMS) are:

- AS/NZS ISO/IEC 27001:2006 Information technology – Security techniques –Information security management systems – Requirements; and

Both have been formally adopted unchanged as Australian & New Zealand standards and the previous standard 17799 has been renumbered as 27002. The standards are reviewed and updated about every 3 years and compliance is always to be to the current editions. Certification is to AS/NZS ISO/IEC 27001 and certifiers must be accredited by an accreditation body authorised by a national government.
9. HEALTH RECORDS AND INFORMATION

The security standards are management standards and there are synergies between information security management and other management standards such as AS/NZS ISO 9001 Quality Management Systems or ISO/IEC 20000 Information technology - Service management (ITIL). It is strongly recommended that agencies that have or are seeking compliance with other management standards reduce their implementation effort by using the same management system infrastructure for compliance with different standards.

7. Roles and Responsibilities

The main objective of NSW Health is to deliver high quality care. The availability of reliable and accurate information is a key factor in the delivery of care. Clearly defined roles and responsibilities assist in the proper protection of the information assets of NSW Health.

Management (CEs or their delegates)
Management commitment to information security is demonstrated by ensuring that:
• this policy and other associated policies are implemented;
• an information security risk management system is established;
• adequate resources are allocated to policy implementation.

The CIO NSW Health
The CIO NSW Health is responsible for the management of the information security policy, procedures and guidelines.

Data/Business/Information Owners
The Data or Information Owners have the responsibility for defining the corporate information requirements and data governance policies which include development of standards and requirements for security, retention and disposal of corporate information for their information assets. They are responsible to also manage the risks to their information assets regardless if they have outsourced ICT or are sharing the risks with service providers.

Data Custodians
The Data Custodian has the responsibility for establishing and maintaining an acceptable level of data protection, for managing the disclosure of data, for ensuring that the data is used in accordance with the reasons for which it is collected and that the data is complete, of acceptable quality and is available to authorised users.

System Administrators
System administrators need to know and follow acceptable procedures for granting/revoking access, identifying and resolving known vulnerabilities, and monitoring system access. They are responsible for development of practices and procedures to support the policy and ensure compliance with the security requirements of information owners.

IT Technical and Support Staff
IT Technical and Support Staff are charged with ensuring the correct and secure configuration of systems such as servers, networks, firewalls and routers. Systems developers and maintenance staff are responsible for delivering reliable software. Technical staff should understand the business use and risks associated with the technologies being used so that security solutions match the criticality and sensitive nature of the systems. They are responsible for development of practices and procedures to support the policy and ensure compliance with the security requirements of information owners.
Users
Users of agency electronic information play an important role in overall electronic information security planning and risk management process. The effective participation of users requires a certain culture, as well as education. The culture must be supported by management directives, an education program and demonstrable support for the protection of electronic information. Users must be aware of their responsibilities with regards to Information Security and Privacy. Users have a role in identifying and reporting security concerns and incidents to management for investigation and review.

Third Party Businesses and Organisations, Consumers and Other Agencies
The growing existence of inter-connected networks requires the extension of the ‘boundaries’ of an agency. Agency executive management must ensure that third parties understand Information Security requirements and ensure that adequate security controls are in place in their own environment. All third parties must adhere to NSW Health and agency policy and procedures.

Independent Reviewer/Audit
The role of independent reviewers and auditors is to assess the effectiveness and efficiency of implemented controls, assess whether controls are being adhered to, and to check compliance against policy and legislative requirements. Review and audit reports should be noted by executive management and remedial action taken, if appropriate.

Policy Maintenance
This policy shall be reviewed by the NSW Ministry of Health and their delegates to ensure that it remains relevant and up to date with NSW Health business objectives and accurately reflects any changes in legislation or business practices that affect the security of electronic information including electronic personal health information, either directly or indirectly.
8. Appendix A – Implementation Guidelines

Intention and Principles
Technological advancement has provided significant benefits within Health and NSW Government; it has also equipped malicious users with more advanced means and tools to obtain unauthorised access to information. Any information system usage or implementation may be a target for a range of serious threats, including computer based fraud, espionage, sabotage, vandalism and other forms of systems failure or disaster. This may result in risk of data loss/leakage from accidental/malicious unauthorised access, misuse, misappropriation, modification or destruction of information and information systems that may impact service delivery. Moreover, sharing of information for business reasons, using new applications and inter-connected resources, increases the threat of information theft, loss and exposure to breaches.

Considering all the above threats, NSW Health intends to implement a structured and consistent approach to address information security risks within NSW Health. The intention is that all NSW Health agencies operate a comprehensive information security management system that meets their business-orientated security needs. This system is to comply appropriately with the national standard for such systems. Appropriateness is determined by the risks to the agency’s information assets and the potential ‘business’ implications of those risks. To provide assurance to stakeholders, including partners in government or business, the main part of the Information Security Management System (ISMS) is to address the risks based on priorities.

The principles for implementing information security are:
• Managing risks to information assets is the basis for selecting and operating information security countermeasures and controls;
• Information security countermeasures and controls are implemented and operated as elements of an Information security management system that is planned and controlled through effective management processes; and
• The cost of information security countermeasures and controls must be proportionate to the risks to information assets.

Risks and Threats
An information security risk is the combination of the likelihood and consequences of a potential information security incident or event. Information security risks arise from threats that may affect information assets in a way that adversely impacts information security objectives:
• Threats usually exploit vulnerabilities in information systems and the people that use them;
• Threats may originate internally or externally, they may be accidental or deliberate, malicious or well-meant and have human, technical or environmental sources;
• The motives behind malicious or criminal threats vary widely and will, in part, depend on how information assets can be exploited for unauthorised purposes;
• The potential value of unauthorised use of information is an important consideration and may indicate the likelihood of a threat; and
• Unacceptable information security risks are those that the ‘business’ cannot tolerate.

The key to managing information security risks in an agency is to understand the agency’s information assets, their ‘business’ significance and active involvement of the information owners in managing security of their information.

An information asset has a ‘business’ owner, ‘business’ purpose and ‘business’ value. Asset value includes both its legitimate value and its value to unauthorised users, as well as its importance to the ‘business’ and wider consequences of a security incident.
Generally an information security incident could have one or more of the following ‘business’ consequences:

- Loss of financial or material assets by agency or public - may include losses through theft or fraud, rectification costs, legal liabilities, other unbudgeted costs or lost entitlements. Losses will usually be a consequence of an information integrity failure but confidentiality or availability failures may create opportunities for loss or illegitimate gain.
- Injury or death of public or staff - could be the result of confidentiality, integrity or availability failures. If the consequences are a direct result of an ICT failure (e.g., in a real-time control system) then that system is ‘safety critical’ and appropriate methods must be applied to it.
- Inconvenience or distress to public or staff - may be a direct or secondary consequence of an event, e.g., a temporary financial loss may cause inconvenience and distress. Could arise from confidentiality, integrity or availability failures.
- Damage to standing or reputation of the Government, an agency or person, including the confidence or morale of stakeholders in a service or agency. It may be lost through confidentiality, integrity or availability failures. Treatments may include publicity campaigns to rebuild reputation or confidence and these have financial costs.
- Assist an offence or regulatory breech, hinder investigation or enforcement - may directly impact law enforcement or regulatory operations. Crime or regulatory avoidance may threaten confidentiality, integrity and availability elsewhere and have other consequences.
- Degrade the capability to deliver services internally or externally - a loss of operating capability is most likely from loss of information integrity or availability. The period required for a failure to become significant will depend on the nature of the information affected and the extent of operating dependency on it. Loss of capability may also cause regulatory non-compliance, adverse effects on stakeholders and loss of control over activities.

**Approach**

The overall objective of a management system is to ensure that current information security risks are properly identified and effectively and efficiently managed. This emphasises that information security is a management issue and a matter of information and communication technology (ICT) governance, not merely a technical problem. Deploying appropriate technical measures is necessary but insufficient to ensure continuing information security. When identifying possible threats a broad ‘business’ approach must be taken to the value of an agency’s information. This approach must consider at least agency, government and public perspectives.

Identification and assessment of the main risks enables suitable management arrangements and key policies to be established. These provide the information security management framework. Once this framework exists critical risks can be assessed more thoroughly and other risks considered. With management arrangements in place appropriate security measures, including procedures and processes, can be planned, adapted or implemented.

**Access Control**

Access control is one of the most important countermeasures in ensuring that individuals are restricted to information on a need-to-know basis and protect corporate information from unauthorised access. This concept is known as the principle of least privilege. Controls and standards for logical access should be detailed, comprehensive, and effective.

Access to NSW Health information assets will be granted based on the business need for such access. To maintain effective control over access to information, the various information asset owners should conduct a regular review of access rights.
9. **HEALTH RECORDS AND INFORMATION**

User registration should be authorised and ensure that unique user identifier is assigned to all users. Passwords used for authentication must be kept secret and should align with appropriate password policies and standards for the agency.

No group or shared credentials and accounts are allowed for interactive login. User ID’s should be unique to each user to ensure audit and control over permissions. The information services director or their delegate may make an exception to this under appropriate circumstances.

Users are accountable for actions performed using their user ID’s.

The allocation and use of access privileges should be appropriately managed and restricted. Privileges should be assigned following the principle of least privilege access control and approved by the relevant information asset owner.

**Backup & Storage Media Handling**

Backup of data and information is required to maintain the integrity and availability of information processing and communication services.

A backup/restore strategy and procedures shall be developed for that purpose to ensure that such information is available in line with business requirements.

Storage media should be appropriately protected and managed based on the classification of information contained on that media.

Usage of personal storage media such as external storage devices is in accordance with the Use and Management of Misuse of NSW Health Communications System PD2009_076.

All storage media which contains information classified “For Official Use Only or Sensitive” or higher should be disposed of securely and safely by, or on behalf of, the asset owner when the media is no longer required. This should be in compliance with the State Records Authority disposal and retention requirements.

**Business Continuity Management**

All NSW Health agencies should develop a business continuity plan for all the high risk and critical business functions. These plans should be periodically tested and regularly maintained.

**Clear Screen and Clear Desk**

Users should ensure that unattended equipment has appropriate protection. Computer screens should be locked when unattended and users should shut down or logoff the machines when not being used.

Users should maintain clean and secure storage and work areas and ensure sensitive documents are secured appropriately. Sensitive documents and information should not be left unattended.

All documents which are no longer required can be disposed of in a secure fashion. This should be in accordance with State Records Authority and any other disposal regulation or applicable policy.

All non-public documents when printed or scanned should be cleared from printers or scanners, as soon as practical, especially if they are classified as for official use only, sensitive or higher.
9. HEALTH RECORDS AND INFORMATION

Confidentiality Agreements
Confidentiality or Non-Disclosure Agreements (NDA) for protection of “for official use only”, “sensitive” or higher classifications - NSW Health information should be signed before granting access to contractors and third parties.

Cryptographic Controls
Based on the risk profile of information systems appropriate cryptographic controls should be used. Cryptographic controls will be deployed and managed as directed by the regulations governing any such usage.

To maintain the security and integrity of the cryptographic keys and their underlying infrastructure, processes and procedures should be developed and documented to avoid risk exposure to information assets.

Electronic Messaging
Electronic messaging such as email can lead to accidental or deliberate disclosure of information to unauthorised users. For this purpose, the Management and Misuse of NSW Health Communications Systems (PD2009_076) Policy Directive should be adhered to by users of the email system.

Sending information that is classified as ‘sensitive’ or higher to the destinations external to the NSW Health should be encrypted using approved encryption technologies, in accordance with local laws and regulations. Communication standards such as email, FTP, telnet, Mobile SMS, instant messaging and web traffic (HTTP) are not considered secure and should be avoided.

Equipment Security
Only authorised equipment can be connected to NSW Health networks and equipment. This includes mobile devices, modems, PDAs, wireless access points, portable storage devices, CD/DVD burners and printers.

Where possible, equipment should be named and labeled as per a standard naming convention.

Fixed equipment such as servers, networking equipment and desktop computers belonging to NSW Health shall only be removed with proper authorisation. Procedures shall be used to secure equipment used outside of NSW Health premises.

All equipment should be maintained in accordance with the recommended service specification and should be disposed securely when no longer required.

Hardcopy Information
The primary focus of these guidelines is on electronic information. In practice the boundary between hard and softcopy is seldom clear-cut from a security perspective because of transformation between them. However, the inherent characteristics of the different media mean that the risks are different.

Generally, the integrity and confidentiality of hardcopy information is less vulnerable to large-scale loss but the difficulty of maintaining hardcopy ‘backups’ can make the availability of this type of information more vulnerable to disasters. It is not the intention that agencies review and update the security measures for all their existing hardcopy information. However, improved physical security for electronic information assets will often improve the security of hardcopy information. Further guidance is given in Premier’s Circular 2002-69 Labeling Sensitive Information.
Human Resources/Personnel - Security
Recruitment and selection processes for personnel, contractors, vendors and contingent workers will be undertaken to ensure adequate background, reference and criminal record assessments. Adequate induction and ongoing training should be provided taking into account the sensitivity of the position, and the classification of information they have access to.

Documented processes managing the change or termination of employment will be followed.

ICT Operations
Controls shall be introduced in networks to segregate groups of information services, users and information systems based on the sensitivity of the information. NSW Health networks should provide segregation between internal and external networks.

Access to network equipment should be restricted to authorised personnel only.

All changes to the ICT environment should be approved through formal change management practices.

Information Asset
Narrowly defined, electronic information assets are the data and software; owned by, licensed, leased or entrusted to an agency. It may be at rest or in transit within an agency’s systems, or being communicated to an external party. An extended definition includes hardware, networks and intangibles such as reputation, goodwill, trust, staff morale and productivity. It may be appropriate to deal with the intangibles as possible consequences of security incidents affecting other information assets.

Each information asset has an owner or custodian within the agency. The ICT group may be the ‘owner’ of ICT infrastructure. However, business information is ‘owned’ by business units. These units are responsible for ensuring that the risks to their information assets are realistically assessed and appropriately treated in accordance with Government and agency policies, etc. The appropriate level of management must formally accept any residual risks to information assets.

Acceptable usage of information assets are broadly outlined in Use & Management of Misuse of NSW Health Communications Systems, PD2009_076.

Interconnection of business and health information systems
Adequate measures should be developed and documented to ensure only approved and authorised interconnection of the NSW Health information systems with other government agencies and any third parties.

Mobile Computing, Tele-working and Remote Access
The use of mobile computing facilities and devices should be strictly governed and controlled. All the mobile computing devices should be adequately secured utilising technologies such as encryption and pass or PIN codes. Where a device is lost or stolen the relevant Information Services department or equivalent should be notified to ensure at-risk services are suspended immediately.

Mobile users should ensure that assets like tokens/laptops/smart devices and mobile phones are not left unattended and visible in public places such as airports, cafes and the back seats of motor vehicles where the risk of theft is higher. Users working remotely should also consider their environment, and take steps to ensure that equipment and information is appropriately secured from theft or disclosure to unauthorised persons.
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Tele-working uses communications technology to enable staff to work remotely from a fixed location outside of their branch site location, also known as Remote Access. Remote access should be appropriately authenticated (use of multi-factor authentication is recommended) and connectivity should be protected by approved controls.

**Monitoring and Logging**

Access of NSW Health networks and resources shall be granted to only those entities who agree on consent of monitoring. Adequate logging mechanism shall be deployed to record user activities, exceptions, and information security events. Logs should be kept for the appropriate retention period to assist in future audit and access control monitoring. These logs should be protected from any accidental or deliberate modification.

The correct setting of computer clocks is important to ensure the accuracy of audit logs, which may be required for investigations or as evidence in legal or disciplinary cases such as forensic investigations. Systems clocks shall be synchronised for accurate recording to a common time source.

**Outsourcing**

Agencies that outsource any of their electronic information operations retain ownership of and responsibility for their information assets. These agencies should maintain an inventory of the external/third-party service providers and any agency’s ISMSs must include these assets if they are in scope.

Agency policies, etc., are to define clearly the detailed security responsibilities of the agency and of the provider of outsourced services affecting the agency’s information assets. These will be reflected in contracts and service level agreements with service providers, including mechanisms to ensure they can be modified to reflect changing risks. The goal is to ensure there are no gaps or ambiguities between the ISMSs of the two parties.

Regular reviews of the outsourced services and operations shall be conducted to identify the changes or improvements to the provision of services. Such reviews should also assess ongoing access requirements and compliance to the NSW Health policies.

Generally, agencies are to require the certification of outsourced service providers’ ISMS’s to the national standard.

Agencies that have outsourced will still require their own compliant and certified ISMS, even when they have no residual ‘insourced’ ICT. Subject to risk assessment, the outsourcing agency’s ISMS Statement of Applicability will focus on the non-technical aspects of their information security environment. This will ensure that the agency has effective measures for the control of their information assets and the use of assets provided by the outsourcer.

Small agencies that function as units of larger ones or are supported by secretariats or staff from larger agencies should be treated as part of the larger agency for information security compliance and certification purposes. Their inclusion should be noted in the larger agency’s Statement of Applicability.

**Physical Security**

NSW Health agencies should ensure adequate physical security is applied on all information processing facilities. The selection and design of information processing premises should take into account the possibility of damage from fire, flood, explosion, accidents, malicious intent, and other forms of natural or man-made disasters.
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In addition, all Health agencies should identify and maintain an inventory of physical locations/facilities especially where business critical/sensitive assets are hosted. Delivery and loading areas shall be controlled and, if possible, isolated from information processing facilities to avoid unauthorised access.

Access to sensitive information and information processing locations/facilities is restricted to authorised persons only. An audit trail of access should be maintained especially when access to facilities where sensitive information is located.

Protection against Malicious code including Mobile Code
Software and information processing facilities are vulnerable to the introduction of malicious software. Appropriate controls should be implemented to detect and prevent the introduction of malicious software, such as computer, viruses, worms, Trojan horses, root-kits, spyware, and other malware. Users must not disable or interfere with these controls.

Publicly Available Electronic Information
Release of electronic information to the public or service provider should be approved by the relevant branch authority and/or Communications Department.

Reporting Security Incidents & Managing Contacts
To reduce the business consequences and to take appropriate action against all security concerns and incidents should be reported to senior management. Consistent and repeatable processes should be adopted to address security weaknesses and events across NSW Health.

The health agencies should maintain contacts with authorities and special interest groups for liaison on operational issues. Examples of some authorities and interest groups are:
- Fire and Rescue Department
- Law Enforcement authorities
- NSW Ministry of Police and Emergency Services
- State Emergency Services (SES)
- Telecommunications Service Providers
- Electricity/Energy Service Providers
- Internet Service Providers
- Digital Information Security Community of Practice
- AUSCERT
- Defense Signals Directorate
- Specialist industry forums and groups

Separation of Development, Test and Operational Facilities
The level of separation between production, testing and development environments needs to be considered to prevent operational impact to services. Testing and development environments should be separated from production (operational) facilities.

Use of production data in test and development environments should be carefully controlled, and where possible, sensitive information should be removed before being utilised for testing purposes.

Security Requirements in Systems and Applications
The design and/or implementation of new applications and systems should take into account the security requirements and objectives of the agency. These requirements should include consideration of the classification of the information to be maintained or managed by these systems or applications.
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Requirements should also take in to account information retention and business continuity requirements.

Changes to applications and systems should also take into consideration the information security requirements.

**Software licensing and use**
Only authorised software should be used. Any exceptions should be authorised from appropriate Information Services Director or their delegate. All software should be used in accordance with specified license or copyright terms and conditions. Unlicensed software shall not be installed for any reason.

**Technical Vulnerability Management**
Sensitive information systems should be subject to periodic vulnerability assessment. Adequate assessment and penetration testing processes should be used to identify the level of risk exposure for other Information systems due to these vulnerabilities. Vulnerabilities and system patches should be prioritised for remediation commensurate with the risk to the NSW agency’s information systems.

Technical audit and assessments reports should be considered sensitive and protected to prevent any possible misuse or exploit.

**Time Scale and Resources**
Agencies are to achieve the Government’s information security objectives as soon as possible. Progress will be monitored through a security status framework. Achievement of the objectives is marked by appropriate certified compliance with the standards and continuance of certification.

Information security, like physical security, is a routine function in which all staff has some role. Agencies are to act economically by making maximum use of their internal resources. Training may be necessary in some agencies. Agencies are also strongly encouraged to share security knowledge and resources. In some agencies external resources may be needed to advise, mentor inexperienced security staff and provide expert review of risk assessments and security plans.

**Online Financial Transaction**
All financial transactions carried out in the public domain or network should deploy the APRA and PCI-DSS recommended controls to protect the systems from fraudulent activity and unauthorised disclosures and modifications. This is in accordance with current regulatory compliance standards.
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SUBPOENAS (PD2010_065)


PURPOSE

Outlines legislative provisions and procedures to be followed when the Department and public health organisations are required to produce documents in response to a subpoena.

MANDATORY REQUIREMENTS

Each NSW Health Agency must have effective systems and procedures in place in order to make sure that subpoenas issued on the agency are complied with appropriately.

IMPLEMENTATION

Roles and Responsibilities

Chief Executives must ensure that:
- The principles and requirements of this policy and attached procedures are applied, achieved and sustained.
- All staff are made aware of their obligations in relation to this Policy Directive.
- Documented procedures are in place to support the Policy Directive.
- There are documented procedures in place to effectively respond to and investigate alleged breaches of this Policy Directive.

Hospital Managers and Staff have responsibility to:
- Understand the legislative requirements of a Subpoena.
- Provide only the documents which are requested under the schedule of the subpoena.
- To be aware of whether any claim for privilege over the documents can be applied and take appropriate action.

1. BACKGROUND

1.1 About this document

The Department and public health organisations are often required to produce documents on subpoena. This policy directive reflects current legislation and assists public health organisations to comply with subpoenas.

1.2 Key definitions

Subpoenaed Party means the person who the subpoena is addressed to.

Issuing Party means the person who has caused the subpoena to be issued, or that person’s legal representative.

PHO means a public health organisation, or a part of a public health organisation.
Patient also includes clients of PHOs.

Plaintiff is the person who has commenced the proceedings.

Defendant is the person against whom the action is brought by the Plaintiff.

Document includes
(a) any paper or other material on which there is writing,
(b) any paper or other material on which there are marks, figures, symbols or perforations having a meaning for persons qualified to interpret them; and
(c) any article or material from which sounds, images or writings are capable of being produced with or without the aid of any other article or device.

1.3 Legal and legislative framework
* Children and Young Persons (Care and Protection) Act 1998
* Coroners Act 2009
* Commonwealth Service and Execution of Process Act 1992
* Criminal Procedure Act 1986
* Evidence Act 1995
* Health Administration Act 1982
* Interpretation Act 1987
* Local Court Rules 2009
* Uniform Civil Procedure Rules 2005

2. INTRODUCTION

A subpoena is an order from a court or tribunal which directs someone that they must on a given date:
(i) produce to a court certain (existing) documents for use in legal proceedings;
(ii) attend a court on a particular date to be a witness in a hearing and give evidence; or
(iii) do both.

A subpoena can only be issued if legal proceedings have been commenced.

In some courts and tribunals subpoenas are called a “summons to produce documents”, “Orders to Produce Documents,” or “notices for non-party or third party production”. In coronial matters, subpoenas may be called “section 53 Directions.” The general principles that apply to these documents are the same.

A subpoena cannot be ignored. It must be dealt with promptly. Failure to comply with a subpoena is a serious matter. It can result in arrest and even being charged with contempt of court (failure to comply with a court order).

All PHOs should have designated officers to co-ordinate responses to subpoenas.

All subpoenas should be brought to the attention of the appropriate branch and the appropriate person within the PHO, for example the medico-legal officer or medical records officer, who should notify the chief executive officer or an executive officer of the PHO in particularly sensitive matters.

All subpoenas in matters in which a PHO, or a unit or employee of a PHO is a party must be brought to the attention of the solicitors acting on behalf of the PHO as soon as possible and certainly before any documents are forwarded to the court.
PART A - SUBPOENAS TO PRODUCE DOCUMENTS

PRELIMINARY ISSUES TO CONSIDER WHEN YOU RECEIVE A SUBPOENA

2.1 Who is the subpoena addressed to?

For a subpoena to be valid it must sufficiently identify the party in possession of the documents that have been subpoenaed. If a subpoena is defective in this regard, the PHO should promptly inform the issuing party in writing and return any conduct money provided. The letter should explain how the subpoena is defective and be copied to the Clerk or Registrar of the court.

If a subpoena is addressed, for example, to a particular hospital or community health service within a PHO only records held by that hospital or community health service need to be produced.

If a subpoena is addressed to the PHO (ie “X Area Health Service”), relevant records from all facilities within the PHO will need to be produced. If the subpoena is addressed to the PHO requesting all records relating to a particular patient, there are two options that can be considered:

(a) Contact the issuing party and ask the solicitor to nominate which facilities within the PHO they require records from. Ask for this to be confirmed in writing.

(b) Search all facilities within the PHO for records relating to the patient. If this needs to be done, a separate fee may be charged for each facility searched. The issuing party should be told that fees will be payable for each facility searched. It is not necessary for the issuing party to issue separate subpoenas each addressed to separate facilities within the PHO.

2.2 What if the PHO is a party to the proceedings?

If the subpoena lists the PHO or a unit of the PHO as a party to the proceedings, (for example as the Defendant) the subpoena should be referred to the solicitor who has been instructed to act for the PHO (or unit) in those proceedings. If no solicitor has been appointed to represent the PHO (or unit) in the proceedings, the executive officer (or delegate) of the PHO (or unit) should be notified so that a solicitor can be appointed.

If this occurs, that solicitor should be instructed to respond to the subpoena. If the PHO decides not to engage a solicitor, the subpoena should be processed in the normal way.

2.3 What if the subpoena relates to a coronial inquest?

A subpoena issued by the Coroner’s Court needs to be signed by the Coroner or Assistant Coroner issuing it and provide a date and place where the document is to be produced. The Coroner may serve a subpoena by way of facsimile and is not required to provide conduct money.

The subpoena should be referred to the solicitor who has been instructed to represent the PHO’s interests at the inquest, or in relation to the investigation. If no solicitor has been appointed, the relevant medical administrator should review the medical records of the deceased and an assessment should be made as to whether the executive officer (or delegate) of the PHO should be notified so that consideration can be given to instructing a solicitor to represent the PHO. It may be appropriate for the relevant medical administrator to also consider notifying the PHO risk manager and the Treasury Managed Fund of the incident, if they have not already been notified.

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If the PHO decides to engage a solicitor that solicitor should be instructed to respond to the subpoena. If the PHO decides not to engage a solicitor, the subpoena should be processed in the normal way.

2.4 Has the subpoena been validly issued?

In most matters, subpoenas must be issued by a court or a tribunal. This means that they should include a court stamp or signature of a court officer.

In some Local Court proceedings, Police Officers and Public Officers, rather than the Local Court can issue subpoenas. These subpoenas do not need to be stamped. For more detail on these types of subpoenas, see section 1.9.

If you are uncertain about whether a subpoena has been validly issued, contact the court in which the proceedings have been commenced and ask for confirmation.

2.5 What are the proceedings about?

From reading the subpoena you will be able to ascertain whether it is a civil or criminal matter and the identities of the parties.

In criminal matters, one of the parties will usually be the Director of Public Prosecutions, (DPP), or ‘Regina’ or ‘R’. It is also possible (but less common) that one of the parties in a criminal matter will be a government department with the power to prosecute offences, such as the Australian Taxation Office or the Environmental Protection Agency.

As well as looking at the names of the parties, subpoenas should state what court, and sometimes what division of the court the matter is to be heard in, which might help ascertain what the proceedings are about. For a description of common courts, see Appendix C.

2.6 Has the subpoena been served in time?

The subpoena should be served in sufficient time to allow the collection of documents and delivery to court. The subpoena will say on it that you need not comply with it if it is served after the due date. The due date will be not less than five working days prior to the return date (ie. the date that the documents are required by the court) unless the court that issued the subpoena has shortened the time for serving it. If the court has made an order to shorten the period in which you must comply, the subpoena will be marked accordingly.

If the subpoena is served after the due date and there is no note or endorsement on the subpoena from the court stating that the time for service has been shortened, then the subpoena need not be complied with. If the subpoena is not to be complied with, the Clerk or Registrar of the court should be contacted and advised in writing that the subpoena will not be complied with and reasons given. The issuing party (or their solicitor if named on the subpoena) should also be informed. The issuing party may then obtain a further return date, (an adjournment) so as to allow sufficient time for the documents to be collated.

Where the subpoena has been served in time, it may be possible to negotiate an extension of time within which to produce the documents with the issuing party. If the PHO has solicitors acting on its behalf in the matter, those solicitors may be able to negotiate an extension of time on behalf of the PHO. If the PHO has not engaged solicitors, the person responsible for responding to the subpoena can contact the issuing party negotiate an extension of time directly.
2.7 Does it make any difference if the subpoena is a facsimile or a photocopy?

As a general rule the original subpoena should be served to ensure it is authentic. Upon receipt of a facsimile the issuing party should be contacted. All reasonable steps should be taken to ensure that the original subpoena is served. This will protect the PHO from claims by patients that their privacy and confidentiality have been breached by the production of the documents without a valid subpoena.

However, this must be balanced against the requirements of the Uniform Civil Procedure Rules (UCPR) which applies to all NSW Courts, the NSW Industrial Relations Commission and the Dust Diseases Tribunal only. The UCPR states that despite the requirement that a subpoena must be served personally on the subpoenaed party, the subpoenaed party must comply with the requirements of a subpoena even if it has not been served personally, even if the subpoenaed party has by the last date of service for the subpoena, actual knowledge of the subpoena and its requirements.

Finally, the NSW Coroner’s Court can serve a subpoena by way of facsimile. (S105 Coroner’s Act 2009)

2.8 What is the date the subpoena must be complied with?

A failure to comply with a subpoena is a serious matter, the return date of each subpoena served on the PHO should be carefully noted as soon as it is received.

The Subpoena allows the PHO to produce documents by either attending the Court at the date, time and place specified and produce the subpoena or a copy of it and the documents or things to the court. Alternatively the PHO may deliver or send the subpoena and the documents or things requested in the schedule of the subpoena, via a courier or mail to the Registry at the address specified in the subpoena. If electing to send the documents or things via mail they should be received at the Court Registry at least 2 clear working days before the date specified in the subpoena for production.

As noted in paragraph 2.6 above, it may be possible to negotiate an extension of time within which to produce the documents with the solicitor or person who issued the subpoena. This should be done prior to the original return date.

2.9 What if the subpoena has been issued in a Local Court Criminal Matter or Children’s Court proceedings?

Police Officers and a Prosecutor who is a Public Officer have the power to issue subpoenas in the following types of Local Court proceedings:
- Local Court criminal summary and committal hearings;
- Local Court Application Notice proceedings;
- Children’s Court criminal proceedings;
- Apprehended Violence Proceedings.

Under the Criminal Procedure Act, prosecutor means the Director of Public Prosecutions or other person who institutes or is responsible for the conduct of a prosecution and includes (where the subject-matter or context allows or requires) an Australian legal practitioner representing the prosecutor.

Public Officer is defined as any of the following persons, if acting in an official capacity:
(a) an employee in the Public Service or the Police Service,
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(b) an officer or employee of a statutory body representing the Crown,
(c) an employee of a council within the meaning of the Local Government Act 1993,
(d) an officer or employee of a livestock health and pest authority within the meaning of the Rural Lands Protection Act 1998,
(e) the Director of Public Prosecutions, Deputy Director of Public Prosecutions or Solicitor for Public Prosecutions

Subpoenas issued by police officers or a Prosecutor who is a public officer will not have been signed and dated by a registrar of the Local Court. They will not have a court stamp. They are still valid subpoenas and should be complied with. Except where the Court otherwise makes an order, it is not necessary for a police officer or a prosecutor who is a public officer to tender conduct money when serving a subpoena.

Any other party who issues and serves a subpoena on a party is required by section 224 of the Criminal Procedure Act 1986 to tender conduct money at the time of service for the reasonable expenses of the person in complying with the subpoena.

2.10 What if an interstate court issued the subpoena?

It is common for some hospitals in NSW to receive subpoenas issued by interstate courts. For example, hospitals in northern NSW often receive subpoenas issued by courts in Queensland.

The Commonwealth Service and Execution of Process Act allows for interstate subpoenas to be validly served in NSW. The general rule is that subpoenas served interstate should be served 14 days prior to the return date. This time can be shortened by the court that issues the subpoena, if a shorter time period is necessary in the interests of justice and there will be enough time for the subpoenaed party to comply without serious hardship or inconvenience.

PHOs are entitled to request that the original subpoena (or a copy of the original), rather than a faxed copy of the subpoena is served. They are also entitled to the usual amount of conduct money.

3. CONDUCT MONEY

3.1 What is conduct money?

Subpoena to Give Evidence

When a subpoena to give evidence is served on a person, the person named is not required to attend court unless conduct money has been handed or tendered to the named person a reasonable time before the date on which attendance is required. This means “an amount sufficient to meet the reasonable expenses” of the person named is paid or tendered at the time of service.

If there is a dispute about conduct money the named person should contact the person who has issued the subpoena and negotiate further conduct money. If no agreement has been reached, but some conduct money has been provided at the time the subpoena was served, the person should still attend the court on the date specified in the subpoena, but advise the court that the conduct money provided is not reasonable and seek an Order from the court that additional conduct money be paid by the person who issued the subpoena.
Subpoena to Produce Documents

When a subpoena is served on a person or corporation, the person named is not required to attend or produce any document or thing under the subpoena unless conduct money has been paid. This means an amount sufficient to meet the ‘reasonable expenses’ of the person named is paid or tendered at the time of service.

The court in the event of a dispute will determine what is ‘reasonable’ conduct money. In reaching a decision the court is likely to take into account NSW Health policy when determining what is reasonable.

The rates to be applied for servicing a subpoena are advised annually by NSW Health in an information bulletin titled Health records and medical/clinical reports - rates.

Even if original documents are being produced to court, the photocopying charge will still apply. It will cover the cost of copying the records so that the PHO can maintain a copy whilst the originals are removed.

If a subpoena asks for records relating to more than one patient, the PHO has the discretion to charge separate fees for each patient.

If a subpoena requires searches for records to be undertaken at more than one facility of the PHO, the PHO has the discretion to charge separate fees for each facility searched.

For subpoenas issued by Police Officers and Prosecutors who are Public Officers (as discussed in section 1.9), conduct money does not need to be paid.

There is also no requirement for the Victims Compensation Tribunal or the NSW Coroner’s Court to tender conduct money if they are the issuing party.

3.2 What if the conduct money is inadequate?

If the conduct money is inadequate, the PHO representative should:
(i) Call the issuing party to inform him or her of your requirements.
(ii) If there is still a refusal to provide conduct money, or you consider it insufficient, contact the issuing party and attempt to negotiate some compromise on the amount.

(ii) In the event that conduct money was not provided by the issuing party and/or the amount of conduct money is considered to be ‘unreasonable’ the PHO or solicitor acting on behalf of the PHO should advise the Court on the day the documents are produced to the Court and request the Court make an order to the issuing party that they pay conduct money and the amount of any reasonable loss or expense incurred in complying with the subpoena.

3.3 What if too much conduct money has been provided?

The PHO is entitled to retain the minimum amount of conduct money.

If more than the minimum amount is provided and the cost of producing the records is less than the amount provided, the records should be copied and delivered to the court and the excess conduct money should be refunded to the issuing party.
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3.4 Are there any special procedures with respect to conduct money if the subpoena involves a lot of work?

If the record is lengthy, or will require a number of files to be searched or otherwise take up staff time so that it will cost more than the amount provided to produce the record, the issuing party should be contacted and advised of the estimated cost of compliance including staff time in searching and locating the relevant records, photocopy costs and mail or courier fees. Such contact may be by telephone but should be confirmed in writing.

In the event that the actual costs exceed the estimate, a further account should be raised against the issuing party.

If compliance with a subpoena involves a significant amount of work, consideration should be given to discussing with the issuing party whether they are prepared to narrow the scope of the subpoena. (See 5.1 of this Policy Directive)

3.5 Can the PHO keep the conduct money if it has no documents to produce?

If the PHO receives a subpoena, conducts searches for the records requested, and has no records to produce, it may retain the conduct money to cover the cost of conducting the searches, and the cost of writing to the Court explaining that it has no records to produce.

If the records have been lost, misplaced or destroyed, then the court should be advised that there are no records to be produced and the conduct money should be refunded.

4. WHAT DOCUMENTS HAVE BEEN REQUESTED IN THE SUBPOENA?

4.1 How do I determine the scope of the subpoena?

The subpoena must be read very carefully to ascertain its breadth. This is critical because the PHO is under an obligation to produce only those documents covered by the description set out in the subpoena. A subpoena may call for the production of health and/or non-health related records. The applicable procedures are the same.

The next task is to undertake appropriate inquiries to determine whether the PHO is in possession of any records which fall within the scope of the subpoena, the likely location of the records and the number of files that may have to be searched.

Where files are located containing documents which fall within the scope of the subpoena, care should be taken to ensure that only those documents which fall within the subpoena are collated for the purposes of copying and production.

Documents that do not come within the scope of the subpoena should be removed from the medical record before it is copied and documents are sent to court. A clear record of which documents have and have not been produced and a copy of the subpoena should be kept by the PHO. This may involve keeping an additional copy of the records that were sent to the Court, if the records that were sent are a small extract from the medical record.

If the subpoena requests “any records” or “all records”, this includes the entire file relating to the patient, including correspondence and x-rays, even if they are stored separately to the medical record. The definition of ‘document’ captures an electronic medical record or information contained on a computer file, such as photos and/or video.
Sometimes there may be letters from specialists who state that the letter should not be released to a third party without the consent of the author, contained within the clinical record of a patient whose records have been subpoenaed. If the letters are included in the clinical record which has requested in the schedule of the subpoena, the documents must be sent to Court. There is no need to obtain the permission of the specialist.

Only material specifically referred to in the subpoena should be collated.

**Examples**

**Scenario:** A patient, Sara X, attends Chester Public Hospital on 28/9/2000 after being sexually assaulted. There are several later attendances to the hospital over the next three months. Some of these admissions being for surgical procedures unrelated to the sexual assault.

Sara also visits the Chesterfield Sexual Assault Service, (a separate facility of the Chester Area Health Service, located in Main St, Chester) in relation to the sexual assault on 30/9/2000, and there are several sessions with a sexual assault counsellor Jenny K, after this initial presentation.

Some months later, the defence in a criminal trial decide to issue a subpoena to the Chester Area Health Service, seeking access to documents held on Sara X. Some of the requests they consider putting in the subpoena include:

- **“All notes relating to the visit by Sara X to the Chester Hospital on 28/7/2000”**
  The hospital holds no records relating to an admission of Sara X on 28/7/2000. The hospital is not required to, nor should it volunteer any information in relation to other visits Sara X may have made to the Hospital.

- **“All notes of the visit by Sara X to the Chester Hospital on 28/9/2000”**
  The only records relevant to the subpoena are the actual notes which relate to the visit on 28/9/2000. No reference is made to other visits Sara X made to the Hospital, or the Community Health Centre at later dates, so these documents are not covered by the subpoena.

- **“All notes relating to the visit by Sara X to the Chester Hospital on 28/9/2000 or any time thereafter”**
  All notes included on Hospital records are covered, including notes on the unrelated surgical procedures. The subpoena does not, however, cover any records generated by the SAS. The SAS is a separate facility of the Area Health Service, and is located outside the hospital campus. As such, the AHS is not required to, nor should it volunteer any information on visits made by Sara X to the Chesterfield Sexual Assault Service. Had the SAS been located within the hospital campus, the result in this case would have been different.

- **“All notes and counselling records prepared by counsellor Mary G in relation to any counselling sessions conducted with Sara X.”**
  The subpoena does not identify the records of a particular facility. As such, and as the subpoena is addressed directly to the Area Health Service, all AHS records should be checked, including those held by the SAS. Note, however, that the subpoena names a specific counsellor, and only requests her notes. Mary G did not see Sara X, so the AHS does not hold any records covered by the subpoena. The AHS is not obliged to inform the court that another counsellor saw Sara X.

- **“Any records, notes reports or any other written material held by any facility of the Chesterfield Area Health Service, including but not limited to the facilities at the Chester Hospital and the Chesterfield Sexual Assault Service relating to Sara X and dealing with an alleged sexual assault on 28/9/2000.”**
  This is a more usual approach. The terms of the subpoena are broad, and clearly covers all the relevant documents held by the AHS on Sara X. The only documents not covered would be those dealing with the unrelated surgical procedures. Note however, the reference to “Chesterfield Area Health Service”, when the actual legal entity is the “Chester Area Health Service”. If the subpoena also wrongly names the AHS, arguments could be raised against complying with it.
9. HEALTH RECORDS AND INFORMATION

4.2 What if the subpoena captures reports to Community Services (Department of Human Services)

Under section 29, Children and Young Persons (Care and Protection) Act 1988 risk of harm reports made to the Director General, Human Services, are not produced in response to a subpoena, summons or notice to produce (other than care proceedings in the Children’s Court, or any appeal arising from those care proceedings).

Section 27(A) (7) of the Children and Young Persons (Care and Protection) Act 1988 provides that a referral by a mandatory reporter to their relevant Child Wellbeing Unit is also protected from production under Section 29 of the Act.

It is possible for a court or other body before which proceedings relating to the report are conducted to grant leave to a party or a witness to disclose the identity of the mandatory reporter if the court or other body is satisfied that the evidence is of critical importance in the proceedings and that failure to admit the evidence would prejudice the proper administration of justice. If a court or other body grants leave for this to occur reasons must be provided as to why leave is granted, and the court or body must ensure that the holder of the report is informed that evidence as to the identity of the person who made the report, or from which the identity of that person could be deduced, has been disclosed.

4.3 What if the subpoena captures sensitive records?

For medical records, the prime criterion of sensitivity is whether the patient would consider the data sensitive. Examples of sensitive records include: sexual assault, drug and alcohol, HIV/AIDS, domestic violence, genetic information, transgender status, mental health and records of children considered to be at risk and records containing information on other persons. Records relating to people or patients who are not directly involved in the legal proceedings can also be classified as sensitive. Examples include where genetic counselling or medical records contain information relating to persons other than the patient.

The fact that records are sensitive does not itself mean that privilege can be claimed over them, or that they do not need to be produced. If a subpoena requests sensitive records and there are no grounds for challenging the subpoena or claiming privilege (see section 5), the procedure set out in section 6.4 may be followed.

4.4 What if there are no documents?

If there are no records, a letter should be written to the court advising the court that there are no records to be produced. This letter should be copied to the issuing party. The conduct money may be retained.

However, if there are no records but there is evidence that there were relevant records that have been lost, misplaced or destroyed, then the court should be advised that there are no records to be produced and the conduct money should be refunded.

A file note should be created outlining efforts made to find the relevant records. If records were destroyed in accordance with a disposal authority approved under the State Records Act 1998, a copy of the disposal authorisation should be included and the relevant disposal category cited.
5. ON WHAT GROUNDS CAN A SUBPOENA BE CHALLENGED?

5.1 The subpoena is too wide and/or oppressive

A subpoena may be set aside:
- where its terms are so wide and insufficiently precise that compliance (i.e. collation and production of documents) would impose an onerous obligation on the PHO; or
- where a subpoena is used for the purpose of “fishing” for information which a party hopes, but does not reasonably expect is in existence. This may apply particularly to broad requests for protocols and investigation documents.

Subpoenas which request the production of medical records relating to persons who are not parties to the proceedings, or which request records relating to multiple, unrelated patients may be an abuse of process or oppressive.

The subpoena may also be oppressive if it is not clear what documents are sought by a subpoena, or if it appears that the documents sought will have little, or no relevance to issues in the proceedings. The scope of a subpoena can be narrowed in two ways:
- by agreement with the issuing party; and
- by successfully challenging the subpoena in court. (See section 6 of this Policy Directive)

If you believe that the scope of the subpoena is too broad and calls for documents to be produced which are demonstrably not relevant to the proceedings, an option available is to approach the issuing party with a view to seeking a compromise on the range of documents that are required. If a compromise is reached, written confirmation should be obtained from the issuing party.

If the issuing party refuses to negotiate the scope of the subpoena as is suggested above and you still wish to challenge a subpoena on the basis that it is an abuse of process or oppressive, you should consult your immediate manager, who may need to consult the PHO Executive, and obtain advice from the PHO’s solicitors if appropriate.

You should be aware that where a subpoena is challenged unsuccessfully, the PHO may be liable to pay the court costs (associated with argument over the subpoena) of the party which issued the subpoena.

5.2 The subpoena is an abuse of process or lacks a legitimate forensic purpose

A subpoena that has been issued for reasons other than for the purpose of obtaining relevant evidence for the proceedings may be set aside.

In criminal matters, an accused person must have an objective basis for demonstrating a real possibility that the subpoenaed material would assist his or her defence. Only documents that have a legitimate forensic purpose need to be produced. Legal advice is recommended in order to argue that records have no legitimate forensic purpose.

5.3 Public interest immunity

Where the public interest that would be served by withholding certain documents is so strong that it overrides the public interest in the following of due process, a subpoena may be set aside. A challenge on this basis applies only to very limited types of documents and will usually only be available to documents which may affect national security, the workings of the NSW Cabinet or some other extraordinary public interest.
If you wish to challenge a subpoena on a public interest immunity basis, you should contact the Legal Branch on telephone (02) 9391 9606.

5.4 Client legal privilege

Client legal privilege can protect certain documents from being disclosed in court proceedings. This privilege applies to confidential communications between a client and another person, or between a lawyer acting for the client and another person, if the communication was for the dominant purpose of the client being provided with professional legal services relating to a court proceedings or an anticipated or pending court proceedings in which the client is or may be, or was or might have been, a party.

If a claim for legal professional privilege is contested, evidence will be required from the author of the documents and/or the person who requested that the document be created, that it meets this test; and/or other investigations will need to be undertaken as to the document’s dominant purpose. If a PHO wishes to claim client legal privilege over documents it has created for legal proceedings, the lawyer that the PHO instructs in those proceedings will be responsible for claiming the privilege.

5.5 Qualified Privilege

NSW qualified privilege legislation (Division 6B of the Health Administration Act) applies to approved quality assurance committees. It operates to prevent committee members and documents produced by the committee from being used in any legal proceedings.

Qualified privilege applies to records that are under the control of an approved quality assurance committee, or a member of an approved quality assurance committee and were created at the request of or solely for the purpose of the committee. If documents created by an approved quality assurance committee but have been disclosed to other units of the PHO, the privilege may be waived, however, if the committee has not waived privilege over the documents and a subpoena is received for these records, the PHO should write to the party who issued the subpoena and to the court stating that the records are protected by qualified privilege legislation and will not be produced.

If records relating to quality assurance activities and morbidity and mortality case reviews or committees are requested, the PHO Executive should be contacted to confirm whether the records are records created by an approved quality assurance committee.

In addition to approved quality assurance committees, the Minister has approved the following committees under section 23 of Health Administration Act 1982, to be specially approved committees.

- Special Committee Investigating Deaths Under Anesthesia
- Special Committee Investigating Deaths Associated with Surgery
- Maternal and Perinatal Committee
- Mental Health Sentinel Events Review Committee

These committees do not need to comply with subpoenas. If one of these committees is subpoenaed, it should not comply with the subpoena unless it has the approval of the Minister to do so, or the consent of the person from whom the information was obtained. A letter should be sent to the solicitor issuing the subpoena explaining the committee’s special status and stating that records will not be produced.
5.6 Sexual Assault Communications Privilege

Records relating to the counselling of victims of sexual assault (protected confidences) may be protected from production if they are covered by sexual assault communications privilege. Sexual assault communications privilege can only be claimed in criminal proceedings, including proceedings relating to Apprehended Violence Orders (AVOs) in NSW Courts. The sexual assault communications privilege may also be claimed in NSW Courts in civil proceedings, in limited circumstances, usually when the privilege was granted in criminal proceedings. The privilege cannot be claimed in federal courts, such as the Family Court.

PHOs have an obligation to their patients to take steps to protect confidential sexual assault counselling communications from being disclosed where disclosure would harm the patient.

See Appendix A for further detail about the privilege.

5.7 Professional Confidential Relationship Privilege

This privilege may apply to a communication made by a person, in confidence, to another person in the course of a relationship in which the confidant was acting in a professional capacity and where the confidant was under an express or implied obligation not to disclose the contents of the communication. The privilege can only be claimed in NSW courts. The privilege cannot be claimed in federal courts, such as the Family Court.

A protected confidence may include a communication between a health professional and a patient. The definition potentially covers many aspects of clinical records. See Appendix B for further detail about the privilege.

6. PROCEDURES FOR RESPONDING TO A SUBPOENA

6.1 Should I notify anyone of the subpoena?

All subpoenas should be brought to the attention of the relevant person or branch within the PHO to whom the subpoena relates, for example the medical records department or, to medico-legal person or risk manager if the PHO has one. Subpoenas should also be brought to the attention of the CEO of the PHO if the subpoena requests sensitive information. In addition, the senior health care provider and the treating health care provider are to be advised (where possible) of subpoenas for health records, even if neither they nor the PHO are party to the proceedings.

Where a patient whose health record has been subpoenaed is not named on the subpoena as a party to the proceedings before the court, he or she should be notified by the PHO that the subpoena has been received and advised of the “return date” on the subpoena (i.e. the date the documents must be provided to the court) in sufficient time to allow the patient to arrange to attend the court if the patient wishes. Telephoning the patient, or writing to the patient’s last known address is sufficient. A note should be made outlining measures taken to advise the patient of the subpoena.

NB If you have concerns about the scope of a subpoena you should consult your immediate manager who may need to consult the PHO Executive and obtain advice from the PHO’s solicitors if appropriate.
9. **HEALTH RECORDS AND INFORMATION**

6.2 Are photocopies sufficient or must originals be produced?

Documents can be provided to the Court by way of:
(a) a photocopy
(b) in PDF format on a CD-ROM or,
(c) in any other electronic form that the issuing party has indicated will be acceptable.

Unless a subpoena specifically requires the production of the original document, photocopies of the records or a CD-ROM should be provided. If the PHO is required to produce originals, it should ensure that a complete copy of the records remains with the PHO to ensure continuity of care.

6.3 What is the procedure for delivering subpoenaed documents to the court?

Documents produced under NSW subpoenas must be produced to the court at the address referred to in the subpoena and **not to** the issuing party. They should not be provided to the person who serves the subpoena, even if the matter is ‘urgent’.

Documents produced on subpoena should be delivered to the Registrar or Clerk of the court in question. They should be:
(i) sealed in an envelope;
(ii) the PHO should allocate a unique number to the envelope from a register held by the PHO in which the name of the patient, the court to which the record is sent and the date of the hearing should be entered against the number;
(iii) a copy of the subpoena should be secured inside the envelope. (If the Court requires the original subpoena, the PHO should make a copy for its records.);
(iv) the PHO should keep a copy of the subpoena (and any original documents being sent to court with the subpoena); and
(v) the envelope should be delivered by hand by an employee of the PHO, registered post or courier not less than 2 clear working days before the return date specified in the subpoena.

On delivery, if practicable, a receipt should be obtained from the court which indicates the number of the record, the date the record was received at the court, the name of the court and the signature of the court official receiving the record.

If the PHO is a party to the proceedings in which the subpoena has been issued, or has sought legal advice in relation to the subpoena, the documents collated in response to the subpoena should be forwarded to the solicitor who is acting on behalf of the PHO. That solicitor will review the documents and arrange for them to be forwarded to the court on behalf of the PHO.

6.4 Can any additional precautions be taken for sensitive records?

A subpoena cannot be challenged merely because it requests sensitive records.

When responding to a subpoena that requests sensitive information, (and where there are no grounds for challenging the subpoena or claiming privilege over the documents), the following steps should be followed.

a. Contact the issuing party and ascertain why the information is required. It may be possible to negotiate with the issuing party to either exclude these records from production, or produce copies of the records with the names of the affected people deleted.
9. HEALTH RECORDS AND INFORMATION

b. Request that the court limit access to the documents to certain people. For example, courts can give orders limiting access to the parties’ legal representatives and independent experts on the condition that they give confidentiality undertakings. The responsibility for raising this issue rests with the subpoenaed party. A letter should be sent to the court setting out the concerns arising if the documents are provided in open court. The letter should not contain any sensitive information itself.

c. If sensitive records are to be produced, they could be placed in a separate envelope marked “sensitive”, however, this is no guarantee that the Court will treat these records differently

7. PROCEDURES FOR CHALLENGING A SUBPOENA IN COURT

7.1 Subpoenas for records that are privileged (other than sexual assault and confidential communications privilege)

A solicitor’s assistance will be necessary depending on the complexity of the case.

If a PHO decides to challenge a subpoena without legal representation the following procedures will apply:

(i) Follow 6.1 - should I notify anyone of the subpoena
(ii) Follow 6.3 - procedure for delivering subpoenaed documents to the court
(iii) Place the records which are to be produced in a sealed envelope. Place any records over which a claim for privilege will be made in a separate envelope and mark the word “privileged” on the envelope.
(iv) Attach a copy of the subpoena to the outside of each envelope.
(v) Place the envelope(s) marked “privileged” inside another envelope and send to the court with a letter to the Registrar setting out:
(a) what type of privilege is claimed; and
(b) the reasons supporting the claim for privilege.
(vi) Consider attending in person on the return date, or instructing the PHO’s solicitor to attend, in order to argue in support of the claim for privilege.

7.2 Steps to follow when a subpoena for sexual assault records or confidential communications records is received

7.2.1 Determine whether either privilege can be claimed in the proceedings

See Appendix A for a discussion of the types of proceedings in which sexual assault communications privilege can be claimed.

See Appendix B for a discussion of the types of proceedings in which it is possible to claim professional confidential relationship privilege.

7.2.2 Family Court subpoenas

Sexual assault communications privilege and professional confidential relationship privilege are created by NSW legislation. This means that they only apply in NSW courts. They do not apply in federal courts, such as the Family Court.
9. HEALTH RECORDS AND INFORMATION

If you receive a Family Court subpoena requesting a patient’s sexual assault counselling communications records and the subpoena was not issued by the patient or the patient’s legal representative, and you are concerned about producing the records, although privilege cannot be claimed, you could consider treating the records as ‘sensitive records’ (see section 6.4).

Keep in mind that sexual assault communications records relating to children can be important evidence and highly relevant for the Family Court to have available when determining parenting orders for the care of a child.

7.2.3 Protected Confidence Notice

A protected confidence means a counselling communication that is made by a victim of a sexual assault. If the issuing party wants a document containing a protected confidence produced, they must give notice to the patient that production has been sought. Notice should also be given to the other parties. This is a requirement of the Criminal Procedure Act 1986.

This means that if the issuing party is aware that the documents sought contain protected confidences, the patient should have been made be aware that they can seek to appear in court on the return date to challenge the subpoena.

7.2.4 Determine whether the PHO should claim privilege on behalf of the patient

The following issues should be considered when deciding if the PHO should claim either sexual assault communications privilege or professional confidential relationships privilege:
• The views of the patient and whether the patient proposes to claim either privilege themselves;
• Whether harm is likely to occur to the patient if the material is disclosed.

7.2.5 The views of the patient

Sexual assault communications privilege and professional confidential relationships privilege belong to the patient.

When a subpoena requesting sexual assault counselling records or records of a protected confidence is received the PHO should contact the patient and inform them that the subpoena has been served. The PHO should then:
(a) explain nature of the privilege which may apply;
(b) ask the patient whether s/he will consent to waive the privilege. If so, a consent to waive the privilege should be obtained from the patient in writing;
(c) if the patient does not want to waive the privilege, advise the patient of the steps (if applicable) that the PHO is taking to claim the privilege on the patient’s behalf.

If the patient chooses to waive the privilege, the documents must be produced to the court.

Reasonable attempts should be made to contact the patient if a subpoena for sexual assault counselling records is received. What constitutes reasonable steps will vary depending on the individual circumstances of the patient. If the file shows that there is a potential that the patient will suffer serious harm if the records are disclosed, taking reasonable steps to locate the patient may involve doing more than attempting to telephone the patient or writing a letter, such as contacting the police for assistance. If the patient cannot be contacted, the PHO should write a letter to the court explaining this, and noting that the records contain confidential counselling material. This letter should be sent to the court with the records.
In proceedings where the patient is represented, the PHO will meet its obligation by referring the matter to the patient’s legal representative.

7.2.6 Whether harm is likely to occur to the patient of the material is disclosed

The treating counsellor (or, if that person is not available, another qualified professional) should review the file and form a preliminary view as to whether harm is likely to occur to the patient from disclosure.

This preliminary view will need to later be supported by the preparation of a harm statement or an affidavit. A harm statement or affidavit made by a professional with appropriate qualifications is an essential element to claiming the privilege. Before a decision is made to claim privilege, the professional/s involved should be comfortable they can adequately prepare a harm statement or affidavit for the court. If a decision is made to claim privilege, the most appropriate way to ensure the claim is argued effectively is for the PHO to obtain legal representation.

7.2.7 Instructions to be given to lawyers engaged by the PHO to argue a privilege claim

If the PHO decides to engage lawyers to argue a claim for privilege, a letter of instruction setting out the following should be sent to the lawyers. The letter should include the following information:

- When the subpoena is returnable (attach a copy of the subpoena);
- The nature of the documents held;
- The patient’s views on disclosure;
- The name and contact details of the other party/parties to the proceedings (or their legal representatives);
- If the matter is a criminal matter, the name and contact details for the police officer in charge of the criminal investigation;
- The name of appropriate contact officer at the PHO;
- The date that the hearing starts. This information can be obtained from the issuing party. The date that the hearing starts will usually be a date some time after the return date for the subpoena. This allows time for the return date for the subpoena to be adjourned by the court if the PHO wishes to put forward arguments objecting to disclosure. Where the subpoena is returnable at the start of the trial it is more difficult to negotiate additional time.
- Whether the documents have been subpoenaed before. This is important, as if the records were previously released, it will be more difficult to argue for their non-release in response to a later subpoena. Alternatively, the court may have prevented disclosure in earlier cases and made comments which may assist in arguing for non-disclosure in relation to the later subpoena.

7.2.8 The harm statement or affidavit

In order to support a claim for privilege, it is necessary for the patient or the PHO to provide the court with evidence about the nature and extent of the harm that the patient would suffer if the documents were disclosed. However, specific details about the patient should not be provided – to do this would negate the purpose for the privilege claim.

If the PHO has instructed a lawyer to argue the privilege, the lawyer will advise staff on whether affidavits, or harm statements, or a combination of both, are required, and will assist staff in preparing these documents.
9. HEALTH RECORDS AND INFORMATION

If the PHO does not instruct a lawyer, it may consider asking staff to draft a harm statement. When drafting harm statements, keep in mind that they are likely to be read by all parties to the proceedings.

A professional with appropriate qualifications should prepare a harm statement. It should include:

(a) the qualifications and experience of the professional preparing the statement;
(b) the employed position of the professional at the time of preparing the statement;
(c) if the person preparing the statement is the treating counsellor, the statement should state this, and explain for how long the counselling relationship has been established;
(d) if the person is not the treating counsellor, the statement should state that fact. It should explain why the treating counsellor is not available to make the statement and state that the person who is preparing the statement has read all the relevant counselling notes;
(e) a statement that the counselling notes that have been subpoenaed were made in confidence and relate to the impact of alleged sexual assaults.
(f) a statement to the effect that the symptoms, concerns, and worries of the patient would be seriously aggravated if the contents of the documents were disclosed.
(g) if applicable, a statement to the effect that the patient expected the counselling records to remain confidential.
(h) a statement that the writer of the harm statement claims sexual assault communications privilege in respect of the records.

8. WHAT HAPPENS AFTER THE DOCUMENTS HAVE BEEN PRODUCED?

8.1 Who can see the documents after they have been produced to the court?

After documents have been produced to court, the court will make orders about who may access them. Usually, the parties to the proceedings and their legal representatives will be granted access to the documents.

If a patient’s medical record has been produced to court, and the patient is also a party to the proceedings, his or her legal representative may ask for ‘first access.’ This means that the patient’s legal representative can inspect the records before the other parties, in order to determine whether a privilege claim can be made to limit further access to the documents.

The question of who may have access, whether a party will have first access, or whether any other special access orders will be made, is often determined on the return date.

The following courts determine access issues in particular ways.

District Court - civil claims

The issuing party in a District Court civil matter is required to include a ‘proposed access order’ on the subpoena. This is an order for access that the issuing party thinks is appropriate. For example, the proposed access order may be “plaintiff to have first access to the documents for 7 days”. This type of access order may be appropriate if the plaintiff was the patient whose records had been produced, as it would allow the plaintiff/patient’s solicitor to view the records and determine whether any claims for privilege should be made, prior to the other parties accessing the records.

If the PHO wishes to object to the proposed access order (for example, if a privilege is being claimed), the PHO should first notify the issuing party to attempt to negotiate an agreement as to what the proposed access order should be. If an agreement cannot be reached, a representative of the PHO, or the PHO’s legal representative will be required to appear at Court on the return date and argue the question before the presiding registrar.
9. HEALTH RECORDS AND INFORMATION

In any District Court civil case where there is no appearance at the return date, the proposed access order will be made automatically by default.

Supreme Court

If a general access order allowing all parties access to the subpoenaed documents at the same time is not objected to, the Supreme Court will automatically make a default order for general access to the documents at the return date.

If PHO wishes to object to a general access order being made (for example, by claiming a privilege), it should notify the party that issued the subpoena and attend court, or arrange for a lawyer to attend court, on the return date and inform the Registrar of its position.

8.2 What if I receive a request for permission to ‘uplift’ documents?

Courts have photocopying facilities available on site; however, occasionally parties to litigation seek permission from the court to uplift, or temporarily remove the documents from the court to arrange for them to be copied externally, or reviewed in a more convenient setting. A party may request to uplift x-rays or scans which have been provided to the Court in order to obtain a copy to provide to a medical expert for an opinion. The documents are then returned to the court.

As the documents still belong to the subpoenaed party while they are at the court, some courts seek the consent of the subpoenaed party before they will allow the documents to be uplifted.

If a PHO is asked to consent to a party uplifting records, it is recommended that:

• If original documents have been produced, consent to uplift should generally be refused;
• If copies have been produced, consent can be granted on the basis that the documents do not leave the custody of the parties’ legal representatives and/or the medical or other professional expert whom the parties’ legal representatives have engaged to provide an expert opinion and the document/s are returned to the court in the same condition.

If a court allows documents to be uplifted, it will normally require the legal representative uplifting them to sign a receipt, accepting responsibility for the records whilst they are in the legal representative’s possession.

8.3 Are subpoenaed documents returned?

Original documents should always be returned to the PHO.

Subpoenaed documents that are copies should be returned by the court at the conclusion of the matter, unless the PHO has informed the court that the documents may be shredded. If you have any queries contact the Clerk or Registrar of the court.

9. REQUESTS FOR INFORMATION UNDER CHAPTER 16A OF THE CHILDREN AND YOUNG PERSONS (CARE AND PROTECTION) ACT

Chapter 16A of the Children and Young Persons (Care and Protection) Act provides a mechanism for NSW Health staff exchange information with other human services and justice agencies, to ensure the safety, welfare and wellbeing of children and young people in NSW.
9. HEALTH RECORDS AND INFORMATION

These changes have been introduced under *Keep Them Safe - A shared approach to child wellbeing 2009 - 2014*, the NSW Government’s response to the Report of the Special Commission of the Inquiry into Child Protection Services in NSW. The legislation introduced as part of *Keep Them Safe* is intended to free up information exchange between certain human service and justice agencies including NSW Health, to facilitate improved interagency collaboration.


10. REQUESTS FOR INFORMATION FROM COMMUNITY SERVICES

Pursuant to s248 of the *Children & Young Persons (Care and Protection) Act*, PHOs may be required to provide information to Community Services. Section 248 is designed to allow an exchange of information about the safety, welfare and wellbeing of children and young people between an agency and Community Services.

Information can only be provided in response to a s248 request if it relates to the safety, welfare and well being of a particular child or young person.

Once records have been provided to Community Services in answer to a s248 request, Community Services may use them as evidence in legal proceedings. If records are to be used in legal proceedings, they are usually annexed to an affidavitt (a sworn statement) prepared by Community Services staff in accordance with arrangements agreed upon between NSW Health and Community Services. Community Services staff are not to attach confidential information provided in response to a s248 requests to affidavits without the consent of the person who provided the information.

If the document that Community Services wish to attach to their affidavit is particularly sensitive, the PHO should refuse to consent, (unless the patient’s guardian does not object) and ask Community Services to issue a subpoena seeking a copy of the document instead. Once a subpoena has been served, the PHO may consider whether production can be opposed, or whether any type of privilege can be claimed in respect of the document.


11. PRIVACY

Compliance with a subpoena is required by law. Complying with a subpoena will not breach the PHOs obligations under the *Health Records Information Privacy Act 2002*. For further information about privacy obligations, see NSW Health Privacy Manual.

PART B - SUBPOENAS TO GIVE EVIDENCE

1. A subpoena to give evidence is addressed to a specific individual. It will indicate the time and place the person will be required to give evidence as a witness.

2. A person who receives a subpoena should report that fact to his/her administrator/supervisor as soon as practicable.

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3. A person who has been subpoenaed should contact the solicitor who requested the issue of the subpoena to:
   a. confirm that their attendance is still required;
   b. to obtain some better guidance as to when he or she might be required to give evidence; and
   c. confirm that if the solicitor who has issued the subpoena requires the witness to remain on 'standby' rather than come to Court, sufficient notice will be provided if the witness is to be called to Court so that alternative work arrangements can be made.

4. If a solicitor indicates that a person’s attendance is not required, this should be confirmed in writing.

5. Witnesses are entitled to receive conduct money and reasonable expenses from the solicitor or person who has issued the subpoena. Conduct money means a sum of money, or its equivalent, such as pre paid travel, sufficient to meet the reasonable expenses incurred by the subpoenaed party in attending court as required by the subpoena, and returning from court after attending.

   For medical officers, the AMA has published guidelines relating to reasonable expenses.
Appendix A

Sexual Assault Communications Privilege

The Sexual Assault Communications Privilege is set out in the Criminal Procedure Act 1986. This privilege allows courts, to exclude evidence which would disclose confidential communications made in the course of a professional or sexual assault counselling, relationship. “Professional” is not defined in the Act but would include a health care worker, social worker, counsellor or youth worker.

The Act not only restricts the use of material as evidence in court, it also places restrictions on who can have access to documents which have been requested under a subpoena. The onus is on the person requesting the documents to show why they should have access to the victim’s counselling notes.

The privilege does not apply to federal courts, for example the Family Court.

1. **What is a protected confidence for the purpose of claiming sexual assault communications privilege?**

A protected confidence means a counselling communication that is made by, a victim or alleged victim of a sexual assault offence.

A counselling communication is a protected confidence even if:

(a) it was made before the relevant sexual assault offence occurred, or is alleged to have occurred, or
(b) was not made in connection with a sexual assault offence or alleged sexual assault offence.

This means that the privilege could apply to any counselling communications, and not just to counselling following a sexual assault. (For example, the privilege could apply to drug and alcohol counselling provided prior to the sexual assault taking place.)

A counselling communication may be made in confidence even if it was made in the presence of a third party if the third party was present to facilitate communication or to otherwise further the counselling process. For example a counselling communication will be protected by the privilege in cases where a parent, carer or other supportive person was present during the counselling process to facilitate communication between the counselled person and the counsellor.

A person counsel’s another person if the person has undertaken training or study or has experience that is relevant to the process of counselling persons who have suffered harm and the person

- listens to and gives verbal or other support or encouragement to the other person, or
- advises, gives therapy to or treats the other person whether or not for fee or reward.

2. **Can the sexual assault communications privilege be claimed in all types of court proceedings?**

The sexual assault communications privilege can be claimed in criminal proceedings, including proceedings relating to Apprehended Violence Orders (AVOs).
The sexual assault communications privilege can also be claimed in NSW civil proceedings, but only if:
(a) substantially the same acts are in issue in the civil proceedings as were in issue in relation to previous criminal proceedings; and
(b) the evidence was found to be privileged in the previous criminal proceedings.

The privilege cannot be claimed in federal courts, such as the Family Court.

3. Principles applying to sexual assault subpoenas

(a) PHOs have an obligation to their patients to take steps to protect confidential sexual assault counselling communications from being disclosed where disclosure would harm the patient.
(b) This obligation is most critical where the patient is a child, or where the disclosure is sought in relation to criminal proceedings and the victim of the assault does not have legal representation. In these cases, the PHO may consider obtaining legal representation to challenge the production of material in response to the subpoena.
(c) In cases where there is a high risk of serious harm such as, for example, a high likelihood of suicide or self harm, to the patient if the records are disclosed, the PHO should consider obtaining legal representation to challenge the production of material in response to the subpoena. Harm can be actual physical bodily harm, financial loss, stress or shock, damage to reputation or emotional or psychological harm (such as shame, humiliation and fear).
(d) In proceedings where the patient is represented, the PHO may meet its obligation by referring the matter to the patient’s legal representative.
(e) If the patient has legal capacity and chooses to waive the privilege, the PHO must respect that decision.

4. How does sexual assault communications privilege operate?

Preliminary Criminal Proceedings

Preliminary criminal proceedings are committal or bail proceedings (whether or not they relate to a sexual assault offence).

A person cannot be required (by subpoena or otherwise) to produce a document recording a protected confidence in connection with any preliminary criminal proceedings. Evidence that would disclose a protected confidence, or the contents of a document recording a protected confidence cannot be used in any preliminary criminal proceedings.

Criminal Proceedings

Evidence is not be used in any criminal proceeding if the court decides that using it would disclose a protected confidence, or the contents of a document recording a protected confidence.

Before a court can make a decision about the documents, they must be produced to court, with an objection to their production noted, so the court can rule on the objection. This means that the PHO must produce the documents to the court in a sealed envelope marked “sexual assault communications privilege claimed”. The court will inspect the documents in order to determine whether the claim for privilege will be upheld. Some courts will not uphold a claim for privilege without hearing legal argument from the issuing party and the subpoenaed party. PHOs should recognise that producing the documents marked privilege may not be sufficient for a claim for privilege to be successful. Legal argument may be necessary.
The court will not allow evidence about a protected confidence or the contents of a document recording a protected confidence to be used unless the court is satisfied that:
(a) the evidence could affect the assessment of a fact in issue in the proceedings; and
(b) other evidence of the protected confidence or the contents of the document recording the protected confidence is not available; and
(c) the public interest in preserving the confidentiality of protected confidences and protecting the confider from harm is substantially outweighed by the public interest in admitting into evidence information or the contents of a document that will affect the assessment of a fact in issue.

The person seeking to adduce the evidence (the issuing party) must provide the patient with notice that they are seeking to adduce the protected confidence, and inform the patient that they may, with the leave of the court, appear in the proceedings.

The court can also make orders to limit the possible harm, or the extent of the harm caused, for example, by ordering that evidence is to be heard ‘in camera’ (in a closed court), or making orders suppressing the publication of the evidence, or part of the evidence, or the identity of the confider. The court may also make orders limiting who may inspect documents produced.
Appendix B

Professional Confidential Relationship Privilege

1. **What is a protected confidence for the purpose of claiming professional confidential relationship privilege?**

A protected confidence is a communication made by a person, in confidence, to another person in the course of a relationship in which the confidant was acting in a professional capacity and where the confidant was under an express or implied obligation not to disclose the contents of the communication.

A protected confidence may include a communication between a health professional and a patient. The definition potentially covers many aspects of clinical records.

The aim of the privilege is to protect marginalised groups (other than victims of sexual assault in relation to whom the sexual assault communications privilege may apply) such as mental health patients and HIV positive patients, who may not seek medical treatment if they are concerned that professional confidentiality will not be maintained.

The rationale for the privilege is that some relationships between health professionals and patients will be severed, if trust and confidentiality are not maintained. This rationale may not apply to a patient’s relationship with a Hospital or PHO, where the patient is treated by a team, and may not form a special relationship with a particular health professional.

2. **Can the professional confidential relationship privilege be claimed in all types of court proceedings?**

No - the privilege cannot be claimed in federal courts, such as the Family Court.

3. **How does professional confidential relationship privilege operate?**

The court may direct that evidence not be used in proceedings, if the court finds that using it would disclose a protected confidence, or the contents of a document recording a protected confidence.

The court can come to this decision on its own initiative, or on an application from the protected confider (the patient) or the confidant (the health professional).

The court must decide not to use evidence about a protected confidence if, it is likely that harm would be caused to the protected confider (the patient) if the evidence is used and if the nature and extent of the harm outweighs the desirability of the evidence being given. It is generally desirable, however, for the evidence to be given. The more important the evidence is, particularly if it is not available from an alternative source, the more desirable it is.

Harm includes actual physical bodily harm, financial loss, stress or shock, damage to reputation or emotional or psychological harm (such as shame, humiliation and fear).

The court can also make orders to limit the possible harm, or the extent of the harm caused, for example, by ordering that evidence is to be heard ‘in camera’ (in a closed court), or making orders suppressing the publication of the evidence, or part of the evidence.

The privilege can be waived if the confider consents.
9. HEALTH RECORDS AND INFORMATION

4. What will the court take into account when deciding whether the privilege applies?

The court will consider a range of factors, including the following:

1. the extent to which the evidence could affect the assessment of a fact in issue in the proceedings;
2. the importance of the evidence in the proceeding;
3. the nature and seriousness of the relevant offence, cause of action or defence and the nature of the subject matter of the proceeding,
4. the availability of any other evidence concerning the matters to which the protected confidence or protected identity information relates,
5. the likely effect of using evidence of the protected confidence, including the likelihood of harm, and the nature and extent of harm that would be caused to the patient,
6. the means available to the court to limit the harm or extent of the harm that is likely to be caused if evidence of the protected confidence or the protected identity information is disclosed,
7. if the proceeding is a criminal proceeding - whether the issuing party is a defendant or the prosecutor, and
8. whether the substance of the protected confidence or the protected identity information has already been disclosed by the patient or any other person.
Appendix C

Common Courts and Tribunals

The Family Court of Australia

The Family Court resolves and determines family disputes, including disputes about the care, custody and maintenance of children.

The Family Court also provides consent for special medical treatment (such as sterilisation, surgical gender reassignment & the harvest of bone marrow blood cells from a disabled child for transplantation into a relative) to be carried out on minors.

The Supreme Court of New South Wales

The highest court in the State is the Supreme Court of NSW. It has unlimited civil jurisdiction and handles the most serious criminal matters.

The Court of Appeal and Court of Criminal Appeal hear appeals from decisions made in most of the Courts of New South Wales and from decisions made by a single judge of the Supreme Court.

District Court

The District Court is the intermediate Court in New South Wales and deals with criminal and civil cases. The District Court has jurisdiction to hear:
- all indictable criminal offences (except murder, treason and piracy); and
- civil matters with a monetary value up to $750,000, - or greater with the consent of the parties. The Court also has an unlimited jurisdiction in respect of motor accident cases.

The Court can also deal with applications under the De Facto Relationships Act 1984, and the Family Provision Act 1982, that involve property worth up to $250,000. The Court’s judges hear appeals from the Local Court and also preside over a range of administrative and disciplinary tribunals.

Local Courts

The Local Courts are the courts of general access in New South Wales. There are 157 Local Courts in NSW. They have jurisdiction to deal with:
- the vast majority of criminal and summary prosecutions;
- civil matters with a monetary value of up to $60,000;
- committal hearings;
- family law matters;
- child care proceedings;
- juvenile prosecutions and care matters; and
- coronial inquiries.

In the Local Court, Magistrates hear criminal cases that do not need a judge and jury. There are called summary offences and include traffic matters, minor stealing, offensive behaviour, and some types of assault. Magistrates also hear applications for apprehended violence orders where one person is seeking a restraining order against another.
9. HEALTH RECORDS AND INFORMATION

A magistrate conducts committal proceedings to decide if there is enough evidence for a serious matter, such as armed robbery, or attempted murder, to go before the District Court or the Supreme Court.

Children’s Courts deal with criminal matters involving children who are younger than 18 and with children who are in need of care or protection.

**Administrative Appeals Tribunal**

The main role of the Administrative Appeals Tribunal is to review administrative decisions of New South Wales government agencies, including freedom of information decisions. The Tribunal also has original decision-making jurisdiction in:
- disciplinary proceedings relating to certain professions;
- equal opportunity complaints under the *Anti-Discrimination Act 1977*; and
- retail lease claims.

**Workers Compensation Commission**

The Workers Compensation Commission deals with workers compensation disputes arising out of work related injury or disease suffered by a worker in New South Wales. In addition, the Commission administers medical panels which assess a worker’s condition or fitness for employment in circumstances specified in legislation.

**Coroners Court**

Coroners are situated around New South Wales in Local Courts. They inquire into the circumstances surrounding deaths that are reported to them.

The State Coroner’s role is to ensure that all deaths, suspected deaths, fires and explosions which are under the Coroner’s jurisdiction are properly investigated, and where the law requires an inquest to be held, or in cases whether the Coroner believes an inquest is necessary, a full inquest is undertaken.

**Drug Court**

The Local or District Court in the defined catchment area must refer offenders who appear to meet the Drug Court obligatory criteria, to the Drug Court.

The aim of the Drug Court is to protect the public by ensuring drug dependent offenders engage in longer term treatment. The Court works in collaboration with a number of other organisations. These include the Department of Corrective Services, including the Probation and Parole Service, and the Department of Health.

**Dust Diseases Tribunal**

The Dust Diseases Tribunal hears and determines claims for dust related diseases suffered as a result of exposure to dust. Dust diseases include mesothelioma, asbestosis, silicosis and certain types of lung cancer. The Dust Diseases Tribunal follows the procedural rules of the Supreme Court of New South Wales.
9. HEALTH RECORDS AND INFORMATION

HEALTH RECORDS AND MEDICAL/CLINICAL REPORTS - CHARGING POLICY
(PD2006_050)


The contents of this policy directive are to be effective from the date of issue and replaces PD2005_235 (dated 14 February 2002).

The following relates to charges for health records and medical/clinical reports that are to apply unless specific legislation specifies a lesser rate or exemption from fees. Health Services should develop local policies, which detail the content of records and reports as they relate to these charges. These policies should take into account the function of the health facility, the type of report produced and the amount of information to be provided.

Rates are advised separately via Information Bulletin.

The decision to charge for requests for health records and medical/clinical reports from researchers is a matter for local determination depending upon the type of request and possible future benefit to the health system. Such charges should be determined on a cost recovery basis.

For the purposes of this policy directive a health record is defined as a documented account, whether in hard or electronic form, of a client/patient’s health, illness and treatment during each visit or stay at a health service (and includes a medical record).

Charges relating to categories A, B and C (below) are taxable supplies (ie subject to GST) unless deemed GST - free under the provisions of the ‘A New Tax System (Goods and Services Tax) Act 1999’ (GST Act). The criteria to be followed by the Area Health Services/Hospitals in assessing the GST status are advised in the GST section of this circular. Please note that where the service is determined as being ‘GST-free’ the rates as advised by Information Bulletin apply. Where the GST free test is not satisfied the service is therefore a taxable supply (subject to GST) and the rates as advised by Information Bulletin are to be grossed-up by 10%.

A CHARGES FOR MEDICAL/CLINICAL REPORTS apply based on the following categories:

1. Preparation of a medical report by a medical practitioner appointed to or employed by the health institution/hospital requiring no further examination of the patient. This applies to the treating medical practitioner or a medical practitioner who has not previously treated the patient.

2. A report made by a treating medical practitioner appointed to or employed by the health institution/hospital where a re-examination of the patient is required.

3. A report made by a medical practitioner appointed to or employed by the health institution/hospital who has not previously treated the patient where an examination is required.

4. Preparation of a report by an allied health professional, other than a medical practitioner, appointed to or employed by the health institution/hospital.
9. HEALTH RECORDS AND INFORMATION

B OTHER CHARGES apply based on the following criteria:

1 \( (a) \) Charges for access to clinical notes requested by a patient/client, or by a person acting on behalf of the patient.

A patient/client can apply for access to their own personal health information held by a public health organisation, by contacting the medical records department for that organisation. In addition, the Freedom of Information Act 1988 and the Health Records and Information Privacy Act 2002 provide a statutory right for individuals to apply for access to information held about them.

These laws also allow for other persons to apply for access to a client/patient’s personal health information. A person can apply for access on behalf of the patient/client with their consent, such as a solicitor, interpreter or employer. Alternatively, where the patient lacks the capacity to consent, or is deceased, a person who is the authorised representative for the patient/client can apply for access to the patient/client’s personal health information.

NB. Further details are contained in NSW Health Privacy Manual Version 2, Sections 5.6 and 11.2.2.

Copies of clinical notes supplied in response to the above requests may typically include, as a minimum: patient registration/front sheet, consent to treatment, discharge summary, referral/transfer letters, ambulance report, continuation notes, operation reports (including anaesthetists and nursing reports), radiology and pathology reports, and nursing care plan. Where additional information is held by a hospital but not routinely released, the person making the request should be made aware that such additional information exists but has not been supplied. A further request for such additional information should be considered as forming part of the original request and no additional charge (other than photocopying, where appropriate) should be raised.

(b) Charges for information requested by an insurer.

Health facilities should not provide clinical notes or photocopies of notes to the insurer, but may supply a “Medical Report” or “Summary of Injuries” (Section A or C) if provided with a Statutory Declaration signed by the claimant on the insurer’s claim form in respect of Compulsory Third Party (CTP) insurance or a declaration signed by the claimant on the insurer’s claim form in respect of Workers Compensation Insurance. Such reports should only provide information relevant to the claim. This will necessitate the insurer detailing the nature of the claim. Health facilities will be required to exercise their judgement in determining what is relevant information. A photocopy of the CTP Statutory Declaration is acceptable irrespective of the date of signing.

If clinical notes, or part of the clinical notes, are requested by an insurer, the insurer should be requested to provide written consent from the patient stating that the patient:

- agrees to allow the insurer to have a copy of all or part of the clinical notes and
- the patient is aware that clinical notes, or part of the clinical notes, will inevitably include confidential medical information, which is irrelevant to the claim.

In the absence of clearly documented written consent, as detailed above, hospitals are not required to provide clinical notes to insurers.
The charge applicable in respect of 1(a) and 1(b) (above), which includes search fee, photocopying charges, labour costs, administrative charges and postage, is based on the following criteria:

- A set fee for the provision of a copy of the medical record, or part thereof, eg continuation notes, pathology reports, charts. (Maximum eighty pages.)
- An additional per page rate in excess of eighty
- An additional charge at cost recovery for the provision of other material (eg reproduction of X-rays, audiovisual tapes, copies of photographs & operation footage contained on DVD’s).

Where a patient wishes to access her/his records under the Freedom of Information Act, the requirements of that Act (including charges) apply.

Search Fees - Other than requests made by a party concerned with a patient’s continued treatment or future management.

The search fee should be charged:

- for searching for the health record, irrespective of whether the health record is found. If however, the Patient Master Index (PMI) or other indexes showed that the patient was treated in that health institution but the record cannot be found because it has been destroyed, misplaced or lost, the fees should be refunded in full;
- where the applicant subsequently advises that a report/record is no longer required, or where a thorough search has ascertained that the patient has never attended that health institution for that particular episode of illness;
- for information on date or time of birth, including requests from the Registry of Births Deaths and Marriages in relation to enquiries on hospitals to verify birth details;
- for Motor Accident and Work Cover medical certificates completed at other than time of consultation;
- **NOTE** - The search fee is a component of the fees charged for the preparation of reports, summaries or the production of health records required by subpoena, ie additional fees should **not** be charged on top of those for the preparation of reports, summaries and the production of health records required by subpoena.

The fee covers processing time, which includes time for locating the information, decision-making and consultation where necessary.

**C SUMMARY OF INJURIES** charges apply based on the following:-

“Summary of Injuries” - this is generally requested by Compulsory Third Party Insurers for patients whose fees are covered by the Bulk Billing Agreement.

The “Summary of Injuries” should include:
- Identifying information (name, date of birth, medical record number)
- Date of first attendance,
- Whether patient was admitted. If so, specify dates,
- Positive findings on examination,
- Level of consciousness, if documented,
- Diagnosis, if known.
A standard form letter may be appropriate.

If a discharge summary, or appropriate correspondence that provides this minimum information, is available at the time of the request, a copy of this may be sufficient. Should further information be required, the appropriate report charge as applicable to Section A or B should be raised. There is no requirement to provide the full clinical notes to third party insurers.

The purpose of the “Summary of Injuries” in relation to the bulk-billing agreement is to establish that the admission occurred as a result of a motor vehicle accident.

If the information contained in the “Summary of Injuries” is insufficient or unavailable and a medical practitioner (or other treating health professional, where appropriate) is required to prepare a report, charges for a medical report (or report by a treating health professional) should be raised.

Health Information Managers should consult with the requesting solicitor/insurer/other party to determine which is required before a fee is raised or report is prepared.

**Goods and Services Tax (GST) in relation to categories A, B & C (above).**

In relation to categories A, B & C above the fees/charges set by NSW Health that are taxable supplies or that Health Services are to consider for GST implications are as follows:

- Where revenue derived from the preparation of Clinical Reports is in the context of the Medical Officers Rights of Private Practice the service is to be regarded as a taxable supply.
- Where the income derived is treated as public hospital revenue, consideration is to be given as to whether it satisfies GST-free status under section 38-250 of the ‘A New Tax System (Goods and Services Tax) Act 1999’ (*GST Act*).
  - Supplies are GST-free if:-
    - the charge is less than 50% of the GST inclusive market value of the supply; or
    - the charge is less than 75% of the cost to the supplier of providing the supply.
- NB. Further details are contained in section 3.3 (pages 22 to 24) of the “NSW Health - Finance and Commercial Services - Tax Reform - GST Manual” which is available on the NSW Health Intranet.
- All Area Health Services need to ensure that documentation/systems exist to compare the costs (including overheads) of providing health records and medical reports, and being able to assess the GST status as detailed above.
- Where the service is determined as being ‘GST-free’ the rates advised by Information Bulletin apply, or
- Where the GST free test is not satisfied the service is therefore a taxable supply (subject to GST) and the rates advised by Information Bulletin are to be grossed-up by 10%.

**D HEALTH RECORDS REQUIRED TO BE PRODUCED BY SUBPOENA**

This refers to the retrieval of all the information required by the schedule noted on the subpoena and forwarding it to Court.
9. HEALTH RECORDS AND INFORMATION

Charges apply based on the following:
1. where at least 5 working days notice is given for the production of the record to Court
2. where less than 5 working days notice is given

plus a photocopying charge per page as advised by Information bulletin.

- Multiple requests on a subpoena should be charged on a fee-per-patient basis.
- In a situation where no record is found, it is appropriate to raise a Search Fee for each record, particularly in situations where incorrect details are given or “blanket” subpoenas are issued and considerable time is spent in locating the record. However, if the PMI or other indexes shows that the patient was treated in that health institution but the record cannot be found because it has been destroyed, misplaced or lost, the search fee should not be charged.
- Charges under this category are not subject to GST as they are ‘out of scope’ under a Division 81 Determination.
- Reference should also be made to PD2010_065 headed ‘Subpoenas’, which outlines legislative provisions and procedures to be followed when public health organisations are required to produce documents on subpoena.

E ADMINISTRATIVE PROCEDURES

1. Policies and procedures regarding access to health records and disclosure of personal information should be made in accordance with the NSW Health Privacy Manual Version 2.

2. Applicants should be asked to put all requests in writing and to provide as much information as possible. A patient’s solicitor should include consent by the patient for access to personal records as detailed in the Information Privacy Code of Practice.

3. Where the original of a health institution’s health record leaves the institution (eg health records being tendered to a Court under subpoena), a copy of those records should generally be made beforehand and kept in the institution. Charges for photocopying should be charged at the appropriate per page rate as advised by Information Bulletin. This charge does not apply to Coroner’s or Complaints Unit cases.

4. Charges should be collected in advance, where appropriate. For government departments, reimbursement may be sought subsequently from the relevant department or authority. Even where health records are required to be produced by subpoena, payment should still be sought in advance. It is emphasised that a hospital or organisation is expected to comply in due time with the requirements of a subpoena. Non-compliance may result in contempt of Court, which is punishable by fine or in certain cases imprisonment.

5. It may be decided that an examination of the patient (by either the treating medical practitioner or a medical practitioner who has not previously treated the patient) is required. Under such circumstances, the applicant should be asked to pay the balance of the money for the higher fee before proceeding with the request.

6. Fees collected are to be recorded as revenue in the General Fund.

7. Where there are disputes regarding fees or the amount of information, attempts should be made to resolve the matter between the parties involved. This would normally involve the Chief Health Information Manager and/or the General/Medical administration of the health facility.
9. HEALTH RECORDS AND INFORMATION

F  CIRCUMSTANCES UNDER WHICH A CHARGE SHOULD NOT BE RAISED

1. When the request has been made by a party concerned only with the patient’s continued treatment and/or future management, no charge should be raised (eg where a medical practitioner requests information from a health institution to assist him/her with that patient’s treatment);

2. The GIO or EML as Managers, Treasury Managed Fund or solicitors acting for the GIO or EML in such matters, in respect of claims for workers compensation for employees of Public Hospitals, Public Psychiatric Hospitals (former 5th schedule hospitals), the NSW Ambulance Service and the NSW Department of Health. Health facilities should ensure that solicitors acting for the GIO or EML specify in writing that this is the case;

3. Medical Services Committees of Inquiry established by the Commonwealth Government for purposes of detecting fraud and controlling over servicing;

4. The Department of Community Services or the Police in respect of children suspected of being abused, or of a parent of a child so suspected;

5. The completion of medical certificates at the time of consultation - no charge should be made as the forms for motor accident and WorkCover certificates are in the nature of a certificate and not a report. If not completed at the time of consultation, a search fee may be raised.

G  CIRCUMSTANCES UNDER WHICH CHARGES SHOULD BE RAISED

In all cases where the conditions in Section F have not been met including:

1. When medical reports/records are requested by individuals, solicitors, insurance companies, health professionals and government departments (with the exception of those indicated in Section F) for purposes other than the patient’s continued treatment or future management.

2. The Department of Veterans’ Affairs and Centrelink for the purpose of pension/benefits assessment;

3. Interstate Health Authorities in respect of the eligibility of candidates for appointment to the relevant Public Service.

4. NSW Compulsory Third Party Insurers, in respect of a “Summary of Injuries”. (Refer to Section C).

5. Release of information under the NSW Adoption Information Act 1990. Charges should be raised in accordance with PD2016_036 or any document subsequently amending its provisions.

ENQUIRIES

- pertaining to the level of charges and GST implications refer to the latest Information Bulletin on ‘Charges for Health Records and Medical/Clinical Reports and the “NSW Health - Finance and Commercial Services - Tax Reform - GST Manual” (available on the NSW Health Intranet site) respectively or contact Trevor Smith, Finance and Business Management on (02) 9391 9158.

- pertaining to access of information refer to Privacy Manual for Health Information (March 2015), or contact Legal Branch on 9391 9606.

- pertaining to records management policy should be referred to the Informatics Senior Project Officer on (02) 9391 9155.

Health Records and Medical/Clinical Reports rates and Fees for Cremation Certificates Issued by Salaried Medical Practitioners of Public Hospital are advised annually by Information Bulletin. Refer to the Policy Distribution System for the latest Information Bulletins.

PATIENT INFORMATION AND CONSENT TO MEDICAL TREATMENT (PD2005_406)

Introduction

This Circular contains NSW Health’s policy for the provision of information to patients and consent to medical treatment. The Circular emphasises the importance of ensuring that patients are provided with adequate information to enable them to make informed decisions as to whether to undergo medical or other treatment in health organisations. The Circular is designed to foster the improved provision of information to patients to enable them to make informed decisions regarding treatment and to assist medical practitioners to discharge their legal obligations.

Mandatory Policy

Compliance with this policy is mandatory.

Application

This Circular applies to all public health organisations (Area Health Services, Statutory Health Corporations and Affiliated Health Corporations in respect of their recognised establishments and recognised services). The Circular also applies to all people who work within these organisations and are involved in the provision of health care, including employees, contractors and other health service providers. The policy and procedures in this Circular apply to people whose employment is part time, temporary, contractual, casual or short term.

Main Points

The Department released PD2005_406 – Patient Information and Consent to Medical Treatment in March 1999. This Circular updates that policy. In particular, the following changes have been made:

• The Circular allows local policies to be developed for the administration of blood products by nursing staff, where certain conditions are met. This is to overcome difficulties in remote areas where a hospital may not have medical officers immediately available at the time a blood transfusion is required.

• The revised Circular provides additional detail on procedure to follow where conflicts arise between minors and their parent/s guardians in relation to consent for treatment for the minor.

• The revised Circular also includes new sections on issues such as refusal of treatment, Advance Care Directives, consent for treatment provided by Nurse Practitioners, delegation of consent and consent for the use of tissue removed during surgery to be used for other purposes, such as research.

• New Request/Consent Forms are attached which should be adopted by all public health organisations as soon as practicable. The Forms have been amended to comply with requirements of the Human Tissue Act 1983.

Consultation

All Area Health Services were consulted. Consultation also took place with the Department of Community Services, the NSW Guardianship Tribunal, The Royal College of Medical Administrators, the Medical Services Committee, the AMA, the NSW Nurses Association, the College of Nursing, The Royal Australasian College of Pathologists, the Australian and NZ College of Anaesthetists, ICE, Health Ethics Branch, Aboriginal Health Branch, and others.
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A: HOW TO OBTAIN CONSENT

1. Why is it necessary to obtain patient consent?

As a general rule, no operation, procedure or treatment may be undertaken without the consent of the patient, if the patient is a competent adult. Adequately informing patients and obtaining consent in regard to an operation, procedure or treatment is both a specific legal requirement and an accepted part of good medical practice. The NSW Health Patient Charter also contains a commitment to patients that public health organisations will clearly explain proposed treatment including significant risks and alternatives in a way patients can understand and obtain patient consent before treatment, except in an emergency or where the law says patients must have treatment.

Consent to the general nature of a proposed operation, procedure, or treatment must be obtained from a patient. Failure to do this could result in legal action for assault and battery against a practitioner who performs the procedure.

The obligation to obtain consent is distinct from the obligation disclose information to a patient and warn a patient of material risks.

2. Why is it necessary to warn a patient about material risks?

As a general rule, all patients have a choice as to whether or not to undergo a proposed procedure, operation or treatment. Whilst a patient might consent to a procedure once he or she has been informed in broad terms of the nature of the procedure, this consent will not amount to the exercise of choice unless it is made on the basis of relevant information and advice.

Patients must also be provided with sufficient information about the condition, investigation options, treatment options, benefits, possible adverse effects or complications, and the likely result if treatment is not undertaken, in order to be able to make their own decision about undergoing an operation, procedure or treatment. A medical practitioner has a legal duty to warn a patient of a material risk inherent in the proposed treatment. What amounts to a material risk is explained in section 7. Failure to do this may be a breach of the practitioner’s duty of care to the patient and could give rise to legal action for negligence.

Patients have a legal right to refuse treatment. This is discussed in section 6. Consent of the patient is therefore required to be obtained in nearly all cases.

3. When is the consent of the patient not required or when do different arrangements apply to obtaining consent?

There are a number of exceptions to the general rule that the consent of a patient must be obtained before commencing treatment. In some cases, consent from another authority or person may be required before treatment can proceed. The circumstances where consent is not required or a different arrangement applies for seeking consent are as follows:

a. Consent is not required where immediate treatment is necessary to save an adult person’s life or to prevent serious injury to an adult person’s health where the person is unable to consent, subject to there being no unequivocal written direction by the patient to the contrary (See section 22).
b. Except in the above emergency situation where a person aged sixteen years or over is unable to consent, a guardian, a “person responsible” or the Guardianship Tribunal may be authorised to give consent on behalf of the patient in accordance with the provisions of the Guardianship Act 1987. In limited circumstances, minor treatment may proceed without the need to obtain consent (although specific requirements must be met). The requirements for determining whether a person is unable to consent are set out in section 21 of this Circular. The requirements for seeking a ‘substitute’ consent or proceeding without consent are set out in Attachment A.

c. Specific arrangements apply for the obtaining of consent from a parent or guardian of a child patient. The arrangements for seeking consents are outlined in section 25.

d. Pursuant to section 174 of the Children and Young Persons (Care and Protection) Act 1998, consent is not required to treat a child or young person if treatment is required urgently to save the life, or prevent serious damage to the health of the child or young person (see section 25).

e. Consent of the patient is not required for treatment which is authorised by an order of a Court, for example, an order of the Supreme Court for specific treatment of a minor.

f. Some procedures authorised by statute may proceed without consent, eg compulsory blood drug and alcohol estimation on the request of a police officer.

g. Specific methods and forms of consent are provided under the Mental Health Act for patients receiving ECT or psychosurgery and for treatment provided to an involuntary patient. (See section 23)

4. Does “written” consent need to be obtained?

Generally, the law does not require consent or the provision of information, including warnings about material risks, to be documented in writing. (Exceptions to this general rule include some consents obtained under the Guardianship Act 1987.) Indeed, patient consent can be “express”, either orally or in writing, or it can be “implied” from a person’s conduct, for example a patient may hold out their arm to receive an injection. Irrespective of whether the consent is obtained orally or is documented in writing, a consent will only be valid where it satisfies the requirements outlined in section 5 of this Circular. Consent documented in writing is only as valid as the consent it represents.

**However**, consent obtained in writing will assist practitioners in any subsequent legal proceedings as it will support their view that the treatment has been discussed with the patient and that consent has been obtained. The absence of a consent form could give rise to the implication that the procedure has not been discussed or that consent has not been obtained. The use of an adequate consent form will also assist practitioners in providing appropriate and adequate information to their patients under their care in line with community expectations and legal requirements.

It is the Department’s policy that written consent using the attached model consent form is to be sought for major procedures including:

(i) all operations or procedures requiring general, spinal, epidural, or regional anesthesia or intravenous sedation;

(ii) any invasive procedure or treatment where there are known significant risks or complications;

(iii) blood transfusions or the administration of blood products;

(iv) experimental treatment for which the approval of an ethics committee is required (unless there are sound reasons for doing otherwise).

Abbreviations should not be used on consent forms.
The consent form should remain a separate ‘stand alone’ form and form part of the patient’s clinical record. This should not be read as preventing consent forms from being printed on the reverse side of admission forms, or from being published as part of an admission booklet. It is essential however that the patient information and consent processes be given adequate emphasis when admission decisions are made. Where the consent form is published as part of an admission booklet, the relevant sections of the form must not be separated.

Signed consent forms are not required for minor procedures performed under local anesthesia, eg insertion of IV cannulae, urethral catheterisation, or suture of minor lacerations. However, the criteria for obtaining a valid consent must still be met, the procedure must still be explained to the patient and it is advisable for a written note to be made in the patient’s medical records to this effect.

If the consent is provided orally, or is implied (ie by body language), the procedure must still be explained to the patient and it is advisable for a written note to be made in the patient’s medical records indicating that they consented to treatment and how they consented. If there is a particular reason why consent was not obtained in writing, this should also be documented.

5. What are the requirements for obtaining a ‘valid’ consent?

For a patient’s consent to be valid a number of criteria will need to be met.

First, the person must have the capacity to give consent, that is, the person must be able to understand the implications of having the treatment. Some examples of where patients are not considered as having this capacity include: a child under the age of fourteen, some people affected by mental illness, and some people who are affected by dementia, brain damage or intellectual disability, and some people who are temporarily or permanently impaired by drugs or alcohol. As noted above, where a patient is found to be lacking in capacity, there may be alternatives to obtaining consent. These are addressed later in this document.

A patient who is not fluent in English, is deaf or has other special communication needs does not lack capacity to make decisions, unless another factor, such as those listed above, is also present.

The second requirement is that consent must be freely given. The patient must not be pressured into giving consent. This would include pressure from hospital staff, a medical practitioner or family. Pressuring a patient into making a quick decision could be considered coercion.

Thirdly, the consent must be specific, and is valid only in relation to the treatment or procedure for which the patient has been informed and has agreed to. Medical practitioners need to be aware that there is legal precedent whereby practitioners have been found liable for damages for trespass to the person if, when performing a procedure for which consent has been obtained, they undertake an additional procedure without obtaining specific consent for that procedure, even where the additional procedure appears desirable. Such specific consent is not required where during a procedure, further immediate treatment becomes necessary to save an adult person’s life or to prevent serious injury to that person’s health where that person is unable to consent.

Finally, the patient must be informed in broad terms of the procedure which is intended, in a way the patient can understand

These criteria must be met irrespective of whether the consent is obtained in writing or orally. The mere mechanical signing of a consent form is, of itself, of limited value. The requirements for obtaining a valid consent as outlined above must be met.
Can a patient refuse treatment?

A competent patient is entitled to refuse medical treatment. The High Court of Australia first articulated this principle in Marion’s case, stating that a legally competent person has a right “to chose what occurs with respect to his or her own person.”17 For a competent patient, the right to refuse treatment exists, notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent. Treating a competent patient who has validly refused treatment could constitute an assault or battery.

Like consent to medical treatment, a refusal must be freely given, and be specific. As with consent, if the patient’s circumstances change significantly, the refusal may not remain valid and may need to be confirmed.

A refusal can be express, implied or in writing, however, it is preferable that a refusal of treatment is recorded in writing and signed by the patient. Any discussions with patients about refusal of treatment should be recorded in detail in the medical record.

6.1 Pregnant patients

Australian law does not recognise a foetus as a separate legal entity until it is born alive. Therefore, legally, a competent pregnant woman has the right to make decisions about her own treatment.

Pursuant to section 25 of the Children and Young Persons (Care and Protection) Act 1998, a person who has reasonable grounds to suspect, before the birth of a child, that the child may be at risk of harm after his or her birth may make a report to the Director-General of the Department of Community Services. The intention of this section is to provide assistance and support to the pregnant woman to reduce the likelihood that her child, when born, will need to be placed in out-of-home care. The principle is that of supportive intervention rather than interference with the rights of pregnant women.

6.2 Refusal via Advance Care Directives

Health practitioners should not provide treatment or perform a procedure where there is an unequivocal written direction, such as an Advance Care Directive, by the patient that such treatment is not to be provided in the circumstances which now apply to the patient.

Advance Care Directives may not contain instructions for illegal activities, such as euthanasia.

Should a patient give such a written direction, the medical practitioner should consider whether it is specific enough to apply to the clinical circumstances which have arisen. Consideration should also be given to the currency of the advance care directive, and whether it appears to be made in contemplation of the current circumstances (for example, was it made after the diagnosis of the current illness). Medical practitioners should also consider whether there is any reason to doubt the patient’s competence at the time that the advance care directive was signed, or whether the patient was under undue pressure to make the directive. If the practitioner establishes that the refusal is invalid, or based on a false assumption or misinformation, s/he can treat the patient in accordance with his of her professional judgment of the patient’s best interests.

Concerns may arise about the legality applicability of an advance care directive, especially where the patient refuses treatment considered to be usual medical practice, and/or where the refusal may be life threatening. In an emergency, the medical practitioner can treat the patient in accordance with his or her professional judgment of the patient’s best interests, until legal advice can be obtained. Where

17 Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 – 58 (Marion’s case).
9. **HEALTH RECORDS AND INFORMATION**

9.16 There are concerns about an Advance Care Directive in a non-emergency situation, the medical practitioner may wish to consult with the patient’s relatives, or those close to the patient, seek legal advice, discuss the issue with colleagues, or other clinicians involved in the patients care. All discussions should be documented in the patient’s medical record.

If a patient presents with an Advance Care Directive or other document that refuses treatment, a copy of the document should be made and placed on the patient’s medical record.

Further information can be found in “Using Advance Care Directives”

7. **How do I properly inform a patient about a procedure and warn of material risks?**

In addition to meeting the requirements for obtaining a valid consent, the patient must be provided with sufficient and material information for there to be a genuine understanding of the nature of the operation, procedure or treatment. Failure to warn a patient about the material risks inherent in a proposed procedure is a breach of the medical practitioner’s duty of care to the patient and could give rise to legal action for negligence.

The legal duty of practitioners to disclose information regarding treatment was defined by the High Court of Australia in the case of Rogers v. Whitaker (1992). The principles concerning the provision of information to patients have been developed by the courts with regard to the paramount consideration that a person is entitled to make their own decisions about their treatment.

Practitioners should give information about the ‘material’ risks of any intervention, especially those likely to influence a patient’s decision. A risk is ‘material’ if, in the circumstances, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it (Rogers v. Whitaker). Known risks should therefore be disclosed when an adverse outcome is a common event though the detriment is slight, or when an outcome is severe even though its occurrence is rare. Further, practitioners should carefully consider whether knowing about a risk is likely to influence a patient’s decision. In addition practitioners should carefully consider patients’ reactions to specific risks, however unlikely those risks might be, particularly where specific concerns regarding adverse outcomes are raised, however unlikely.

8. **What are the NHMRC guidelines for in forming patients about the risks associated with medical treatment?**

The National Health and Medical Research Council (NHMRC) in 1993 produced a set of guidelines for medical practitioners on providing information to patients which is largely in accord with the findings in Rogers V. Whitaker. The NSW Health Department strongly favours the use of the NHMRC guidelines by practitioners when informing patients on the risks associated with medical treatment. The NHMRC recommends that practitioners discuss:

(i) the possible or likely nature of the illness;
(ii) the proposed approach to investigation and treatment including:
- what the proposed approach entails,
- the expected benefits;
- common side effects and material risks;
- whether the procedure is conventional or experimental; and
- who will undertake the intervention.

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18 NHMRC General Guidelines for Medical Practitioners on Providing Information to Patients, Canberra: Commonwealth of Australia June 1993. As at August 2004, these guidelines were under review. They can be accessed at http://www.nhmrc.gov.au
9. HEALTH RECORDS AND INFORMATION

(iii) other options for diagnosis and treatment;
(iv) the degree of uncertainty of the diagnosis and any therapeutic outcome;
(v) the likely outcome of not having the diagnostic procedure or treatment, or of not having any procedure or treatment at all;
(vi) any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with the proposed intervention; and
(vii) the time and cost involved including any out of pocket expenses.

The NHMRC guidelines note that a practitioner’s judgment about how to convey risks will be influenced by a number of factors. These include: the seriousness of the patient’s condition, the nature of the intervention (complex interventions require more information); the likelihood of harm and the degree of possible harm; the questions asked by the patient; the patient’s temperament, attitude and level of understanding (including literacy and intelligence level); and accepted medical practice. Information should be provided in a form and manner which helps patients to understand the problem and the treatment options available, and which is appropriate to the patient’s circumstances.

9. Can a patient information form, brochure or other material about a treatment be used to inform a patient when obtaining consent?

Pre-prepared material (translated where relevant) about a procedure or treatment may be useful if given to the patient as a means of stimulating discussion and for guiding the medical practitioner when informing the patient. However pre-prepared material should not be used as a substitute for ascertaining whether a person understands the nature of, and risks involved in, the procedure or treatment, as the provision of the pre-prepared material alone will not discharge the legal duty in most cases. The practitioner should assist the patient to understand the material and explain any information that the patient finds unclear. The practitioner must give the patient an opportunity to read the material and raise any specific issues of concern either at the time the information is given to the patient or subsequently.

The practitioner informing a patient must consider that individual patient’s circumstances. This can be done by considering any personal knowledge of the patient, their prior medical history and other issues directly raised by the patient. The practitioner will also need to consider whether pre-prepared material is up to date, accurate and appropriate for the patient.

It is essential that patient information material discloses all “material risks”, at least in general terms. The more likely the risk the more specific the detail that should be provided. An inadequate or inaccurate information sheet could have significant implications in subsequent litigation because it could be inferred the patient has not been properly informed. It must be emphasised that since a patient’s reactions and views plays an important part in determining what “material risks” should be disclosed, an information form cannot be a substitute for a full and frank discussion with the patient.

Any additional information provided should be specifically noted on the information sheet by hand. The NHMRC guidelines on the provision of information to patients should be followed as a guide to the information that must be provided in preparing such material. Such material should be regularly reviewed to ensure it remains accurate.

10. What if the person is from a non-English speaking background?

To ensure that a valid consent is obtained, interpreters should be used for any non-English speaking patients in accordance with the Department’s current policy on the use of interpreters (PD2006_053).

A professional interpreter should be present to ensure patient consent and understanding when a recommendation for surgery, treatment or research is communicated to a non-English speaking patient.
The consent form signed by a non-English speaking patient must contain a statement signed by the Interpreter that he/she has interpreted the content of the form and all the information supplied by the treating practitioner to the patient.

Consent for treatment may not be valid if it is obtained through a child or family members other patients, visitors or non-accredited staff acting as interpreters.

11. Can information be withheld from the patient?

The circumstances in which information can be withheld from the patient are limited. The withholding of information on the grounds of ‘therapeutic privilege’ denies the patient the right to participate in decision making. The scope of the privilege is uncertain and the discretion to exercise ‘therapeutic privilege’ should only be used in very limited cases having regard to the basic legal rights of patients to make decisions about their own medical treatment and uncertainty surrounding the scope of the ‘privilege’. Consideration should be given to consultation with other colleagues before such a decision is made.

The only situations where the duty to inform can be breached are as follows.

(i) The patient expressly directs the practitioner to make the decisions, and does not want the offered information. Even in this case the practitioner should give the patient basic information about the diagnosis and treatment.

(ii) The practitioner may exercise “therapeutic privilege,” that is the practitioner can withhold information if they hold a reasonable belief that disclosure of a risk would prove damaging to the patient’s health. To withhold information in these circumstances, the practitioner would need to make a judgment, on reasonable grounds, that the patient’s physical or mental health might be seriously harmed by the information. The types of factors governing therapeutic privilege include the patient’s personality, temperament or attitude; their level of understanding; the nature of the treatment and the likelihood of adverse effects resulting from the treatment.

Information cannot be withheld from substitute decision makers appointed pursuant to the Guardianship Act. Therapeutic privilege is not recognised by the Guardianship Act as a ground for failing to provide information to the person responsible. If, for some reason, information cannot be provided to the person responsible, consent to the treatment should be sought from the Guardianship Tribunal.

12. Does ‘written’ consent need to be obtained for every procedure or step in a ‘treatment program’?

Some treatments involve a number of separate procedures or the administration of medication or blood products over a period of time or a series of patient visits. Chemotherapy and the administration of blood products to patients with haemophilia are examples where this may be the case.

Where such a treatment program is proposed, the patient should be provided with information and advice about the procedure, including advice about the material risks and consent should be obtained and documented, in the normal fashion prior to beginning treatment. An explanation of the treatment program, the steps or separate treatments/procedures involved and the ‘material’ risks associated with the treatment program should be provided. Generally a form documenting that this has occurred for each stage of the treatment program will generally not be necessary as patient consent can be implied from continuing conduct.

However, a new form should be completed if a new treatment is proposed which was not previously explained to the patient, where alternative treatments become available or if new risks associated with the treatment are identified. Medical officers and hospital staff should remain alert to any issues or concerns raised by the patient during the treatment program. Before continuing with the treatment program, such concerns should be discussed with the patient and documented in the patient’s medical record. If the issues raised are significant, a ‘new’ form should be completed.
9. HEALTH RECORDS AND INFORMATION

13. Can a consent form be faxed?

A consent form constitutes evidence that a patient has consented to a procedure and has been provided with relevant information and is important in protecting the hospital and attending medical officer from certain legal liabilities. It is the Department’s view that an original consent form is preferable to a faxed or photocopied form and that originals should always be obtained where possible. If it is not possible to obtain an original consent form, the reasons why the original could not be obtained should be noted in the patient’s medical record. When faxing or photocopying consent forms, special care should be taken to ensure that double sided documents are transmitted or copied in their entirety.

14. For how long does consent remain valid?

The general rule is that consent will remain valid until it is withdrawn by the patient or until the patient’s circumstances change in a material respect.

Hospitals and practitioners should bear in mind, however, that a change in patient’s circumstances could encompass a number of situations. This would include a change in the patient’s condition which would affect treatment, the development of alternative treatments to the recommended procedure or the identification of new risks or side effects associated with the recommended procedure.

It is suggested, therefore, that a new consent form be obtained or the patient be asked to affirm their previous consent if a significant period of time has lapsed since the original consent was obtained. What constitutes a “significant amount of time” will depend on the individual circumstances of the case.

B: WHO SHOULD OBTAIN CONSENT

15. Who is legally responsible for ensuring a patient has the necessary information and advice and for obtaining consent?

A practitioner who performs a procedure, operation or treatment without obtaining consent may be liable in an action for assault and battery. This does not mean the practitioner cannot ask another practitioner to seek consent on their behalf, although they should be aware they could still be held responsible if a valid consent has not been obtained.

Where a practitioner recommends or advises that a patient undergo an operation, procedure or treatment, they will be responsible for ensuring they provide sufficient, appropriate and relevant information and advice to enable the patient to make their own decision to undergo the operation, procedure or treatment. Once again, this does not mean that they cannot have another person undertake that task, although they may be held responsible in some circumstances if this is not done properly.

In general, the attending medical officer (AMO) under whose care a patient is admitted either as a private or a public patient will have, or may share, legal responsibility for the overall care of the patient. Health services and hospitals also may have legal responsibilities in this area, depending on the circumstances of the individual patient. For many of the patients admitted under its care, the hospital may have certain duties, including a duty to take reasonable steps to ensure that consent has been obtained.

In many cases, the AMO who recommends a procedure may not perform the procedure. This is likely to arise in two main situations: (i) For patients who are not admitted as private patients of a particular practitioner, the task of performing a procedure may be delegated in accordance with hospital protocol to a hospital staff member by the AMO under whose care the patient is admitted; and (ii) Certain
9. HEALTH RECORDS AND INFORMATION

major radiological procedures, invasive investigations and some operations are often initiated by the primary AMO but are performed by another medical practitioner, radiologist, physician or surgeon. Practitioners should be aware that even though the AMO will not be performing the procedure, both the AMO and the practitioner performing the procedure (or providing advice to a patient) will have legal and professional responsibilities to the patient in regard to the provision of information and advice and to ensure consent has been sought.

16. Can information be provided to a patient or consent obtained by another practitioner on my behalf?

To ensure that hospitals’ resources are utilised appropriately and that treating practitioners are able to manage their time effectively, arrangements may be put in place to delegate the task of providing the necessary information to patients to enable them to make a decision to undergo a treatment and for seeking consent. The arrangements set out below have been developed having regard to: the respective legal obligations of hospitals (independently and through its staff) and AMOs arising from the admission status of patients; the rights and expectations of patients; and the appropriate use of practitioner time and hospital resources.

These arrangements apply where consent is required to be documented in writing in accordance with this policy.

Where the task of informing the patient and seeking consent has been delegated, the AMO must be satisfied that the practitioner is competent to undertake that task and, in appropriate cases, take reasonable steps to ensure that the patient has been properly informed and that a consent form has been completed. However, the AMO should be aware that the practitioner performing the task will also have legal and professional responsibilities to provide all necessary and proper information to assist the patient in making a decision and for obtaining a valid consent. Senior practitioners should be aware that more junior practitioners have a responsibility to refuse to undertake the task if they do not consider they have sufficient skill or experience. Decisions made by junior staff in this regard must be respected. The medical practitioner performing the procedure cannot always assume that someone else has properly informed the patient and obtained a valid consent. Therefore, the medical practitioner performing the procedure should verbally confirm that the patient understands the procedure and that the material risks have been discussed prior to the procedure commencing.

It is the Department’s policy that every public patient should know which practitioner the hospital has arranged to be primarily responsible for their care. The issue of which practitioner will be performing the procedure should be canvassed with the patient at the time of providing information to the patient and obtaining consent. Public patients should be advised accordingly where the doctor who is to perform the procedure has not yet been nominated.

17. Who may obtain patient consent and when should it be obtained?

17.1 Admission from a practitioner’s private rooms

It is the Department’s policy that prior to admission to a public hospital, a patient who is seen by an AMO in their private rooms should be provided with the necessary information about the procedure, including information about the material risks involved, in the AMO’s rooms. The AMO should also satisfy themselves as to the other requirements for obtaining a valid consent, as outlined in section 5.

The relevant sections of the consent form should be completed by the AMO and the form provided to the patient. The patient can give consent and complete the form either at the same time or prior to admission into hospital. This arrangement will apply irrespective of whether the patient is to be admitted as a public or private patient. However, the following points should be noted.
9. HEALTH RECORDS AND INFORMATION

(i) In some cases it may be necessary for information about the procedure to be provided to the patient and for the consent to be obtained in the practitioners rooms, for example where an interpreter has been in attendance. In such cases the form may need to be completed by the patient in the rooms. Where this occurs care should be taken to ensure that the patient is not pressured or rushed into signing the form as such consent of the patient will not be valid. (See the requirements for obtaining a valid consent in part 5.)

(ii) In all cases where the patient wishes to have more time to consider the proposed treatment, the AMO should sign the relevant parts of the form and provide the form to the patient who can subsequently complete the consent form. In such cases, the patient should be made aware that admission to the hospital will be conditional on production of a completed consent form.

(iii) Admissions staff should be aware that on occasions, admission may be arranged through an AMO’s private rooms, without the patient having been seen there. This situation is likely to arise in the case of recurring conditions or long term treatment programmes. Where this reasonably appears to be the case, the provision of information to the patient and the seeking of consent from the patient should be arranged in accordance with the procedures outlined below for patients that present to the hospital.

(iv) An AMO may provide the necessary information to a patient and seek consent in their rooms for a procedure that will be carried out by, or that will require the involvement of, another practitioner. In light of the nature of and risks involved with the procedure, the AMO should consider whether an additional consultation with the other proceduralist should be arranged. A common example of this may be where the risks of anesthesia need to be explained separately by the attending anesthetist.

17.2 Admission through the hospital Emergency or Outpatients Department

Where a patient presents to the hospital for treatment and is to be admitted through Emergency, the AMO should inform the patient, seek consent and complete the consent form at the pre-operative consultation. The necessary information should be provided and a valid consent should be obtained and documented prior to any pre-operative medication being given, and prior to the operation, procedure or treatment. The tasks may be delegated in the following circumstances:

(i) Where the patient is to be admitted as a public patient, and the AMO is to perform the procedure, registrars and resident medical officers may be delegated the task of informing a patient and obtaining consent where:
   (a) it is not possible for the AMO to obtain consent personally;
   (b) the delegated practitioner does not object to undertaking the task; and
   (c) the AMO is satisfied that the delegated practitioner has the necessary skills and experience to inform the patient so as to discharge the respective legal obligations of the AMO and the hospital.

(ii) Where the patient is to be admitted as a public patient and the performance of a procedure or treatment has been delegated to a registrar or resident by the AMO, that staff member may obtain consent where the AMO is satisfied that the delegated practitioner has the necessary skills and experience to inform the patient.

(iii) Where the patient is to be admitted as a private patient - As the AMO will ordinarily provide the necessary information, including information about material risks, and obtain consent from a patient who elects to be admitted as a private patient of the AMO, hospital staff will not be required to be involved in the provision of such information or in obtaining consent from such patients. AMOs should ensure they are available to seek patient consent for their private patients prior to the administration of pre-medication. In exceptional circumstances senior experienced hospital medical staff may be required to seek consent from private patients of an AMO where:
   (a) the AMO is unable to obtain consent personally; and
   (b) the procedure is required as a matter of urgency; and
   (c) the delegated practitioner does not object to undertaking the task; and
   (d) the AMO is satisfied that the delegated practitioner has the necessary skills and experience to inform the patient so as to discharge the legal obligations of the AMO.
9. HEALTH RECORDS AND INFORMATION

Out-patients being booked for elective procedures/treatments may be informed by a registrar who shall complete the patient consent form and ensure that patient consent is given. Such patients should be advised by the registrar that they will not necessarily be carrying out the procedure when the patient is admitted.

Interns are not to be delegated the task of seeking consent and informing the patient for operations or procedures unless the AMO is satisfied, in addition to the requirements outlined above at 17.1(i), that: the procedure is a minor procedure; and the intern has, under the supervision of a senior experienced practitioner, undertaken and discharged in a competent manner the task of informing a patient with the same condition or similar circumstances. This does not prevent an intern from having a form completed in the circumstances outlined in the next paragraph.

18. What is the role of other nurses and other health professionals in providing information and obtaining consent for procedures that are performed by medical staff?

Administrative and nursing staff cannot be delegated the task of informing a patient about the material risks of an operation, procedure or treatment and obtaining consent, where consent is required to be documented in writing in accordance with this policy. However in some cases, an AMO may inform the patient and obtain verbal consent and subsequently ask a hospital staff member to have the patient complete the form. (Note that the AMO is still required to complete the “Provision of Information to Patient “ or “Medical Advice” section of the form.) While this practice should not be encouraged, it is recognised this may be necessary in some circumstances. In these situations the staff member is not seeking the consent, they are simply having the patient confirm their prior consent. Any outstanding issues of concern to the patient should be brought to the attention of the AMO.

Many other procedures are performed in hospitals which are not performed by medical practitioners. In most cases, consent will be implied from the patient acquiescing to the procedure.

19. What is the role of other nurses and other health professionals in providing information for procedures?

Patients may seek advice from another medical practitioner, nurse or other health care professionals regarding the nature of a treatment, operation or procedure. All health care professionals need to be aware they are under a general duty to exercise reasonable care where they provide any advice or information to a patient. All practitioners, including nurses, are responsible for the advice they give to patients.

In circumstances where information is sought from a health care professional who is not the practitioner responsible for ensuring that the patient is appropriately informed about a procedure and seeking consent, the health care professional should ensure that any additional advice is accurate and documented in the patient’s record. If a health care professional becomes concerned that the patient lacks a sufficient understanding about the procedure, operation or treatment to have made a valid decision to undergo that operation, procedure or treatment, the health professional should take reasonable steps to ensure the person receives the necessary additional information from the treating practitioner.

20. Can nurse practitioners obtain consent for the treatment they perform?

Nurse practitioners are registered nurses working at an advanced practice level. They are authorised by the Nurses Registration Board of New South Wales to use the title ‘nurse practitioner’.

Authorised nurse practitioners may initiate medications, order diagnostic tests and make referrals only when they are operating within guidelines approved by the Director-General. Nurse practitioners have the same obligations as do medical practitioners, when obtaining consent for the procedures which they are authorised to perform.
C: PATIENTS WHO ARE INCAPABLE OF GIVING CONSENT

21. When is a person incapable of giving consent?

A person is incapable of giving consent if they are not “competent”. There is no single legal test or definition of competency. However, in order to be competent to consent to or refuse treatment, a patient must be able to comprehend and retain treatment information and consider the information in order to reach a decision. At determination of competency is a determination of the particular patient’s capacity to perform a particular decision-making task at a particular time. It is possible that a patient could be competent to make some, but not all decisions concerning their treatment.

A patient may lack competency due to a number of reasons. These include:

- Temporary factors such as the patient’s medical condition (i.e. unconsciousness). (For treatment in an emergency, see section 23);
- Mental illness (See section 24);
- Intellectual impairment, dementia, or brain damage (See Attachment A);
- A child aged 14 or less (See section 25).

The Guardianship Act provides methods for obtaining consent to treat those persons aged 16 years or over who are incapable of giving consent. A person is incapable of giving consent, within the meaning of that Act, where the person is incapable of understanding the general nature and effect of the proposed treatment, or is incapable of indicating whether or not the patient consents to the treatment. A summary of relevant provisions is provided at Attachment A.

The Department is aware that in some instances a patient will have been administered pre-medication without a consent form having being completed. All hospitals should adopt procedures to prevent this situation from occurring. However if such a situation arises, staff should be aware that the absence of a signed form does not prevent the procedure from proceeding provided that a valid verbal consent was previously obtained and the patient had been provided with sufficient information. If the AMO is satisfied that this has occurred, such a procedure may proceed. Of course, this should be documented in the medical record.

22. Is the consent of a patient’s spouse required for any procedure?

Where the patient is capable of giving consent, there is no specific requirement to obtain the consent of the spouse (or any other family member) and this should only be done with the specific authority of the patient.

If a person is 16 years of age or over and incapable of giving consent, the provisions of the Guardianship Act 1987 will apply and the consent of the patient’s “person responsible” will be required (unless consent is not required, or the consent of the Tribunal is necessary). (See Attachment A)

The person responsible for a patient will often be the patient’s spouse. Spouse includes husband or wife or de facto, and can include a same sex de facto.

23. What if treatment is urgently required but the person is incapable of giving consent?

In an emergency, where the patient is unable to give consent and the treatment is required immediately:

(i) to save the person’s life; or
(ii) to prevent serious injury to a person’s health; or
(iii) except in the case of special medical treatment - to prevent the patient from suffering or continuing to suffer significant pain or distress;
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the procedure/treatment may be carried out in the absence of consent. See Attachment A for further information concerning ‘special medical treatment’.

Legal authority suggests that a medical practitioner should not provide treatment or perform a procedure in an emergency where there is an unequivocal written direction by the patient that such treatment is not to be provided in any circumstances. Should a patient give such a written direction, a medical practitioner should take reasonable steps to ascertain the true scope of the patient’s refusal to consent and whether the patient had the capacity to decide at the time the direction was signed. In such a case, if the medical practitioner establishes that the patient’s refusal was invalid or if the patient lacked the capacity to give the direction, the medical practitioner can treat the patient in accordance with his or her professional judgment of the patient’s best interests. The circumstances surrounding an event of this sort should be carefully documented. See section 6 for further information on refusal of treatment and Advance Care Directives.

24. What if the patient involved is affected by a mental illness?

If a voluntary patient does not have the capacity to consent due to mental illness, the substitute consent provisions of the Guardianship Act will apply (See Attachment A).

The remainder of this section relates to the treatment of patients under the Mental Health Act.

24.1 Emergency Surgery

A medical superintendent can consent to emergency surgery on behalf of an involuntary patient suffering from a mental illness, if, in the medical superintendent’s opinion, the patient is incapable of giving consent, or is capable of giving consent and refuses to do so, or neither gives nor refuses consent and the surgery is necessary, as a matter of urgency, in order to save the life of the patient or to prevent serious danger to the health of the patient.

A medical superintendent can consent to emergency surgery on behalf of a voluntary patient or a forensic patient not suffering from mental illness, if in the medical superintendent’s opinion, the patient is incapable of giving consent, and the surgery is necessary, as a matter of urgency, in order to save the life of the patient or to prevent serious danger to the health of the patient.

Consent given by a medical superintendent should be in writing and signed.

In this section, references to a medical superintendent also include a deputy medical superintendent, responsible medical officer or authorised officer.

24.2 Operations and Treatment other than Emergency Treatment

A medical superintendent may apply to the Mental Health Review Tribunal, or to an authorised officer, for consent to perform a surgical operation or special medical treatment (see below) on a temporary patient, continued treatment patient, forensic patient (suffering from mental illness) or any other patient detained in a hospital if, the patient is incapable of giving consent, or is capable of giving consent and refuses to do so, or neither gives nor refuses consent and the medical superintendent is of the opinion that the surgery or special treatment is desirable, having regard to the patient’s interests.

A medical superintendent may apply to the Mental Health Review Tribunal or to an authorised officer, for consent to perform a surgical operation or special medical treatment on an informal patient or a forensic patient (not suffering from mental illness), if in the medical superintendent’s opinion, the patient is incapable of giving consent, and the medical superintendent is of the opinion that the surgery or special treatment is desirable, having regard to the patient’s interests.

Applications to perform surgical applications can only be made to the Tribunal, or to an authorised officer, 14 days after written notice of the intention to obtain consent from the Tribunal or the authorised officer, for the surgery, has been given to the patient’s nearest relative.
9. HEALTH RECORDS AND INFORMATION

In this section, references to a medical superintendent also include a deputy medical superintendent, responsible medical officer or authorised officer.

24.3 Electro-Convulsive Therapy (ECT)

ECT treatment cannot be given to involuntary patients without the consent of the Mental Health Review Tribunal. For further information on ECT treatment for involuntary patients see http://www.mhrt.nsw.gov.au/civil-patients/electro-convulsive-therapy.html

24.4 Special Medical Treatment

Any treatment, procedure, operation or examination that is intended, or is reasonably likely, to render a patient permanently infertile cannot be provided to psychiatric patients unless the medical practitioner providing the treatment is of the opinion that the treatment is necessary in order to save the patient’s life, or prevent serious damage to the patients health, or the Mental Health Review Tribunal has consented to the treatment. This type of treatment cannot be performed on patients under the age of 16 years.

25. What if the patient is a minor?

25.1 Emergency Treatment

Pursuant to section 174 of the Children and Young Persons (Care and Protection) Act 1998, a medical practitioner may carry out medical treatment on a child (a person aged under 16 years) or young person (a person aged 16 or 17) without the consent of the child or young person or a parent of the child or young person, if the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person in order to save his or her life or to prevent serious damage to his or her health. This means that emergency medical treatment, and emergency first aid treatment (including any procedure, operation or examination) may be provided without the consent of the minor or a parent or guardian.

25.2 Non-Emergency Treatment

It is NSW Health policy that if the patient is under the age of 14 years, the consent of the parent or guardian is necessary.

A child aged 14 years and above may consent to their own treatment provided they adequately understand and appreciate the nature and consequences of the operation procedure or treatment. However, where the child is 14 or 15 years of age, it is prudent for practitioners or hospitals to also obtain the consent of the parent or guardian, unless the patient objects.

Generally, the age at which a young person is sufficiently mature to consent independently to medical treatment depends not only on their age but also on the seriousness of the treatment in question relative to their level of maturity. The health practitioner must decide on a case-by-case basis whether the young person has sufficient understanding and intelligence to enable him or her to fully understand what is proposed.

Pursuant to the Minors (Property and Contracts) Act 1970, if a minor aged 14 and above consents to their own medical treatment the minor cannot make a claim against the medical practitioner for assault or battery. Also, where medical treatment of a minor aged less than sixteen years is carried out with the consent of a parent or guardian of the minor, the minor cannot make a claim against the medical practitioner for assault or battery.

For patients 16 years or over, their own consent is sufficient.
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Suggested procedure to follow where treatment is not urgent and consent is refused by either the parents of a minor, or a minor aged 14 or above.

1. Establish that there is no suitable alternative treatment available to which consent would be forthcoming;
2. Obtain a second medical opinion and discuss this with the parent(s) or guardian and/or patient;
3. Attempt to reach agreement by counseling and mediation with the family. These efforts should be documented;
4. If applicable, explain to the parent(s) and patient that although the treatment is not urgent at this stage, if it is not provided in a timely manner, the situation may become urgent. Explain how delay would affect the patient. Explain that in urgent circumstances, treatment can be provided without parental consent, or the consent of the patient, but that the PHO would prefer to provide the treatment now, with consent;
5. If the parents do not consent to treatment on behalf of their child, consider making a report to DoCS that the child is a child at risk. Parents should be told that the PHO intends to notify DoCS before the notification is made. Once DoCS receives a notification, it will appoint a case manager to investigate the situation. This may ultimately lead to a guardian being appointed to consent to the treatment in place of the parents;
6. As a last resort, a court order can be sought authorising the treatment.

Legal Branch, NSW Health, or the Department of Community Services can be contacted for advice at any stage in this process.

26. Who gives consent for a minor if their parents have separated?

The Family Law Act makes it clear that each parent has full responsibility for each of their children who is under 18. Parental responsibility is not affected by changes to relationships (ie if the parents separate). Each parent has the responsibility for their child’s welfare, unless the Court has made an order stipulating that one parent has certain responsibilities to the exclusion of the other parent.

This means that the consent of either parent to their child’s medical treatment is usually sufficient. There are two circumstances where the consent of either parent may not be sufficient:

1. Where no formal court orders have been made, and one parent consents and the other refuses. The best way of handling this situation is by counselling the parents and trying to reach agreement on what is in the child’s best interests.
2. Where the Court has made an order stipulating that a particular parent has particular responsibilities, i.e. for health care decisions, in which case, consent will have to be obtained in accordance with that order.

The Court can make four types of parental orders. The four types are residence orders, contact orders, child maintenance orders and specific issues orders.

A residence order or specific issues may stipulate that one parent has sole responsibility for the child’s day-to-day care welfare and development. If this type of order has been made, that parent will be the only parent that can consent to medical treatment.

If there is an arrangement for a child to live with one parent for part of the time and the other for part of the time, this is a residence order. Both parents would retain full parental authority for the child, however, the consent of either parent would be sufficient to authorise medical treatment.

If a specific issues order is made granting one parent the sole responsibility for health care decisions, that parent will be the only parent that can consent.

Health care workers should assume that either parent can consent (alone) unless a court order stipulating something different is brought to their attention.


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27. Can a parent or guardian of a minor delegate their responsibility for providing consent to another adult?

Occasionally, a parent delegates their responsibility for consenting to medical treatment on behalf of their minor child, to another adult. This may occur for example, in relation to Aboriginal children, where an extended family member, rather than the child’s mother or father, is responsible for giving consent on their behalf.

A parent or legal guardian can authorise another adult to consent to treatment on behalf of their minor child. Ideally, this delegation would be in writing. If a written delegation exists, a copy of it should be placed on the minor’s medical record.

If the delegation was given verbally, it should be documented in the minor’s medical record.

If a minor presents with an adult other than a parent, the attending medical officer should attempt to ascertain the adult’s relationship to the child and whether the adult is the child’s guardian. Where the adult does not appear to be the child’s guardian, but bears some relationship to the child, and confirms that the parent/guardian is aware that they are accompanying the child, it is reasonable to assume that the parent or guardian has delegated responsibility to that person, unless there is any indication to the contrary (ie a previous objection by the parent to that person exercising any authority in relation to the child).

28. What is ‘special medical treatment’ in relation to children?

Practitioners should be aware that the Children and Young Persons (Care and Protection) Act 1998 classes some procedures as “special medical treatment”. These procedures cannot be carried out on a child under 16 years unless:

(i) the treatment is required as a matter of urgency to save the child’s life or to prevent serious damage to the child’s health; or

(ii) if the treatment is described in paragraphs (a), (b) or (c) below, the Guardianship Tribunal consents to the treatment.

The definition of ‘special medical treatment’ under the Children and Young Persons (Care and Protection) Act includes the following:

(a) procedures or treatments that are intended to remediate a life threatening condition intended or reasonably likely to have the effect of rendering the child permanently infertile,

(b) any medical treatment that involves the administration of a long-acting injectable hormonal substance (such as medroxyprogesterone acetate in aqueous suspension) for the purpose of contraception or menstrual regulation,

(c) any medical treatment in the nature of a vasectomy or tubal occlusion,

(d) any medical treatment that involves the administration of a drug of addiction within the meaning of the Poisons and Therapeutic Goods Act 1966 over a period or periods totalling more than 10 days in any period of 30 days, except for medical treatment in circumstances where the drug is administered in accordance with a written exemption granted, either generally or in a particular case, by the Director-General of the Department of Community Services on the written request of the Director-General of the Department of Health,

(e) any medical treatment that involves an experimental procedure that does not conform to the document entitled National Statement on Ethical Conduct in Research Involving Humans published by the National Health and Medical Research Council in 1999,

(f) any medical treatment that involves the administration of a psychotropic drug to a child in out-of-home care for the purpose of controlling his or her behaviour.
9. HEALTH RECORDS AND INFORMATION

The Guardianship Act applies to adults who are unable to consent to their own treatment, however, the Guardianship Tribunal’s consent is also required in order to provide some special medical treatment to children under 16, as set out above.

D: CONSENT FOR SPECIFIC TREATMENT/PROCEDURES

29. Blood Transfusions

Section 4 of this Circular requires consent to be documented in writing for certain procedures. This includes the administration of a blood transfusion or the administration of blood products. Blood products includes red cells, white cells, platelets, albumin products, fresh frozen plasma, Anti-D Immunoglobulin, coagulation factors, autologous transfusions and any biologically derived products such as thrombin products.

Section 20 of the Circular provides that administrative and nursing staff cannot be delegated the task of informing a patient about the material risks of an operation, procedure or treatment and obtaining consent, where consent is required to be documented in writing in accordance with this Circular. Taken together, these two parts require that consent must be obtained and a consent form must be completed by the attending medical officer, or a medical officer to whom that task is properly delegated in accordance with section 16 of the circular.

The provision of information to patients and the obtaining of a valid consent for blood transfusions should, whenever practicable, be documented using a consent form, except of course in emergency situations where the patient is unable to give a valid consent. These arrangements however, may not be practical in small rural hospitals where there are no resident medical staff. In some cases, it may not be practical for a medical practitioner to be present to provide the information to the patient, and obtain a completed consent form and instead, nursing staff are required to administer the transfusion. To address these practical problems where necessary, Area Health Services may develop local policies so that senior nursing staff administering a transfusion can provide the necessary information to patients, obtain a valid consent and complete the consent form.

In developing such policies, Area Health Services should have regard to the following:
1. A local policy may only be developed to be used in circumstances where there is no resident medical officer on duty.
2. The decision to recommend a blood transfusion or administer blood products to a patient must be made on a case by case basis. To ensure that the clinical need for such treatment is established, appropriate arrangements should be put in place so that such decisions are made by a medical officer who is fully informed of the clinical circumstances of the patient.
3. Area health services should provide, where necessary, additional training to senior nursing staff so that they can provide clinically relevant, and accurate information. The need for additional training as circumstances change should be considered.

Consideration should be given to developing patient information sheets in English and other languages to assist with the consent process. These should be reviewed on a regular basis.

30. Obstetric procedures

Written consent is not required for a normal delivery. Should an operation such as a Caesarean section or a blood transfusion be required, the consent process as detailed should be completed, insofar as it is practicable to do so in the circumstances.

If implied or oral consent is given to a particular procedure, (such as the use of forceps) this should be noted in the patient’s medical record. Discussions about alternatives and material risks should be documented in the record. It may be appropriate for practitioners to discuss these additional procedures during the term of the pregnancy.
31. **Anaesthetics**

Patients must be informed about the material risks associated with anaesthesia for their planned procedure. If alternative types of anaesthetic, eg regional or general, are commonly used for the procedure, these must also be discussed. Where alternatives exist, options should be outlined, together with their advantages and disadvantages. This information can be provided by an anaesthetist if a separate consultation occurs, or by the attending medical officer.

Section 17.1(iv) states that the attending medical officer should consider whether a separate consultation with an anaesthetist is required, and if so, arrange for that separate consultation to take place.

Where an attending medical officer refers a patient for a separate anaesthetic consultation, the anaesthetist should have the patient sign a separate consent form in relation to the anaesthetic. The attending medical officer should make a note that the patient has been referred for a separate anaesthetic consultation.

This provision is not intended to infer that a separate anaesthetic consultation is generally required, however, where anaesthesia involves particularly high risks, an anaesthetist should explain these. Whether a consultation with an anaesthetist is appropriate is a decision for the attending medical officer exercising his or her professional judgment, in the circumstances of the particular case.

32. **Autopsy and tissue donation**


33. **Use of tissue removed for the purposes of medical, surgical or dental treatment**

The *Human Tissue Act 1983* requires the written consent of a person if tissue removed from their body during medical, surgical or dental treatment is to be used for any medical, therapeutic or scientific purposes, other than the ongoing treatment of the patient. Tissue includes any organ, or part of a human body, and any substance, including blood, extracted from a part of the human body. If, for example, tissue is removed during medical treatment for diagnostic purposes, a separate consent for a pathological examination is not required. However, if a tumour removed from a person’s body is to be retained, and used in the future for the education of students and other medical professionals, or for research or for quality assurance purposes, then the consent of the person from whom the tumour was removed is required before the tumour can be used for these other purposes.

If the person is a person who is a patient to whom the *Guardianship Act* applies (ie the patient is 16 years of age or over and incapable of giving consent) their “person responsible” who is consenting to the medical, surgical or dental treatment may also consent to other uses of the tissue.

If the person is a child, the senior available next of kin may consent to the use of the child’s tissue. The senior available next of kin are the child’s parents, or if there are no parents available, the child’s guardian. However, tissue removed from children who are in the care of the State may not be used for any other medical, therapeutic or scientific purposes.

Tissue removed during a medical, dental or surgical procedure may be retained for a period not exceeding 72 hours, if the tissue was removed from the person during a procedure performed as a matter of urgency in order to save the life of the person, or prevent serious damage to the health of the
9. HEALTH RECORDS AND INFORMATION

person (if the person was an emergency patient). This means that if the person is unable to consent to the procedure and the use of any tissue removed before the procedure takes place, they may consent to the use of the tissue removed within the 72 hours following the surgery. If the person is a child, or dies during the course of their treatment, a senior available next of kin may consent to the use of the deceased person’s tissue. A separate form is available for this. (See PD2005_341 & PD2012_014.)

However, if possible, it is best to obtain the consent of the person themselves, or their person responsible (as the case may be) prior to treatment taking place. Accordingly, the consent form allows a person to consent to the use of any tissue removed during their treatment, for medical, therapeutic or scientific purposes.

It is noted that this applies only to tissue which must necessarily be removed as part of the procedure. It does not authorise the removal of any additional tissue from the person’s body. For this to occur lawfully, the person must specifically consent to the removal of that tissue under different provisions of the Human Tissue Act 1983.

The patient should be given a brief description of the sort of uses to which their tissue may be put (scientific and medical research, teaching, study etc). The patient must also be informed that their consent to the use of tissue is separate from their consent to treatment, and their treatment is in no way affected by a decision not to consent to use of tissue. The optional use of removed tissue section of the consent form should be completed by the patient after discussion with the AMO or a delegate of the AMO.

If the patient does not consent to their tissue being used for other medical, therapeutic or scientific purposes, it should be disposed of in accordance with usual waste management procedures, or in accordance with the patient’s wishes if possible.

34. Consent for procedures that a medical practitioner does not “recommend”

The consent forms attached to this Circular require the medical practitioner to sign a section which states s/he has informed the patient about the nature, results and risks of the “recommended procedure”. The patient also signs an acknowledgement which states that the medical practitioner has recommended the treatment.

NSW Health’s policy is that public health organisations use these consent forms.

However, it is recognised that some procedures, such as terminations of pregnancy and elective circumcisions, are performed which may not be “recommended” by a medical practitioner, or which a medical practitioner may feel uncomfortable about recommending.

PHOs may adopt the following alternative wording on consent forms used for these types of procedures (changes in bold type):
9. **HEALTH RECORDS AND INFORMATION**

**PROVISION OF INFORMATION TO PATIENT**

To be completed by Medical Practitioner

I, Dr ………………………insert name of medical practitioner ………………………have **discussed** the following:

………………………………………………………………………………………………………………………………………………………………………………………….

………………………………………………………………………………………………………………………………………………………………………………………….

………………………………………………………………………………………………………………………………………………………………………………………….

I have informed this **patient** of the matters as detailed below including the nature, likely results, and material risks of the **above** procedure or treatment.

<table>
<thead>
<tr>
<th>Signature of Medical Practitioner</th>
<th>Date</th>
<th>Time</th>
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Interpreter present *

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**PATIENT CONSENT**

To be completed by Patient

Dr ……………………………………..and I have discussed my present condition and the

各种 ways in which it might be treated. **I have requested** the above procedure or treatment:

35. **Research or experimentation?**

The approval of the hospital institutional ethics committee must be sought for specific consent protocols for all operations, procedures and treatments involving experimentation. **Patient consent should also be obtained in writing.**

Special arrangements apply where a person is sixteen years of age or above and is unable to consent. (See Attachment A).

36. **Procedures that may affect persons other than the patient**

Some procedures, such as HIV testing and genetic testing, may have implications for persons other than the patient undergoing the test or procedure.

In these situations, it is advisable to discuss the possible test results with the patient, and ascertain whether the patient intends to inform identifiable potentially affected third parties of the results. It may even be possible to obtain the patient’s written consent to disclose results to an identifiable third party at this stage.
GUARDIANSHIP ACT 1987 - SUBSTITUTE CONSENT

This attachment sets out the circumstances in which substitute consent can be obtained, from whom and the legal requirements for ensuring that substitute consent is valid.

1. **What is the purpose of the Guardianship Act 1987?**

The Guardianship Act 1987 establishes who can give valid substitute consent in circumstances where a person is unable to consent to medical or dental treatment. The object of the Act is to ensure that:

- people are not deprived of necessary treatment merely because they lack the capacity to consent to the carrying out of such treatment; and
- any treatment that is carried out for such people is carried out to promote their health and well being.

The Act therefore identifies a substitute decision maker for patients unable to consent which is consistent with the level of treatment proposed. In some cases (outlined below) treatment may proceed without consent.

2. **When do the provisions of the Guardianship Act apply?**

The Act applies to a patient who is of or above the age of sixteen years and who is incapable of giving consent to the carrying out of medical or dental treatment. Section 33(2) of the Guardianship Act provides that a person is incapable of giving consent if the person is incapable of understanding the general nature and effect of the proposed treatment, or is incapable of indicating whether or not he or she consents or does not consent to the treatment.

3. **What if the treatment is required in an emergency?**

The Guardianship Act provides that treatment may be provided to a person who is unable to consent where the medical practitioner or dentist carrying out or supervising the treatment considers treatment is necessary as a matter of urgency to save life, to prevent serious damage to patient’s health, or (except in the case of special medical treatment), to alleviate significant pain or distress. A substitute consent is not required in these circumstances.

4. **Is medical or dental treatment defined in the Guardianship Act?**

Medical or dental treatment is defined to mean:

- medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care) normally carried out by or under the supervision of a medical practitioner; or
- dental treatment (including any dental procedure operation or examination) normally carried out by or under the supervision of a dentist.

In the case of a clinical trial, medical treatment is taken to include the giving of placebos to some participants in the trial.

However, the Act specifies that this does not include:

(i) any non intrusive examination made for diagnostic purposes (including a visual examination of the mouth, throat, nasal cavity, eyes or ears);
(ii) first aid medical or dental treatment; or
(iii) the administration of a pharmaceutical drug for the purpose, and in accordance with the dosage level, recommended in the manufacturer’s instructions for which a prescription is not normally required and which is normally self administered.

These minor procedures may proceed without consent.
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5. **What must a medical practitioner do before they carry out treatment when a person is unable to consent?**

Practitioners should be aware, it is an offence under section 35 of the Act to provide medical or dental treatment to a person who is 16 years or older who is incapable of giving consent unless:

- a substitute consent for the treatment has been obtained in accordance with the *Guardianship Act 1987 NSW*; or
- the carrying out of the treatment is authorised by the *Guardianship Act* and no consent is required.

Therefore practitioners need to determine whether treatment can proceed without consent or whether a substitute consent is required, and from whom.

The Act makes different arrangements for obtaining consent depending on the level of intervention proposed. Distinctions are drawn between **minor treatment**, **major treatment** and **special medical treatment**.

It is the legal responsibility of the medical practitioner carrying out the treatment to ensure that consent has been obtained.

6. **What is special medical treatment?**

Special medical treatment is defined as:

(a) any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out;

(b) any new treatment that has not yet gained the support of a substantial number of medical practitioners or dentists specialising in the area of practice concerned; or

(c) any treatment declared by the regulations to be special treatment for the purposes of the *Guardianship Act*.

The following treatments have been declared by the Regulations to be special treatment:

(a) any treatment that involves the administration of a drug of addiction (other than in association with the treatment of cancer or palliative care of a terminally ill patient) over a period or periods totalling more than 10 days in any 30 days;

(b) any treatment that is carried out for the purpose of terminating pregnancy;

(c) any treatment in the nature of a vasectomy or tubal occlusion;

(d) any treatment that involves the use of an aversive stimulus, whether mechanical, chemical physical or otherwise.

Special medical treatment does not include treatment administered in the course of a clinical trial. Special arrangements apply to such treatment - see paragraph 11.

7. **Who provides substitute consent to special medical treatment?**

Consent to the initial administration of special medical treatment may only be granted by the Guardianship Tribunal. The process for making an application to the Tribunal is detailed later in the document.

Once the initial consent of the Guardianship Tribunal has been obtained, the guardian of a person may consent to the carrying out of continuing or further special treatment if the Tribunal has authorised the guardian to give consent to the continuation of treatment or to further treatment of a similar nature.
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Practitioners should note that the Guardianship Regulations identify two specific types of special medical treatment for which different criteria apply for obtaining consent from the Tribunal. These include: (i) any special treatment that involves the administration to a patient of one or more restricted substances for the purpose of affecting the central nervous system of the patient, but only of the dosage levels, combination of the numbers of restricted substances used or the duration of the treatment are outside the accepted mode of treatment; and (ii) any special treatment that involves the use of androgen reducing medication for the purpose of behavioral control. If these treatments are to be administered, the matters should be discussed with the Tribunal.

8. What is major medical treatment?

The definition of major medical treatment is broad. It includes:
(i) any treatment that involves the administration of a long acting injectable hormonal substance for the purpose of contraception or menstrual regulation;
(ii) any treatment that involves administration of a drug of addiction (except where classified as special medical treatment as outlined above);
(iii) Any treatment that involves the administration of a general anesthetic or other sedation, but not involving treatment involving:
(a) sedation used to facilitate the management of fractured or dislocated limbs; or
(b) sedation used to facilitate the insertion of an endoscope into a patient’s body for diagnostic purposes unless the endoscope is inserted through a breach or incision in the skin or a mucous membrane.
(iv) Any treatment used for the purpose of eliminating menstruation;
(v) Any treatment that involves the administration of a restricted substance for the purpose of affecting the central nervous system, but not a treatment;
(a) substance that is intended to be used for analgesic, antipyretic, anti-Parkinsonian, anti-convulsant, antiemetic, anti-nauseant or antihistaminic purposes; or
(b) that is to be given only once; or
(c) that is a PRN treatment (that is, given when required, according to the patients needs that may be given not more than 3 times a month); or
(d) given for sedation in minor medical procedures.
(vi) Any treatment that involves a substantial risk to the patient (that is risk that amounts to more than a mere possibility) of: (a) death; or (b) brain damage; or (c) paralysis; or (d) permanent loss of function of any organ or limb; or (e) permanent and disfiguring scarring; or (f) exacerbation of the conditions being treated; or (g) an unusually prolonged period of recovery; or (h) a detrimental change of personality; or (i) a high level of pain and stress.
(vii) Any treatment involving testing for the HIV virus.

Major dental treatment is defined to include treatments involving the administration of a general anesthetic or simple sedation, a procedure intended or likely to result in removal of all teeth, a treatment likely to result in the patient’s ability to chew food being significantly impaired for an indefinite or prolonged period.

Major treatment does not include treatment administered in the course of a clinical trial.

9. What is minor treatment?

Minor treatment is any medical or dental treatment which does not fall within the meaning of special medical treatment or major treatment. As noted at point 4, this does not include a number of specific minor procedures for which no consent is required.

Minor treatment does not include treatment administered in the course of a clinical trial.
10. How is consent obtained for major and minor medical treatment?

Consent to carry out major and minor medical treatment can be obtained from the person responsible for the patient within the meaning of the Act. A consent given by a person responsible has effect as if the treatment had been consented to by the patient. However, the consent of a person responsible is not valid if the practitioner carrying out or supervising the treatment is aware or ought to be aware the patient objects to the procedure or treatment or if the proposed treatment is to be carried out for any purpose other than that of promoting or maintaining the health and well-being of the patient.

An objection by the patient may be disregarded if
(a) the patient has minimal or no understanding of what the treatment entails, and
(b) the treatment will cause the patient no distress or, if it will cause the patient some distress, the distress is likely to be reasonably tolerable and only transitory.

If the patient objects to the treatment and the objection cannot be disregarded, the request for consent must be referred to the Tribunal except where a legal guardian of the patient has been specifically authorised by the Tribunal to override the patient’s objection. This applies whether the proposed treatment is major or minor.

In the case of major medical treatment the Guardianship Tribunal may also consent to treatment. However, in all instances, practitioners should first ascertain if there is a person responsible for a patient unable to consent before seeking the consent of the Guardianship Tribunal.

Whilst the Guardianship Tribunal can also provide consent to minor treatment, such treatment may be carried out on a patient without consent if there is no person responsible for the patient or the person responsible is unavailable or unwilling to make a decision concerning the patient. In such cases, the practitioner carrying out the minor treatment is required to certify in writing in the patient’s clinical record that the treatment is necessary and is the form of treatment that will most successfully promote the patients health and well being; and the patient does not object to the carrying out of the treatment.

If consent is refused by a person responsible and the practitioner remains of the view that the treatment is in the best interests of the patient, the matter should be referred to the Guardianship Tribunal.

11. Treatment administered in the course of a clinical trial

A clinical trial is defined as a trial of drugs or techniques that necessarily involves the carrying out of medical or dental treatment on the participants in a trial. This includes the administration of placebos to patients.

A person unable to consent may not participate in a clinical trial unless the trial has been approved by the Guardianship Tribunal under the Act. In approving such a trial, the Guardianship Tribunal will decide whether consent can be granted by person responsible or should be granted by the Tribunal.

12. Who is the person responsible for a patient?

The Act establishes a hierarchy for determining who is the person responsible for a person unable to consent to treatment.
• If the person is under guardianship, the guardian is the person responsible.
• If there is no guardian, an enduring guardian appointed by the patient with authority to make decisions regarding medical care (see section 13 of this Attachment)
• If there is no enduring guardian, a spouse (including a de facto spouse) with whom the person has a close continuing relationship is the person responsible.
9. **HEALTH RECORDS AND INFORMATION**

- If there is no guardian or spouse, a person who has the care of the patient unable to consent is the person responsible. Such a person is regarded to have the care of the patient if they have provided, or have arranged to be provided, domestic services and support otherwise than for remuneration. Where the patient has been cared for by a person in a nursing home, hostel, boarding house or other group accommodation, that person does not have care of the person. In such cases the patient remains in the care of the person he or she was immediately with before residing in the institution.

- If there is no guardian, spouse, or carer, a close relative or friend may act as the person responsible provided they are not receiving remuneration for any services provided.

If the person is in the care of the Director-General under s 13 of the *Guardianship Act*, the Director-General of the Department of Community Services is the person responsible.

13. **Who is an enduring guardian?**

Until 1997, guardians were appointed by either the Tribunal or the Supreme Court. However, amendments to the Act provided that an individual may appoint an enduring guardian to carry out certain roles and functions where the individual lacks sufficient capacity to make appropriate decisions.

A person 18 years of age or above may appoint an enduring guardian. Such an appointment must be made on the prescribed form, copies of which are available from the Guardianship Tribunal, and be witnessed by a legal practitioner or a clerk of the local court.

An appointment only has effect during a period in which the person is in need of a guardian. Further, the decisions which an enduring guardian may make on behalf of the person in need of a guardian are determined by the prescribed form appointing the person. As the person appointing the enduring guardian may limit the decisions which may be made by the appointee, practitioners should ask to review the appointment form to ensure that the enduring guardian has power to make decisions in relation to medical or dental treatment.

14. **Guardians appointed under interstate or NZ legislation**

A person who has been appointed as a guardian of another person and is able to consent to medical treatment on behalf of that person pursuant to the guardianship legislation of another State or Territory or the *Protection of Personal and Property Rights Act 1988* of New Zealand, may apply to the NSW Guardianship Tribunal for recognition of their status as such in NSW. If the NSW Guardianship Tribunal recognises the interstate or NZ guardian as such, that person is to be taken as having been appointed as a guardian under the NSW *Guardianship Act*.

15. **What is required to obtain consent from a person responsible?**

A request to a person responsible for consent may be made by any person. Such a request shall specify the following information:

(a) the grounds on which it is alleged that the patient is a patient to whom this part applies;
(b) the particular condition of the patient that requires treatment;
(c) the alternative courses of treatment that are available in relation to that condition;
(d) the general nature and effect of each of the courses of treatment;
(e) the nature and degree of the significant risks (if any) associated with each of these courses of treatment; and
(f) the reasons for which it is proposed that any particular course of treatment should be carried out.
A request to a person responsible is to be made in writing. However:

(i) if the request is for major medical treatment, it may be made orally if it is not practicable to make the request in writing because of the need to provide the treatment quickly.

(ii) if the request is for minor medical or dental treatment, the request may be made orally, if it is not practicable to make the consent in writing or the person whose consent is sought does not require the consent to be made in writing.

Written confirmation of an oral request for consent must be provided for major treatment or for minor treatment where the person whose consent was sought requires confirmation.

16. What must the person responsible do to grant a valid consent?

In all cases, the person responsible must consider the views (if any) of the patient, the information provided by the person requesting consent and the objectives of the Act. Consent to the carrying out of major medical treatment is to be given in writing, however, the consent may be given orally if it is not practicable to do so in writing because of the need to provide treatment quickly. Written confirmation of the consent must be provided where oral consent is provided.

Consent to the carrying out of minor medical treatment is also to be given in writing, although it may be given orally if: (i) it is not practical to give written consent; and (ii) the person by whom the treatment is to be carried out does not require it to be given in writing. However, written confirmation of the consent may be requested.

17. Do records need to be kept?

A person who carries out treatment pursuant to a substitute consent is to keep a written record of the name of the person by whom consent was given, the date, conditions on the consent and the treatment. If written consent was obtained, the form should be kept. Such records must be retained for seven years.

18. The Public Guardian

Guardianship Tribunal may appoint the Public Guardian as a person’s guardian with the functions of providing consent to medical or dental treatment. If the patient’s guardian is the Public Guardian, you should contact the Office of the Public Guardian to seek consent for the proposed treatment from the officer responsible for the patient’s guardianship decisions. The Office of the Public Guardian has an application form for this purpose. It is entitled “Application to carry out medical or dental treatment for a person under the guardianship of the Public Guardian.

19. What if an application needs to be made to the Guardianship Tribunal?

Requests to the Guardianship Tribunal for consent generally require the same information that needs to be provided to a person responsible. A standard request form is available from the Guardianship Tribunal. Further information, including brochures can be found on the Tribunal’s website, http://www.gt.nsw.gov.au.
9.  HEALTH RECORDS AND INFORMATION

ATTACHMENT B

USEFUL CONTACTS

Department of Community Services
Street address: 4-6 Cavill Avenue, Ashfield NSW 2131
Postal Address: Locked Bag 28, Ashfield NSW 1800
Phone: DoCS Helpline 13 3627 (or 13 DoCS) to make a report.
(24hours)
(02) 9716 2222 (Head Office)
Fax: (02)9716 2999 (Head Office)
Website: http://www.community.nsw.gov.au

Guardianship Tribunal
Street address: Level 3, 2a Rowntree Street, Balmain NSW 2041
Postal Address: Locked Bag 9, Balmain NSW 2041
Phone: (02) 9555-8500 or
1800 463 928
Fax: (02) 9555-9049
Website: http://www.gt.nsw.gov.au
Email: gt@gt.nsw.gov.au

Mental Health Review Tribunal
Street address: Building 40 Digby Road, Gladesville Hospital
Gladesville NSW 2111
Postal Address: PO Box 2019, Boronia Park NSW 2111
Phone: (02) 9816 5955
1800 815 511
Fax: (02) 9817 4543
Website: http://www.mhrt.nsw.gov.au
Email: mhrt@mhrt.nsw.gov.au

NSW Health Legal Branch
Street address: 73 Miller Street, North Sydney NSW 2060
Postal Address: Locked Mail Bag 961, North Sydney NSW 2059
Phone: (02) 9391 9606
Fax: (02) 9391 9604
To access copies of NSW Health Circulars: http://internal.health.nsw.gov.au/policies/ (intranet)
Email: legal@doh.health.nsw.gov.au

The Public Guardian
Street address: Level 15, Piccadilly Tower, 133 Castlereagh St
SYDNEY NSW 2000
Postal Address: PO Box A231, SYDNEY SOUTH NSW 1235
Phone: (02) 9265 3184
1800 451 510
Fax: 02 9283 2645

If you need to contact the Public Guardian for an urgent decision outside of office hours, call 02 9265 3184 and you will hear a recorded message which will give you the number for a pager service. Give the pager service your name and number and a staff member from the Office of the Public Guardian will return your call. Do not give any information regarding the client to the paging service.
ADULT-TO-ADULT LIVING DONOR LIVER TRANSPLANTATION GUIDELINES
(GL2008_019)

The purpose of the guideline is to provide guidance to health professionals and additional protection for prospective adult Living Donor Liver Transplantation (LDLT) donors. This guideline is aimed primarily at the jurisdictions that will endorse LDLT, the institutions that will provide LDLT, and the health professionals directly involved in this practice. To the extent that it is adopted by all jurisdictions in line with the particular requirements of their human tissue legislation, and applied in participating liver transplant units, it will promote ethical, lawful and consistent application of quality processes in provision of this complex procedure to donors, recipients and their families.

It should be read in conjunction with PD2005_406.


CONSENT FORMS (IB2005_054)

Please note that there have been minor format amendments made to the consent forms which were attached to PD2005_406. Copies of the new forms are attached and can be used as pro-formas. However the forms are printed in purple to comply with medical records colour coding.

These forms can be obtained from Salmat - telephone number 9612-8000, facsimile 9612-8070. The following numbers MUST be quoted when ordering:

| Request/Consent Form (over 14 years) | MR3A | Item No. 606006 |
| Request/Consent Form (Guardianship)  | MR3B | Item No. 606007 |
| Request/Consent Form (Children)     | MR3C | Item No. 606008 |

Please note that form MR3B - 606007 is a double-sided form.
(NAME OF HOSPITAL)

REQUEST/CONSENT FOR
MEDICAL PROCEDURE
TREATMENT

(For patients 14 years and above - not for Guardianship Act purposes)

PROVISION OF INFORMATION TO PATIENT

I, Dr ________________________________, have discussed with this patient the various ways of treating the patient's present condition including the following proposed procedure/treatment: ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

I have informed this patient of the matters as detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

________________________________________________________________________

________________________________________________________________________

Interpreter present: ____________________________ Date: ____________________________

PATIENT CONSENT

Dr ________________________________, and I have discussed my present condition and the various ways in which it might be treated, including the above procedure or treatment:

The doctor has told me that:

- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

*"I have been told that another doctor may perform the procedure/treatment."

I request and consent to the procedure/treatment described above for me.
9. HEALTH RECORDS AND INFORMATION

DELETE IF NOT REQUIRED

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent to the following aspects of the recommended procedure or treatment.

Insert Objection

Practitioner's Acknowledgement

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

I consent/do not consent* to a blood transfusion if needed.

................................. ........................................
Signature of Patient            .../....../20...

.................................
Print name of patient

.................................
ADDRESS

USE OF REMOVED TISSUE (SEE SECTION 23 OF CIRCULAR)

I understand that the above procedure may involve the removal of some bodily tissue which may be required for the diagnosis or management of my condition.

I consent/do not consent* to such tissue being used for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of my condition.

My consent is conditional on the following terms:

.................................
(insert terms, if any)

This consent extends only to tissue, which is removed for the purposes of the above procedure.

.................................
Signature of Patient            .../....../20...

* Delete where not applicable
9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>TITLE</th>
<th>FAMILY NAME</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIVEN NAMES</td>
<td>MO</td>
<td></td>
</tr>
<tr>
<td>ADDRESS</td>
<td>STREET</td>
<td>DOB</td>
</tr>
<tr>
<td>SUBURB</td>
<td>POSTCODE</td>
<td>ADMISSION DATE</td>
</tr>
</tbody>
</table>

PROVIDE INFORMATION TO PATIENT

I, Dr. [insert name of medical practitioner], have discussed with this patient's parent/guardian the various ways of treating the patient's present condition including the following proposed procedure/treatment:

[Insert details here]

I have informed this parent/guardian* of the matters detailed below including the nature, likely results, and material risks of the proposed procedure or treatment.

[Signature of Medical Practitioner]

DATE: [./.20_]

Interpreter present*

[Signature of Interpreter]

DATE: [./.20_]

PATIENT CONSENT

Dr. [insert name of medical practitioner] and I have discussed the present condition of [insert name of minor] and the various ways in which it might be treated, including the above procedure or treatment:

The doctor has told me that:
- the procedure/treatment carries some risks and that complications may occur;
- an anaesthetic, medicines, or blood transfusion may be needed, and these may have some risks;
- additional procedures or treatments may be needed if the doctor finds something unexpected;
- the procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and that undergoing the procedure/treatment carries risks.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I may withdraw my consent.

*I have been told that another doctor may perform the procedure/treatment.

I request and consent to the procedure/treatment described above for [insert name of minor].

[Signature of Parent/Guardian]
9. HEALTH RECORDS AND INFORMATION

---

**DELETE IF NOT REQUIRED**

This part must be countersigned by your doctor.

While I consent to the above procedure/treatment, after discussing this matter with the doctor, I refuse consent for my child to have the following aspects of the recommended procedure or treatment: ........................................

..............................................................

Insert Objection .............................................................. Practitioner's Acknowledgement ..............................................................

I note that the Children and Young Persons (Care and Protection) Act 1998 provides that such treatment may be provided notwithstanding my objection if it is necessary to prevent death or serious injury to my child.

I also consent to anaesthetics, medicines or other treatments, which could be related to this procedure/treatment.

**I consent/do not consent** to a blood transfusion if needed.

................................ Signature of Parent/Guardian ........................................... / ..............................................................

................................ ADDRESS ..............................................................

..............................................................

**USE OF REMOVED TISSUE – (SEE SECTION 33 OF CIRCULAR)**

I understand that the above procedure may involve the removal of some bodily tissue, which may be required for the diagnosis, or management of .........................’s condition.

**I consent/do not consent** to the use of such tissue for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of .........................’s condition.

My consent is conditional on the following terms:

.............................................................. (insert terms, if any) ..............................................................

This consent extends only to tissue, which is removed for the purposes of the above procedure.

.............................................................. Signature of Parent/Guardian ........................................... / ..............................................................

*Delete where not applicable*
SUBSTITUTE CONSENT FOR MEDICAL TREATMENT

GUARDIANSHIP ACT 1987
(For patients 16 years and above where consent is provided by a person responsible)

Medical Advice

To be completed by Medical Practitioner

I, Dr. [INSERT NAME OF MEDICAL PRACTITIONER] hereby confirm that [INSERT NAME OF PATIENT] is incapable of consenting to medical treatment because:

☐ he/she cannot understand the nature and effect of the treatment
☐ he/she cannot indicate whether or not he/she consents

(Tick one) or

☐ other

The patient's condition that requires treatment is

[WRITE SIGNIFICANT RISKS IN NOT TREATING]

The site of the proposed procedure or treatment and its general nature and effect are

[WRITE SIGNIFICANT RISKS AND SIDE EFFECTS ASSOCIATED]

The proposed procedure/treatment has the following significant risks and/or side effects

[WRITE REASONABLE ALTERNATIVES]

The proposed treatment is the most appropriate form of treatment to promote the patient's health and well-being.

[FINAL SIGNATURES AND DATES]

I have also explained:

• that other forms of treatment, such as anaesthetics, medicines, or blood transfusions, may be associated with the procedure/treatment and that these may carry some risks;
• that other unexpected procedures or treatments are sometimes necessary;
• that complications may occur or the expected result may not be achieved even though the procedure/treatment is carried out with due professional care.

Interpreter present

[FINAL SIGNATURES AND DATES]
Acknowledgement of advice

Dr. [INSERT NAME OF MEDICAL PRACTITIONER] and I have discussed [INSERT NAME OF PATIENT]'s present condition and the various ways in which it might be treated as above. The doctor has told me that:

- The procedure/treatment carries some risks and that complications may occur;
- The patient may need an anaesthetic, medicines or blood transfusion, and these may have some risks;
- Additional procedures or treatments may be needed if the doctor finds something unexpected;
- The procedure/treatment may not give the expected result even though the procedure/treatment is carried out with due professional care.

I understand the nature of the procedure and the underlying procedure/treatment carries risk. I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

[SIGNATURE OF PERSON RESPONSIBLE OR GUARDIAN] [DATE] [PRINT NAME OF PERSON RESPONSIBLE OR GUARDIAN]

Substitute consent

I consent to the procedure/treatment described above for [INSERT NAME OF PATIENT].

DELETE IF NOT REQUIRED This part must be countersigned by the doctor if retained

Except that after discussing this matter with the doctor, I do not agree to the patient having the following aspects of the recommended procedure or treatment. [INSERT DETAIL].

[SIGNATURE OF PRACTITIONER] [PRACTITIONER'S ACKNOWLEDGEMENT]

I have considered the views of [INSERT NAME OF PATIENT] and consider the treatment should be provided to the patient. I am satisfied the treatment will promote the health and wellbeing of the patient.

I accept the risks involved in the procedure/treatment. I also consent to anaesthetics, medicines or other treatments which could be related to this procedure/treatment.

I consent/do not consent* to a blood transfusion if needed.

[SIGNATURE OF PERSON RESPONSIBLE OR GUARDIAN] [DATE] [PRINT NAME OF PERSON RESPONSIBLE OR GUARDIAN] [RELATIONSHIP TO PATIENT IN TERMS OF THE ACT]

Use of removed tissue – (See Section 33 of Circular)

I understand that the above procedure may involve the removal of some bodily tissue, which may be required for the diagnosis, or management of [INSERT NAME OF PATIENT]'s condition.

I consent/do not consent* to the use of such tissue for any medical, therapeutic or scientific purpose, in addition to purposes related to the diagnosis or management of [INSERT NAME OF PATIENT]'s condition.

My consent is conditional on the following terms:

[INSERT TERMS]

This consent extends only to tissue, which is removed for the purposes of the above procedure.

[SIGNATURE OF PERSON RESPONSIBLE OR GUARDIAN] [DATE]

*Delete where not applicable

10/9

50007 MIT08

54(3/06)
NOTIFICATION OF INFECTIOUS DISEASES UNDER THE *PUBLIC HEALTH ACT 2010*  
(IB2013_010)

IB2013_010 rescinds IB2012_011.

**PURPOSE**

Under the provisions of the *Public Health Act 2010* and the *Public Health Regulation 2012*, doctors, hospital chief executive officers (or general managers), pathology laboratories, directors of child care centres and school principals are required to notify certain medical conditions listed on the Ministry of Health website.

**NOTIFICATION MECHANISMS**

- Infectious disease notifications should be directed to the local Public Health Unit, and should be initiated as soon as possible within 24 hours of diagnosis.
- In order to protect patient confidentiality, notifications must not be made by facsimile machine except in exceptional circumstances and when confidentiality is ensured.
- Disease notification guidelines for notifiers are available at:  

**NOTIFICATION FORMS**

**Doctors and Hospitals**

- Doctors and hospital chief executive officers (or general managers) must notify scheduled medical conditions and provide information specified in the *Doctor/Hospital Notification Form*, either by telephone or in writing. The notification can be found at:  
- Notifications for AIDS must only include the first 2 letters of the patient’s first and last names, and date of birth. Full name and addresses are not to be included.
- The *AIDS Notification Form* can be found at:  

**Laboratories**

- Laboratories must notify scheduled medical conditions and provide information specified in the *Laboratory Notification Form*, either by telephone or in writing.
- The laboratory notification form can be found at:  
- Notifications for HIV infection should only include the first 2 letters of the patient’s first and last names, and date of birth. Full name and addresses are not to be included.
- Laboratories carrying out confirmatory testing for HIV must notify infections directly to Communicable Diseases Branch. The *HIV notification form* can be found at:  
NSW PERINATAL DATA COLLECTION (PDC) - REPORTING AND SUBMISSION REQUIREMENTS FROM 1 JANUARY 2016 (PD2015_025)

PD2015_025 rescinds PD2010_072.

PURPOSE

This Policy Directive is effective from 1 January 2016. It covers reporting and submission requirements for the Perinatal Data Collection (PDC), which is used for statewide surveillance to monitor patterns of pregnancy care, and maternal and newborn outcomes and to support national and state reporting obligations.

MANDATORY REQUIREMENTS

This policy applies to all midwives and doctors working in public and/or private facilities where a birth occurs. Reporting of all births in NSW to the PDC is a statutory requirement under the NSW Public Health Act 2010.

A PDC record must be completed for all births in NSW, including live born babies regardless of gestational age or birth weight, and stillborn babies of at least twenty (20) weeks gestation OR four hundred (400) grams birth weight. In the case of multiple births, a separate record must be completed in full for each baby.

From 1 January 2016 all records must be submitted in accordance with the timeframes described in section 1.3 of the following Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures.

Section 3 of the following Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures details the data items to be reported. Section 5 details the mandatory security requirements for data management.

IMPLEMENTATION

Chief Executives of LHDs and General Managers of Private Hospitals are to ensure:

• This policy directive is distributed to all staff involved in collecting and supplying data for the PDC. This includes staff of obstetric and neonatal units, medical record and information services staff.
• Staff have access to electronic systems able to collect the data items in accordance with Section 3 of the following Perinatal Data Collection (PDC) Reporting and Submission Requirements: Procedures by 1 January 2016.
• Data collected in accordance with the statutory requirement and this policy directive is submitted in compliance to the schedule provided in the form required for submission.

1. BACKGROUND

1.1 About this document

From 1 January 2016, this Policy Directive rescinds and replaces Policy Directive PD2010_072 concerning the NSW Perinatal Data Collection. This Policy Directive applies to reporting of births to the NSW Perinatal Data Collection (PDC) from 1 January 2016.
The Perinatal Data Collection (PDC) is used for statewide surveillance, monitoring patterns of pregnancy care, and maternal and newborn outcomes and to support national and state reporting obligations.

1.2 Key definitions

PDC records must be completed for all births in NSW, including live born babies regardless of gestational age or birth weight and stillborn babies of at least twenty (20) weeks gestation OR four hundred (400) grams birth weight. In the case of multiple births, a separate record must be completed in full for each baby.

1.3 Legal and legislative framework

Reporting of all births in NSW is a requirement of the NSW Public Health Act 2010. A record for each birth occurring within a Collection Period Quarter must be reported no later than three months after the close of the quarter, based on the date of birth of the baby. The following table lists the due dates for submission of PDC data:

<table>
<thead>
<tr>
<th>Collection Period</th>
<th>Last Date for Data Submission in Collection Period</th>
<th>Deadline for Correction and Resubmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 (1 Jan - 31 Mar)</td>
<td>30 June</td>
<td>11 August</td>
</tr>
<tr>
<td>Quarter 2 (1 Apr - 30 Jun)</td>
<td>30 September</td>
<td>11 November</td>
</tr>
<tr>
<td>Quarter 3 (1 Jul - 30 Sep)</td>
<td>31 December</td>
<td>11 February (following year)</td>
</tr>
<tr>
<td>Quarter 4 (1 Oct - 31 Dec)</td>
<td>31 March (the following year)</td>
<td>12 May</td>
</tr>
</tbody>
</table>

Any errors detected in submitted data are to be corrected and resubmitted within 6 weeks of the date of final data submission.

It should be noted that the table above shows the last acceptable date for initial data submission. Data may be supplied and accepted on a more frequent basis (eg weekly or monthly) to allow suppliers to obtain more timely feedback on the quality of births data that may better suit the operational processes of the supplier.

It is intended that the Collection Period and final date will be reduced in subsequent collection years and appropriate advice on the applicable Collection Periods will be published.

2. METHOD OF REPORTING

For births on or after 1 January 2016 PDC records must be submitted electronically in the form specified. The method of submission of PDC records is dependent on the type of collection/submission entity as follows:

- Public Hospitals with maternity units are to submit records directly to EDWARD using a data extract from their maternity information system.
- Private Hospitals are to submit data to PeriPH. PeriPH will apply further processing prior to sending PDC records to EDWARD.
- Independent Midwives will submit data by direct data entry via a secure web-based form (PeriForm). This data, after processing, will be sent to EDWARD. Hospitals without maternity units will be able to utilise PeriForm to submit records for the individual births they manage.

EDWARD will hold the consolidated PDC data for births occurring on or after 1 January 2016.
While the required PDC data is constant, the receipt and processing platform will determine some differences in the extract format.

Paper forms will not be accepted or processed by the Ministry for any births on or after 1 January 2016.

3. DATA ITEMS TO BE REPORTED

3.1 Overview

This section lists the data that must be reported. Details of each of the items, including definitions, reportable values and guide for collection and use are provided in the PDC 2016 Data Dictionary.

As the data are submitted through different mechanisms and from different sources the requirements differ. The tables below specify the data to be reported by collection entity.

<table>
<thead>
<tr>
<th></th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Independent Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal notifier identifier</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Perinatal notifier type code</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

3.2 Perinatal Data Provider

3.3 Mother Details

<table>
<thead>
<tr>
<th>Item</th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Independent Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother Client ID (medical record number or other defined identifier)</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
</tr>
<tr>
<td>Given name</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Middle names</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Family name</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Full address of residence (including street number and name, locality, postcode and state/territory)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Country of residence</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Country of birth</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Indigenous status</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
### 3.4 Newborn Details

<table>
<thead>
<tr>
<th>Item</th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Independent Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Client ID (medical record number or other defined identifier)</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
</tr>
<tr>
<td>Given name</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Middle names</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Family name</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Indigenous status</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Baby birth date</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Baby birth status (livebirth/stillbirth)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Sex</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Plurality</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Birth order</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Birth weight</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Estimated gestational age</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Apgar score at 1 and 5 minutes</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Baby resuscitation type</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

### 3.5 Pregnancy Details

<table>
<thead>
<tr>
<th>Item</th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Independent Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous pregnancy indicator</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Previous pregnancies count</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Last birth by caesarean section indicator</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Previous caesarean section count</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother’s height (cm)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother’s weight (kg)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Antenatal estimated date of birth</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Antenatal care received indicator</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Pregnancy duration at 1st antenatal care</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Number of antenatal visits (Antenatal service contact count)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother tested for HIV Flag</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother immunised against pertussis in this pregnancy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother immunised against influenza in this pregnancy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother diabetes type</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother chronic hypertension flag</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother preeclampsia flag</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother gestational hypertension</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother eclampsia flag</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Hepatitis B surface antigen positive</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Smoking in first half of pregnancy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Average number of daily cigarettes smoked in first half of pregnancy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Smoking in second half of pregnancy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Average number of daily cigarettes smoked in second half of pregnancy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Quit smoking in this pregnancy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>If quit smoking in this pregnancy, at what gestation week?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

246(30/07/15)
### 3.6 Labour and Delivery

<table>
<thead>
<tr>
<th>Item</th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Independent Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour onset type</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Labour induced with oxytocins</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Labour induced with prostaglandins</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Labour induced by artificial rupture of membranes</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Labour induced by other means</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Main indication for induction of labour</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Labour augmented with oxytocins</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Labour augmented by artificial rupture of membranes</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Presentation at birth</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Analgesia provided in labour – various types</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Type of birth</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Main indication for caesarean section</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Anaesthesia provided during delivery – various types</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Perineal status</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Episiotomy indicator</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Surgical repair of the vagina or perineum</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Management type applied in 3rd stage</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

### 3.7 Maternity Care

<table>
<thead>
<tr>
<th>Item</th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Independent Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model of care during pregnancy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Model of care at birth</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Place of birth</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

### 3.8 Postnatal Care

<table>
<thead>
<tr>
<th>Item</th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Independent Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum haemorrhage within 24 hours of birth</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Postpartum haemorrhage within 24 hours of birth requiring blood transfusion</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Postpartum haemorrhage within 24 hours of birth – estimated blood loss</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Congenital condition present flag</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Congenital condition(s) description</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Newborn hepatitis B birth dose</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

### 3.9 Discharge status of mother and baby

<table>
<thead>
<tr>
<th>Item</th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Independent Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge status of mother</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Mother’s date/time of discharge or transfer</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Hospital mother transferred to</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Discharge status of baby</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Baby’s date/time of discharge or transfer</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Hospital baby was transferred to</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Baby feeding on discharge (various)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
9. HEALTH RECORDS AND INFORMATION

3.10 System and Service event details

<table>
<thead>
<tr>
<th>Item</th>
<th>Public Hospital</th>
<th>Private Hospital</th>
<th>Independent Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother client identifier – issuing authority</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Mother client identifier type code</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Mother service encounter record identifier</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Mother service event record identifier</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Mother service event source identifier</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Mother service event type code</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Newborn client identifier – issuing authority</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Newborn client identifier type code</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Newborn service encounter record identifier</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Newborn service event record identifier</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Newborn service event source identifier</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Newborn service event type code</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Perinatal birth record identifier</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
</tr>
<tr>
<td>Perinatal pregnancy record identifier</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
</tr>
<tr>
<td>Perinatal record source identifier</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Source create date and time</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Source modified date and time</td>
<td>Y</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Perinatal record action type</td>
<td>Y</td>
<td>Y</td>
<td>n/a</td>
</tr>
</tbody>
</table>

4. DATA QUALITY

Data quality checks are made to ensure that all data submitted is compliant with the PDC as specified by the PDC 2016 Data Dictionary. Checks are made as the data is submitted to PeriPH or EDWARD or entered via PeriForm.

Incomplete records or records with errors will be identified and an error report made available to the submitting hospital. These records must be corrected and re-submitted by the reporting entity within the time stipulated (i.e. within 6 weeks of the date of final data submission).

In order to validate the enumeration of births for each calendar year a list of reported births are sent to each hospital and is to be validated against the hospital birth register.

5. SECURITY OF DATA

The Privacy Manual for Health Information (March 2015) and the Privacy Management Plan (Policy Directive PD2015_036) must be observed for all data relating to the PDC.

Public hospitals with maternity units will submit data to EDWARD from behind the electronic security framework of NSW Health. Files must be directed to the location specified in the EDWARD Perinatal Interface Documentation (refer to supporting documents).

Private hospital users require an authorised user account to access and submit data to PeriPH.

Independent midwives (and users from hospitals without maternity units) require an authorised user account to access and submit data via the secure online PeriForm.

To apply for authorised access to PeriPH and PeriForm contact the Data Integrity Officer in Health Systems Information and Performance Reporting Branch, NSW Ministry of Health.
6. PDC INFORMATION – ACCESS AND DISSEMINATION

Information collected by the PDC is used for the following purposes:

- State wide surveillance to monitor patterns of care for mothers and babies, and outcomes of care. Summary information for NSW is published annually on HealthStats NSW at: http://www.healthstats.nsw.gov.au/
- Planning, monitoring and evaluation of maternity services by the Ministry of Health and Local Health Districts.
- De-identified unit record data are provided to the AIHW National Perinatal Statistics Unit for inclusion in the National Perinatal Data Collection.
- De-identified data and summary data are provided to the NSW Ombudsman to support the work of the NSW Child Death Review Team.
- Research purposes with the approval of a human research ethics committee.

PDC data may be accessed in the following ways:

- De-identified unit record data may be obtained via Secure Analytics for Population Health Research and Intelligence (SAPHaRI), which is the NSW Ministry of Health population health data warehouse, analysis and reporting system. SAPHaRI is administered by the Centre for Epidemiology and Evidence, and is accessible by staff of the NSW Ministry of Health and public health services subject to signing of a confidentiality agreement.
- Access to de-identified PDC unit record data for research purposes may also be sought by written request to the Executive Director, Centre for Epidemiology and Research.

7. GLOSSARY

<table>
<thead>
<tr>
<th>Term/Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>EDWARD</td>
<td>NSW Health's Enterprise Data Warehouse for Analysis, Reporting and Decision Support.</td>
</tr>
<tr>
<td>PDC</td>
<td>Perinatal Data Collection</td>
</tr>
<tr>
<td>PeriForm</td>
<td>A secure online form to allow the entry and submission of individual PDC records</td>
</tr>
<tr>
<td>PeriPH</td>
<td>The application and data base to be used by private facilities for the submission and data quality checks for PDC records</td>
</tr>
</tbody>
</table>

8. FURTHER INFORMATION

Detailed information on the PDC data items, codes and guidance on completion of each data item is contained in the *New South Wales Perinatal Data Collection Data Dictionary 2016*.

Further information concerning the collection and submission of PDC data is available on the NSW Health Intranet from the following URL: http://internal.health.nsw.gov.au/data/collections/pdc/index.html

Including links to the following resources:

- Data Dictionary – EDWARD Data Stream – Perinatal Notification
- Perinatal Data Collection Classification Changes Effective From 1 January 2016 Information Bulletin
- EDWARD Interface Requirements Specification for File Based Extracts – Perinatal Notification Data Stream
- Data Dictionary EDWARD Control and Audit Data Dictionary (excluding data error concepts)
- PeriPH data submission format specification
9. HEALTH RECORDS AND INFORMATION

- Perinatal Data Set Specification 2015-16 (AIHW; Nov., 2014; [http://meteor.aihw.gov.au/content/index.phtml/itemId/581388](http://meteor.aihw.gov.au/content/index.phtml/itemId/581388))
- Perinatal NMDS 2014- (AIHW; March, 2014; [http://meteor.aihw.gov.au/content/index.phtml/itemId/517456](http://meteor.aihw.gov.au/content/index.phtml/itemId/517456)).

For further information about this policy directive or the PDC, contact:

Komala Goutham
Data Integrity Officer
Information Management and Quality Unit
Health System Information and Performance Reporting Branch
NSW Ministry of Health
Phone: 02 9391 9613
E-mail: kgout@doh.health.nsw.gov.au
NSW REGISTER OF CONGENITAL CONDITIONS – REPORTING REQUIREMENTS
(PD2018_006)

PD2018_006 rescinds PD2012_055

PURPOSE
This Policy Directive provides guidance to NSW Health staff on the procedure to be followed for the reporting of congenital conditions to the NSW Register of Congenital Conditions.

MANDATORY REQUIREMENTS
All hospitals must notify the Register of Congenital Conditions (the Register) of scheduled congenital conditions detected in a fetus during pregnancy or in a child up to one year of age. This includes staff of obstetrics, neonatal and paediatric units, prenatal genetic services for chromosomal and DNA testing, feto-maternal units and anatomical pathology departments.

This Policy Directive outlines the process for submitting paper and electronic notifications to the Ministry of Health, and presents information on data quality, security, access and dissemination. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

IMPLEMENTATION
This Policy Directive should be distributed to all LHD staff. Staff involved in the identification of scheduled congenital conditions during pregnancy or the post-natal period must follow the procedure set out in this policy directive.

BACKGROUND
About this document
All hospitals must notify the Register of Congenital Conditions (the Register) of scheduled congenital conditions detected in a fetus during pregnancy or in a child up to one year of age. This includes staff of obstetrics, neonatal and paediatric units, prenatal genetic services for chromosomal and DNA testing, feto-maternal units and anatomical pathology departments.

The Register is located in the Centre for Epidemiology and Evidence of the NSW Ministry of Health. Information from the Register is used to monitor the occurrence of congenital conditions for service planning purposes and to identify changes in incidence that may warrant investigation.

Key definitions for scheduled congenital conditions
The Register is a state wide surveillance system that monitors the occurrence of scheduled congenital conditions to plan services for affected families, and identify changes in incidence that may warrant investigation.

Scheduled congenital conditions include:

1. All structural malformations. Examples include spina bifida, microcephaly, transposition of the great vessels, ventricular septal defects, pulmonary agenesis, polycystic lungs, duodenal atresia, exomphalos, hypospadias, cleft lip/palate, microphthalmia, limb reductions, polydactyly, birthmarks greater than 4cm diameter, cystic hygroma and multisystem syndromes including at least one structural malformation.

2. Chromosomal abnormalities. Examples include Down syndrome and unbalanced translocations.

3. Four medical conditions: cystic fibrosis, phenylketonuria, congenital hypothyroidism and thalassaemia major.
Congenital conditions that are not notifiable include:

1. Minor anomalies occurring in isolation.
   Examples of minor anomalies include skin tags, deviated nasal septum, tongue tie, benign heart murmurs, clicky non-dislocating hips, sacral dimples, positional talipes, abnormal palmar creases, and dysmorphic features.

2. Birth injuries.

3. Congenital infections which do not result in a structural malformation.

4. Tumours and cysts.

5. Conditions arising from prematurity or asphyxiation.

Legal and legislative framework

Congenital conditions occurring in a child under one year of age or pregnancies where the fetus has a congenital condition are required to be reported under the NSW Public Health Act 2010.

REPORTING METHOD

Notification types

1. Notification of a scheduled congenital condition diagnosed in an infant
   Information in this format should be supplied for congenital conditions detected in stillborn babies or live born babies up to one year of age.

2. Notification of a scheduled congenital condition diagnosed by prenatal diagnosis
   Information in this format should be supplied for congenital conditions detected in the fetus during pregnancy, regardless of whether the pregnancy continues.

Guidelines for notification are printed on the outside cover of each notification pad.

In the case of a multiple pregnancy or multiple birth where both babies are affected, a separate form or electronic record must be completed in full for each fetus or baby.

Methods of notification

Information may be supplied in paper or electronic format.

Paper notifications

For submission on paper forms, forms are provided in triplicate with the original sent to the NSW Ministry of Health, one copy for the hospital medical record and one copy for the parent or family. Information for parents and families concerning the Register is printed on the reverse side of the Parent Copy of both notification forms.

Paper notifications should be mailed to:

   The NSW Register of Congenital Conditions
   Centre for Epidemiology and Evidence
   Level 7
   NSW Ministry of Health
   Locked Mail Bag 961
   North Sydney NSW 2059

Electronic notifications

Electronic notifications of scheduled congenital conditions can be facilitated via a hospital’s Maternity Information System – the electronic system that captures birth notifications from hospitals. Notifications should be entered immediately following diagnosis. Notifications should be sent to the Ministry of Health on at least a quarterly basis. For facilities interested in submitting notifications electronically, please contact: roccadmin@moh.health.nsw.gov.au.
9. HEALTH RECORDS AND INFORMATION

Information to be notified

<table>
<thead>
<tr>
<th>Demographic details (mother)</th>
<th>Indigenous status (baby)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
<td></td>
</tr>
<tr>
<td>Last name</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>Hospital medical record number or laboratory number</td>
<td></td>
</tr>
<tr>
<td>Residential address</td>
<td></td>
</tr>
<tr>
<td>Country of birth</td>
<td></td>
</tr>
<tr>
<td>Indigenous status (mother)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Demographic details (live born or stillborn baby)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
</tr>
<tr>
<td>Last name</td>
</tr>
<tr>
<td>Date of birth</td>
</tr>
<tr>
<td>Hospital medical record number or laboratory number</td>
</tr>
<tr>
<td>Hospital of birth</td>
</tr>
<tr>
<td>Sex</td>
</tr>
</tbody>
</table>

Plurality

<table>
<thead>
<tr>
<th>Baby number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth weight</td>
</tr>
<tr>
<td>Gestation</td>
</tr>
<tr>
<td>Outcome</td>
</tr>
<tr>
<td>Autopsy/histopathology</td>
</tr>
<tr>
<td>Date of death</td>
</tr>
<tr>
<td>Pregnancy details (where applicable)</td>
</tr>
<tr>
<td>Indication for prenatal diagnosis</td>
</tr>
<tr>
<td>Type of prenatal diagnosis</td>
</tr>
<tr>
<td>Date of last menstrual period</td>
</tr>
<tr>
<td>Relevant medical or family history</td>
</tr>
<tr>
<td>Congenital abnormality/syndrome</td>
</tr>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>Laterality</td>
</tr>
<tr>
<td>Date of Diagnosis</td>
</tr>
<tr>
<td>Karyotype – balanced, unbalanced</td>
</tr>
</tbody>
</table>

DATA QUALITY

Data submitted to the Register is checked for any discrepancies and further information is requested from the hospital or reporting clinician if information received is inconsistent or incomplete.

DATA SECURITY

Data collected by the Register is protected under the NSW Public Health Act 2010.

The NSW Health Privacy Manual for Health Information (previously known as the NSW Health Privacy Manual) must be observed for all data relating to the Register. This is located at: http://www.health.nsw.gov.au/policies/manuals/Pages/privacy-manual-for-health-information.aspx.

The Register database is held on the NSW Ministry of Health’s local area network, is password protected and is accessible only to the Register staff.

Paper forms submitted to the Register are securely stored and are destroyed no more than five years after the year of birth or completion of the pregnancy.

Personal identifiers (name, residential street number and name, and medical record number) are removed from the database five years after the year of birth or completion of the pregnancy.

DATA ACCESS AND DISSEMINATION

Information obtained from the Register is made available on request. Specific analyses of Register data, or access to unit record data from the Register, may be obtained on written request to the Executive Director, Centre for Epidemiology and Evidence (email: ceemail@moh.health.nsw.gov.au).

CONTACT INFORMATION

For further information about the Register of Congenital Conditions, or this Policy Directive, please contact: roccadmin@moh.health.nsw.gov.au.

300(07/02/18)
CANCER REGISTRY - NOTIFYING CANCER CASES TO THE NSW CENTRAL CANCER REGISTRY (PD2009_012)

PD2009_012 rescinds PD2005_220.

1. Introduction

1.1 Purpose

The purpose of this policy directive is to describe the mandatory requirement to report cancer cases to the NSW Central Cancer Registry.

1.2 Background

The NSW Central Cancer Registry is a central repository of data relating to cases of cancer diagnosed and treated in residents of the State of New South Wales.

The Registry contributes to the prevention, control and treatment of cancer in the population of NSW in particular, by supplying timely and accurate data based on a total record of all cases of cancer diagnosed in NSW residents.

The aims of the NSW Central Cancer Registry are to:
- Monitor and record the number of new cases of cancer and deaths from cancer in NSW
- Produce regular and ad hoc reports on cancer incidence and mortality patterns
- Utilise the data to support epidemiological and clinical research
- Evaluate the benefits of cancer screening programs to determine their effectiveness
- Assist in planning and monitoring services for the control of cancer and the care of cancer patients in NSW
- Make the data available for use by health providers, planners, educators and research scientists
- Contribute cancer data to national and international agencies to assist in cancer control.

The Public Health Act 1991 identifies cancer as a scheduled medical condition (category 3) and as a notifiable disease. The Act requires notification of cancer to the Director-General of the NSW Department of Health. The Cancer Institute NSW, established under the Cancer Institute (NSW) Act, 2003, acts as the manager of the NSW Central Cancer Registry and custodian of cancer data on behalf of the Director-General.

The NSW Central Cancer Registry also processes all notifications received by the ACT Cancer Registry.

1.3 Audience

The policies described in this directive are relevant to staff working in the following facilities:

Public Sector
- Public Hospitals
- Multi-Purpose Services
- Pathology Laboratories
- Residential Aged Care Facilities
- Forensic medicine
9. HEALTH RECORDS AND INFORMATION

Private Sector

- Private Hospitals
- Day Procedure Centres
- Pathology Laboratories
- Residential Aged Care Facilities

In particular the policies are relevant to:

- Medical Record Departments
  - Health Information Managers
  - Clinical Coders
- Directors of Nursing
- Radiation Oncology Departments
- Oncology Outpatient Departments
- Cancer Care Centres
- Data Managers
- Pathologists and Haematologists
- Directors/Managers of Pathology Laboratories

2 Statutory Context

The Public Health Act 1991 and Public Health General Regulation 2002 give authority to the policy directive relating to the NSW Central Cancer Registry as described in this document.

The Act and Regulation also outline the obligation for health care providers to notify cases of cancer, and describe the penalties for non-compliance.

The Privacy Manual for Health Information (March 2015) describes privacy issues relating to the collection and provision of identified patient data with reference to the Health Records and Information Privacy Act 2002. The Public Health Act 1991 and the Public Health General Regulation 2002 give the authority to provide this information to the NSW Central Cancer Registry within the privacy guidelines and the requirements of Health Records and Information Privacy Act 2002.

Chapter 9 of the Privacy Manual describes the retention, security and protection requirements for identified patient data for all parties involved in the collection of person level information. These requirements must be adhered to by the NSW Central Cancer Registry and its notifiers.

Below are the sections of the Public Health Act and Regulation that are relevant to the NSW Central Cancer Registry.

2.1 Public Health Act 1991

Part 3 – Scheduled Medical Conditions

- Division 3 - Notification and Treatment of Certain Medical Conditions
  - Section 16 - Notification of Test Results - Category 3 Medical Condition
- Division 5 - Death From Scheduled Medical Condition
  - Section 20 - Notification of Certain Deaths
9. HEALTH RECORDS AND INFORMATION

Part 7 - Administration
- Division 2 - Notifications by Hospitals
  - Section 69 - Chief Executive Officer to Provide Information

Schedule 1 - Scheduled Medical Conditions
Schedule 3 - Notifiable Diseases

2.2 Public Health General Regulation, 2002

Part 3 - Scheduled Medical Conditions
- Regulation 8 - Notification of Test Results - Prescribed Tests
- Regulation 9 - Notification of Test Results - Time Limit for Providing Information
- Regulation 11 - Notification of Death from Scheduled Medical Conditions

Part 5 - Miscellaneous
- Regulation 19 - Particulars of Notifiable Diseases

2.3 Cancer Institute (NSW) Act 2003

Section 13 - Collection of Cancer Control Information

3 Notifiable cancers

3.1 Inclusions

The table below shows, at summary level, the cancers for which a notification must be provided.

<table>
<thead>
<tr>
<th>Disease Description</th>
<th>ICD-10-AM 6th Edition Codes (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From</td>
</tr>
<tr>
<td>Human immunodeficiency virus [HIV] disease resulting in malignant neoplasms</td>
<td>B21</td>
</tr>
<tr>
<td>All cases of invasive cancer, other than those specifically listed as excluded in</td>
<td>C00.0</td>
</tr>
<tr>
<td>point 2.2 below.</td>
<td></td>
</tr>
<tr>
<td>Melanoma-in-situ</td>
<td>D03.0</td>
</tr>
<tr>
<td>Breast Carcinoma-in-situ</td>
<td>D05.0</td>
</tr>
<tr>
<td>Polycythaemia vera (1)</td>
<td>D45</td>
</tr>
<tr>
<td>Refractory anaemia without sideroblasts (1)</td>
<td>D46.0</td>
</tr>
<tr>
<td>Refractory anaemia with sideroblasts (1)</td>
<td>D46.1</td>
</tr>
<tr>
<td>Refractory anaemia with excess of blasts (1)</td>
<td>D46.2</td>
</tr>
<tr>
<td>Refractory anaemia with excess of blasts with transformation (1)</td>
<td>D46.3</td>
</tr>
<tr>
<td>Refractory anaemia, unspecified (1)</td>
<td>D46.4</td>
</tr>
<tr>
<td>Other myelodysplastic syndromes (1)</td>
<td>D46.7</td>
</tr>
<tr>
<td>Myelodysplastic syndrome, unspecified (1)</td>
<td>D46.9</td>
</tr>
<tr>
<td>Chronic myeloproliferative disease (1)</td>
<td>D47.1</td>
</tr>
<tr>
<td>Essential (haemorrhagic) thrombocythaemia (1)</td>
<td>D47.3</td>
</tr>
<tr>
<td>Lymphomatoid papulosis (1)</td>
<td>L41.2</td>
</tr>
</tbody>
</table>
In addition to the table above, five squamous cell carcinomas are notifiable when paired with a morphology code in the range of ‘M805’ to ‘M808’ and ending with ‘/3’. These are listed below:

<table>
<thead>
<tr>
<th>Disease Description</th>
<th>ICD-10-AM 6th Edition Codes (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squamous cell carcinomas of skin of anus only</td>
<td>C44.5(3)</td>
</tr>
<tr>
<td>Squamous cell carcinomas of the vermilion surface and border of the lip</td>
<td>C00.0 to C00.9</td>
</tr>
<tr>
<td>Squamous cell carcinomas of skin of vulva</td>
<td>C51.9</td>
</tr>
<tr>
<td>Squamous cell carcinomas of skin of penis</td>
<td>C60.9</td>
</tr>
<tr>
<td>Squamous cell carcinomas of skin of scrotum</td>
<td>C63.2</td>
</tr>
</tbody>
</table>

Note (1): Diseases with ICD-10-AM codes commencing with ‘D’ and ‘L’ were reclassified in ICD-O Third Edition with a malignant morphology code. Despite being located in the ICD-10-AM chapter for ‘Neoplasms of uncertain or unknown behaviour’, these diseases are notifiable when paired with the corresponding morphology code listed in the table above. The NSW Central Cancer Registry officially commenced collection of these additional diseases for cases diagnosed in the year 2003. Cases where such a diagnosis was made prior to 2003 may also be reported, and if the exact date of diagnosis of these earlier diagnosed cases is unknown a default date of 01/01/2001 should be reported.

Note (2): These are codes in the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (6th Edition, 1 July 2008), published by the National Centre for Classification in Health, Faculty of Health Science, University of Sydney, Australia. ICD-10-AM is updated biennially. For later editions of ICD-10-AM check for code changes with Cancer Institute NSW at: http://www.cancerinstitute.org.au/

Note (3): C44.5 also covers Squamous cell carcinomas of skin sites other than anus, which are not notifiable. The determination as to whether a case with a C44.5 diagnosis code is notifiable (i.e. relates to the anus) or not (does not relate to the anus) must therefore be made by a clinical coder.

3.2 Exclusions

The following cases must be excluded from notifications:

1) Squamous cell carcinomas of the skin, other than skin of anus, vulva, penis, scrotum, and vermilion surface and border of the lip.
   Basal cell carcinomas of the skin.
   In-situ cancers and intraepithelial neoplasia with no mention of invasion, other than those listed in section 4.1.
   Cases where patients have benign tumours or pre-cancerous conditions.

2) Cases where patients have declined treatment and do not have a clear confirmation of cancer.

3) Cases where patients have an equivocal diagnosis of cancer; that is, a definitive diagnosis of cancer has not been made radiologically, cytologically or pathologically, and the clinician does not regard the patient as having, or does not treat the patient for cancer.

4) Cases where patients have been admitted solely for routine surveillance of previously treated cancers, for example, check cystoscopy or colonoscopy, where there is no detection of a new notifiable primary cancer.

5) Cases where patients have a past history of cancer but have no current/active evidence of cancer.
9. HEALTH RECORDS AND INFORMATION

4. Admitted patient notifications

4.1 Who must notify

Any facility that provides admitted patient services within New South Wales has an obligation to notify the NSW Central Cancer Registry. This includes:

- Public Hospitals
- Public Multi-purpose Services
- Private Hospitals
- Private Day Procedure Centres

4.2 Cases that must be notified

A notification of cancer is required for each admitted patient episode of care where there is a notifiable cancer diagnosed and/or active or palliative treatment for cancer is provided.

‘Active Treatment for Cancer’ is defined as a clinical treatment intervention (e.g. surgery, course of radiotherapy, course of chemotherapy) for a specific cancer at a single point in time where the cancer is the principal or an additional diagnosis for the episode of care.

A separate notification is required for each primary cancer. Additional primary cancers may be determined by a different topography from the original, or the same topography but a different histological type.

With the exception of cases of recurrent chemotherapy or radiotherapy, one notification must be submitted for each primary cancer for each episode of care. This means:

- if more than one primary cancer is diagnosed during one episode of care, a notification must be submitted for each primary cancer, and/or
- if the patient has one primary cancer, but presents for active treatment over two or more episodes of care, two or more notifications must be submitted (one for each episode of care).

For patients receiving chemotherapy or radiotherapy on an admitted patient basis a single notification for each primary cancer for which active treatment is provided is required once per year only, regardless of the number of treatment sessions provided.

See Section 3 for a detailed list of inclusions and exclusions, described in terms of ICD-10-AM codes.

5. Non-Admitted patient notifications

5.1 Who must notify

Any facility that provides non-admitted patient services within New South Wales has an obligation to notify the NSW Central Cancer Registry of any case that is defined as notifiable.

The type of facilities that must notify include:

- Radiation Oncology Departments
- Oncology Outpatient Clinics
- Cancer Care Centres
- Haematology and Bone Marrow Transplant Services
5.2 Cases that must be notified

A notification of cancer is required for each non-admitted patient once only where there is a notifiable cancer diagnosed and/or active or palliative treatment for cancer is provided.

‘Active Treatment for Cancer’ is defined as a clinical treatment intervention (e.g. surgery, course of radiotherapy, course of chemotherapy) for a specific cancer at a single point in time where the cancer is the principal or an additional diagnosis for the episode of care.

Radiation Oncology Departments, Oncology Outpatient Clinics and Cancer Care Centres must submit one cancer notification only per person for treatment (e.g. chemotherapy or radiotherapy) provided for a primary cancer. If a course of treatment is not provided, a cancer notification must be submitted following the initial consultation for a primary cancer.

A separate notification is required for each primary cancer. Additional primary cancers may be determined by a different topography from the original, or the same topography but a different histological type.

6 Due dates for notifications

Cancer notifications for admitted patients diagnosed with cancer must be submitted to the NSW Central Cancer Registry no later than 6 weeks after the patient’s separation.

Cancer notifications for non-admitted patients must be submitted to the NSW Central Cancer Registry no later than 6 weeks after the patient’s first date of attendance for treatment for each primary cancer.

7 Information that must be reported

The data elements required for reporting a cancer notification for admitted and non-admitted patients are published in the NSW Central Cancer Registry Data Dictionary. This is available on the Cancer Institute NSW’s website.


8 How to submit a notification - Public facilities

8.1 Method of reporting

8.1.1 Admitted patient facilities

Public Hospitals and Multi-Purpose Services must report cancer notifications in an electronic format via the NSW Department of Health’s Health Information Exchange (HIE). The NSW Central Cancer Registry does not support paper form reporting of admitted patient activity notifications from public facilities unless a special written exemption for a limited period is provided by the NSW Central Cancer Registry.

9. HEALTH RECORDS AND INFORMATION

All cancer notifications for admitted patients from public facilities are sourced by the NSW Central Cancer Registry from the NSW Department of Health’s HIE.

To ensure the NSW Central Cancer Registry receives cancer notifications by the due date, admitted patient data should be extracted from patient administration systems and loaded into the Area HIE on a daily basis. This ensures new notifications of cancer are received as early as possible and any data quality issues can be identified and corrected in a timely manner.

Reporting admitted patient cancer notifications via the HIE is a three step process:
1. Data must be extracted from the patient administration system (preferably daily and at least weekly), then transferred and loaded into the Area Health Service HIE by the hospital or Area Health Service.
2. Area Health Service HIE data must be transferred to the Department HIE by the Area Health Service (at least weekly). It is the responsibility of the Area Health Service HIE Coordinator to monitor the status of the transfer and resolve any technical issues with this process that may occur from time to time.
3. The NSW Central Cancer Registry extracts data from the Department’s HIE, and loads it into the NSW Central Registry processing system where case matching and further data quality assurance is performed.

8.1.1.1 Functional requirements for Patient Administration Systems

To comply with the NSW Central Cancer Registry mandatory reporting requirements patient administration systems used by public facilities to record admitted patient activity and cancer notifications must include:

• a module (patient register or patient master index) for recording the demographic data relating to the patient that are in scope of the reporting requirements for the NSW Central Cancer Registry;
• ability to record episodes of care, episode of care start and end dates, and separation mode;
• a coding module for the recording of diagnoses, procedures, and morphologies;
• the capacity to support clinical coding in multiple editions of ICD-10-AM at any point in time, the edition used being linked automatically to the episode end date (episode of care separation date) rather than the date the record is accessed or updated;
• a cancer notification module designed to capture the mandatory cancer specific data;
• automated triggers of cancer notification modules/windows based on the diagnosis codes and paired morphology codes, and referencing the flagged ICD-10-AM edition specific notifiable primary sites of cancer;
• functionality to exclude notifications of exceptions, such as squamous cell carcinomas of the skin (C44 with morphology M805 to M807) and basal cell carcinomas of the skin (C44 with Morphology Code M809 to M811);
• enforced mandatory completion of all cancer notification specific data elements at time of clinical coding for each episode of care and each primary site of cancer;
• a functional and accurate extract that can be scheduled to automatically extract and transfer admitted patient data to the NSW Department of Health’s HIE in a format compliant with the requirements of the NSW Department of Health’s HIE; and
• functionality to flag and re-extract any record modified in any field included in the notification of cancer between extracts of data, and functionality to include that modified record in the next extract for submission to the NSW Central Cancer Registry via the HIE.
9. HEALTH RECORDS AND INFORMATION

Non-admitted patient facilities

Cancer notifications for non-admitted patients must be submitted either:
- In an electronic format via the NSW Health Department’s Health Information Exchange (HIE), or
- Using the standard NSW Central Cancer Registry Notification paper form.

8.1.2.1 Electronic submissions via the NSW Health Information Exchange

Cancer notifications from public sector Radiation Oncology Departments must be submitted to the NSW Central Cancer Registry in an electronic format via the NSW Health Information Exchange (HIE). Electronic submissions must be compliant with the HIE Non-Admitted Patient Cancer Notification Specification for the HIE (reference: PO3591) available at:

Reporting in the standard electronic format via the HIE is currently optional for other non-admitted patient departments, however electronic notification must be implemented where-ever possible and should be a core function of new source systems.

To ensure the NSW Central Cancer Registry receives cancer notifications by the due dates, non-admitted patient data should be extracted from the radiotherapy information system or other source system and loaded into the Area HIE on a weekly basis. This ensures new notifications of cancer are received as early as possible and any data quality issues can be identified and corrected in a timely manner.

Reporting non-admitted patient cancer notifications via the HIE is a three step process:
1. Data must be extracted from the radiotherapy information system or source system (at least weekly), then transferred and loaded into the Area Health Service HIE by the facility or Area Health Service.
2. Area Health Service HIE data must be transferred to the Department HIE by the Area Health Service (at least weekly). It is the responsibility of the Area Health Service HIE Coordinator to monitor the status of the transfer and resolve any technical issues with this process that may occur from time to time.
3. The NSW Central Cancer Registry extracts data from the Department’s HIE, and loads it into the NSW Central Registry processing system where case matching and further data quality assurance is performed.

8.1.2.2 Paper form submissions

Non-admitted patient facilities, other than Public Radiation Oncology Departments, may notify on the standard paper notification form, rather than in the electronic format. There are some additional data items to report when reporting on the standard paper notification form. These include:
- Name of Hospital
- Cancer Registry Notification Code
- Age
- More than one Primary Cancer Indicator

For non-admitted patient notifications, the Date of Attendance must be entered into the “Date of Admission” box, and the “Date of Separation” box should be left blank. The “Status at Separation” question should be left blank as it is not applicable for non-admitted patient notifications.
9. HEALTH RECORDS AND INFORMATION

The paper form used to report cancer notifications to the NSW Central Cancer Registry is a standard form issued by the Cancer Institute NSW. To order stock of the form, contact the NSW Central Cancer Registry (see Section 13 for contact details).

Completed Cancer Notification paper forms must be sent via secure post or courier and marked “NSW Central Cancer Registry - Private and Confidential”. Contact details for the NSW Central Cancer Registry are provided in Section 13.

9 How to submit a notification - Private facilities

9.1 Methods of reporting

9.1.1 Admitted and non-admitted patients

Private Hospitals, Day Procedure Centres, Radiotherapy departments and Outpatient departments must submit Cancer Notifications either:
• Using the NSW Central Cancer Registry Cancer Notification Portal; or
• Using the standard NSW Central Cancer Registry Notification paper form.

The NSW Central Cancer Registry Cancer Notification Portal enables notifying institutions to submit cancer notifications via the Internet using a web-based notification form or by uploading an extract from the patient administration system. The Cancer Notification Portal is available on the Cancer Institute NSW website at: https://notification.cancerinstitute.org.au/LogIn/tabid/36/Default.aspx?returnurl=%2fdefault.aspx

Paper forms will continue to be accepted and processed by the NSW Central Cancer Registry until the staggered implementation of the Cancer Notification Portal is completed.

9.1.1.1 Electronic submissions using the Cancer Notification Portal

The Cancer Institute NSW has a standard specification for electronic notifications from private hospitals and day procedure centres. This specification must be complied with when data are uploaded to the Cancer Notification Portal. The specification is provided in Appendix 2.

A user name and password are required to submit notifications using the Cancer Notification Portal. To obtain a user name and password contact the Cancer Notification Portal Administrator. Contact details are available in Section 13. A user name and password will be sent to you via email.

Electronic notifications from private hospitals, day procedure centres radiotherapy departments and outpatient departments received via the Cancer Notification Portal are loaded directly into the NSW Central Cancer Registry’s data processing system.

9.1.1.2 Paper form submissions

When cancer notifications are reported on paper forms there are some additional data items to report. These include:
• Name of Hospital
• Cancer Registry Notification Code
• Age
• Status of Separation (instead of Mode of Separation)
• More than one Primary Cancer Indicator
9. HEALTH RECORDS AND INFORMATION

For non-admitted patient notifications, the Date of Attendance must be entered into the “Date of Admission” box, and the “Date of Separation” box should be left blank. The “Status at Separation” question should be left blank as it is not applicable for non-admitted patient notifications.

The paper form used to report cancer notifications to the NSW Central Cancer Registry is a standard form issued by the Cancer Institute NSW. To order stock of the form, contact the NSW Central Cancer Registry (see Section 13 for contact details).

Completed Cancer Notification paper forms must be sent via secure post or courier and marked “NSW Central Cancer Registry - Private and Confidential”. Addresses and contact details for the NSW Central Cancer Registry are provided in Section 13.

10 Reviewing data quality and correcting errors

10.1 Notifications submitted via the Health Information Exchange

Following the load of data into the Area HIE, hospital staff, radiation oncology department staff and staff in other non-admitted patient facilities must review data errors and make corrections. Data quality is checked automatically in the HIE following the data load process, and a record of each error is created in a data error log.

The data error checks built into the HIE identify many of the common errors, such as primary sites of cancer diagnoses reported without a paired morphology code, and incomplete mandatory fields.

It is a requirement that staff review the data errors identified by the HIE data quality checking process, and make corrections to those errors immediately after the data have been loaded. Timely correction of data will assist in staff education thereby reducing the rate of errors in future notifications.

Standard data error reports showing the records with errors by the type of error have been issued to all Area Health Services in Business Objects format by the NSW Health Department. Where Business Objects reports are not available, locally developed reports or queries against the HIE “data_error” table may be used. Descriptions of the errors are stored in the HIE reference table “data_error_type”.

Corrections to identified errors must be made in the patient administration system or source system (e.g. VARIAN, Impac or LANTIS Radiotherapy Information Systems). Records that have been updated, added or deleted should be flagged automatically by the patient administration system or source system for inclusion in the next extraction of data to the HIE.

When an updated record is re-loaded into the HIE the suite of data quality checks will be applied by the HIE and if the error has been corrected the active error message will be aged (switched off) and will no longer show in the error report. If the error remains, or new errors have been created, the record must be amended further in the patient administration system or radiotherapy information system or other source system, and then resubmitted to the HIE until all data quality checks relevant to cancer notifications have been passed.

Further data quality checks will be made by the NSW Central Cancer Registry at the time the data is extracted from the HIE and loaded in the NSW Central Cancer Registry data processing system. If data quality issues are detected at this point, an error report will be sent to the notifying hospital by the NSW Central Cancer Registry.

Where an error report is provided, corrections must be made by the staff in the notifying facility and returned to the NSW Central Cancer Registry. Corrections are due 10 working days after receipt of the error report.
9. HEALTH RECORDS AND INFORMATION

Corrections should be sent to the NSW Central Cancer Registry. Contact details for the NSW Central Cancer Registry are provided in Section 13.

10.2 Notifications submitted via the Cancer Notification Portal

Data quality is checked automatically in the Cancer Notification Portal and an error log is generated. Staff must check this log. For batch extracts, errors should be rectified in the Patient Administration System or source system and the data re-extracted and uploaded. For web-based forms, the correct data should be entered in the field. The Patient Administration System or source system should be updated with the correct information.

Further data quality checks will be made by the NSW Central Cancer Registry at the time the data is loaded in the NSW Central Cancer Registry data processing system. If data quality issues are detected at this point, an error report will be sent to the notifying facility by the NSW Central Cancer Registry.

Where an error report is provided, corrections must be made by the staff in the notifying facility and returned to the NSW Central Cancer Registry. Corrections are due 10 working days after receipt of the error report.

Corrections should be sent to the NSW Central Cancer Registry. Contact details for the NSW Central Cancer Registry are provided in Section 13.

10.3 Notifications submitted on paper notification forms

Once received by the NSW Central Cancer Registry cancer notifications submitted on paper forms are entered into the Central Cancer Registry data processing system. A suite of data quality checks is then applied to the data.

Where information is missing, incomplete, inconsistent or illegible a staff member from the NSW Central Cancer Registry will contact the non-admitted patient facility to seek correction or clarification.

Where an error report is provided, corrections must be made by the staff in the non-admitted patient facility and returned to the NSW Central Cancer Registry. Corrections are due 10 working days after receipt of the error report.

Corrections should be sent via secure post or courier and marked “NSW Central Cancer Registry - Private and Confidential”. Addresses and contact details for the NSW Central Cancer Registry are provided in Section 13.

11 Notifications of results from Pathology laboratories

11.1 Who must notify

All public sector and private sector pathology laboratories operating within New South Wales must notify cases of cancer to the NSW Central Cancer Registry.

For the purpose of mandatory reporting, a pathology laboratory is defined as any accredited premises in which pathology services are supplied.

A pathology service is the analysis of a sample of human tissue or fluid, or any other product of the human body, for the purpose of preventing, diagnosing or treating disease. It includes the collection, preparation, preservation and storage of any such sample.
Any pathology laboratory that is not reporting to the NSW Central Cancer Registry must contact the Registry to obtain a facility identifier for reporting purposes.

11.2 Cases that must be notified

All cases reported unequivocally as cancer must be notified to the NSW Central Cancer Registry. The pathology report is considered the definitive source of determining a cancer case, and histological verification is seen as the gold standard.

The qualifiers used in pathology reports that are regarded as acceptable for a diagnosis of cancer are tabulated below.

<table>
<thead>
<tr>
<th>Considered as diagnostic of cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>diagnostic of</td>
</tr>
<tr>
<td>consistent with</td>
</tr>
<tr>
<td>compatible with</td>
</tr>
<tr>
<td>typical of</td>
</tr>
<tr>
<td>in keeping with</td>
</tr>
<tr>
<td>(the features) are those of the features)</td>
</tr>
<tr>
<td>supports a diagnosis of</td>
</tr>
<tr>
<td>equivalent to/of</td>
</tr>
<tr>
<td>extension into</td>
</tr>
<tr>
<td>invasion of</td>
</tr>
</tbody>
</table>

The notifiable cancers are listed in Section 2. These include carcinoma, sarcoma, lymphoma, leukaemia, melanoma, invasive tumour, malignant neoplasm, in situ melanoma in situ cancer of the breast and in situ cancer of the bladder.

Notifications are also required where a person was originally diagnosed with cancer, and that diagnosis was subsequently changed to something other than cancer.

11.3 Due dates for notifications

As the pathology report provides the definitive diagnosis of cancer, the timeliness of notifications from pathology laboratories is essential for maintaining a current register.

Notifications from pathology laboratories should be submitted to the NSW Central Cancer Registry within 4 weeks of the pathology report date.

For larger pathology laboratories with a high volume of reports, batches of reports can be provided weekly.

11.4 Sources and modes of notification

Pathology Laboratories must submit a copy of the full and complete pathology report to the NSW Central Cancer Registry.

A pathology report of a notifiable cancer may originate from the following laboratory areas:

- Histology – a histological diagnosis of cancer as a result of microscopic examination using routine H & E stains, special stains and/or immunohistochemistry
- Cytology – from fine needle aspirations, smears or cytospin preparations, including Flow Cytometry
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- Haematology – from trephines and/or blood smears
- Molecular laboratories – cancer diagnosed as a result of solid tumour cytogenetics, fluorescent in-situ hybridisation (FISH) studies, results of polymerase chain reaction (PCR)

The type of reports that must be submitted to the NSW Central Cancer Registry include:
1. Histology reports diagnostic of cancer
2. Cytology reports diagnostic of cancer
3. Flow cytometry and cytogenetic reports diagnostic of malignant conditions
4. Bone marrow aspirates and trephine reports diagnostic of malignant conditions, including myelodysplastic and myeloproliferative disorders
5. Blood film reports diagnostic of malignant conditions, including myelodysplastic and myeloproliferative disorders
6. Slide reviews, second opinions and amended reports for previously reported cases
7. Receptor assays

The NSW Central Cancer Registry uses the demographic data detailed in pathology reports to ensure accurate registration of cancer patients. It is thus important for the report to include comprehensive and correct patient demographic information, including all given names, any alias names, date of birth and full address. Other demographic data, such as country of birth and Aboriginal and Torres Strait Islander status are useful, if known.

Pathology Laboratories are not required to complete the standard cancer notification items specified for reporting by hospitals for admitted and non-admitted patients diagnosed with cancer.

Data items that are required on the report are listed below:

11.4.1 Reporting authority
- Pathology Laboratory Name (or Central Cancer Registry Facility Code)

11.4.2 Person demographics
- Person’s Family Name
- Person’s Given Names
- Date of Birth
- Sex
- Address of Patient’s Usual Residence
  - Unit/Flat Number
  - Street Number
  - Street Name
  - Street Type
  - Suburb/Locality
  - State
  - Postcode

11.4.3 Referring doctor details
- Doctor’s Family Name
- Doctor’s Given Names
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- Doctor’s Address
  - Unit/Flat Number
  - Street Number
  - Street Name
  - Street Type
  - Suburb/Locality
  - State
  - Postcode

11.4.4 Test details

- Collection Date
- Test Type
- Test Result

11.5 How to submit a notification – Pathology Laboratories

Pathology laboratories are required to submit the pathology report in hard copy only.

Packages must be marked “NSW Central Cancer Registry - Private and Confidential”. Contact details for the NSW Central Cancer Registry are provided in Section 13.

11.6 Requests for further information

Where a notification is received and the diagnosis cancer is equivocal, further information is likely to be requested by the NSW Central Cancer Registry before the case is registered. In such instances, the NSW Central Cancer Registry may contact the pathology laboratory to obtain clarification of the results, or the results of any additional tests performed.

It is a mandatory requirement that, when requested by the NSW Central Cancer Registry, further information or clarification is provided by the pathology laboratory.

12 Notifications of deaths caused by cancer

12.1 Who must notify

Where a patient dies as an admitted patient, the usual admitted patient cancer notification is required and the “Mode of Separation” or the “Status at Separation” should be used to indicate that the patient died.

The following additional facilities and organisations are responsible for reporting deaths caused by cancer:
- NSW Registry of Births, Deaths and Marriages
- Departments of Forensic Medicine
- Public Residential Aged Care Facilities
- Private Residential Aged Care Facilities

Under the Public Health Act 1991 it is a responsibility of the NSW Registry of Births, Deaths and Marriages (a Government Trading Enterprise and a business unit within the New South Wales Attorney-General’s Department) to notify the NSW Central Cancer Registry of any death that was apparently caused by cancer; or where cancer was an incidental finding at post-mortem.
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The Australian Bureau of Statistics provides the NSW Central Cancer Registry with coded cause of death data on behalf of the NSW Registry of Births, Deaths and Marriages.

12.2 Cases that must be notified

A cancer notification must be provided to the NSW Central Cancer Registry for any case where the cause of death has been determined to be cancer and that disease is listed as notifiable (see Section 3 – Notifiable Cancers, Appendix 1 – Full List of Cancers to Notify to NSW Central Cancer Registry and Notifiable cancers which may not be easily recognised).

12.3 Due dates for notifications

Notification of a death caused by cancer from Institutes of Forensic Medicine and residential aged care facilities must be provided to the NSW Central Cancer Registry within 6 weeks of the patient’s death or date of final determination of cause of death.

The due dates for cancer death data from the NSW Registry of Births, Deaths and Marriages and the Australian Bureau of Statistics is negotiated directly between those agencies and the Cancer Institute NSW.

12.4 Information that must be notified

The table below shows what should be notified, by the type of notifier.

<table>
<thead>
<tr>
<th>Notifier</th>
<th>What to Submit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Departments of Forensic Medicine</td>
<td>Coroner’s/autopsy Report</td>
</tr>
<tr>
<td>Public Hospitals, Multi-Purpose Services</td>
<td>All information as listed for Admitted Patients with Mode of Separation indicating “Died”.</td>
</tr>
<tr>
<td>Private Hospitals, Private Day Procedure Centres, Public Residential Aged Care Facilities, Private Residential Aged Care Facilities.</td>
<td>All information as listed for Admitted Patients with Mode of Separation indicating “Died”.</td>
</tr>
<tr>
<td>Australian Bureau of Statistics</td>
<td>Coded cause of death data in an electronic format</td>
</tr>
<tr>
<td>NSW Registry of Births, Deaths and Marriages</td>
<td>Death notification data in an electronic format</td>
</tr>
</tbody>
</table>

12.5 How to Submit a Notification

The table below shows how a notification must be submitted to the NSW Central Cancer Registry.

<table>
<thead>
<tr>
<th>Notifier</th>
<th>How to Submit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Departments of Forensic Medicine</td>
<td>Mail or fax a copy of the coroner’s/autopsy report.</td>
</tr>
<tr>
<td>Public Hospitals, and Multi-Purpose Services</td>
<td>Notification is entered into the Patient Administration System and sent via the admitted patient extract to the Health Information Exchange.</td>
</tr>
<tr>
<td>Private Hospitals, Day Procedure Centres</td>
<td>Notification via the Cancer Notification Portal or mail or fax the NSW Central Cancer Registry Form to the NSW Central Cancer Registry.</td>
</tr>
<tr>
<td>Residential Aged Care Facilities</td>
<td>Notification via the Cancer Notification Portal or mail or fax the NSW Central Cancer Registry Form to the NSW Central Cancer Registry.</td>
</tr>
<tr>
<td>Australian Bureau of Statistics</td>
<td>On media via courier or secure post to the NSW Central Cancer Registry.</td>
</tr>
<tr>
<td>NSW Registry of Births, Deaths and Marriages</td>
<td>Encrypted file via email to <a href="mailto:ccr@cancerinstitute.org.au">ccr@cancerinstitute.org.au</a></td>
</tr>
</tbody>
</table>
9. HEALTH RECORDS AND INFORMATION

Notifications that are sent via secure post or courier must be marked “NSW Central Cancer Registry - Private and Confidential”. Contact details for the NSW Central Cancer Registry are provided in Section 13.

12.6 Requests for further information

After receipt of a notification of a death caused by cancer, the NSW Central Cancer Registry may require further information, and contact the notifier. Responses to requests for further information are required within 10 working days.

For notifications of patients who died as admitted patients, the standard data quality checks will be applied as described in Section 10.

13 Contact details

Further information about the mandatory reporting requirements of the NSW Central Cancer Registry should be directed to the Cancer Notification Manager, NSW Central Cancer Registry.

Contact details for the NSW Central Cancer Registry are provided below:

- **Physical Address:** Cancer Institute NSW
  Australian Technology Park
  Biomedical Building
  Suite 101, 1 Central Avenue
  Eveleigh NSW 2015

- **Secure Post Address:** Locked Mail Bag 1, Kings Cross NSW 1340

- **Phone:** (02) 8374 5749
- **Secure Fax:** (02) 8374 5744

- **E-mail:** ccr@cancerinstitute.org.au

- **Website:** http://www.cancerinstitute.org.au

- **Notification Portal e-mail:** ccr_scnp@cancerinstitute.org.au

- **Cancer Notification Portal website:**
Appendix 1 Notifiable cancers

Full list of cancers to notify to NSW Central Cancer Registry

The table below shows the full list of diseases that must be notified, when paired with the appropriate morphology as described in the summary table in Section 3.

<table>
<thead>
<tr>
<th>Disease Description</th>
<th>ICD-10-AM 6th Edition Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human immunodeficiency virus [HIV] disease resulting in malignant neoplasms</td>
<td>B21</td>
</tr>
<tr>
<td>Malignant neoplasm of lip</td>
<td>C00</td>
</tr>
<tr>
<td>Malignant neoplasm of external upper lip</td>
<td>C00.0</td>
</tr>
<tr>
<td>Malignant neoplasm of external lower lip</td>
<td>C00.1</td>
</tr>
<tr>
<td>Malignant neoplasm of external lip, unspecified</td>
<td>C00.2</td>
</tr>
<tr>
<td>Malignant neoplasm of upper lip, inner aspect</td>
<td>C00.3</td>
</tr>
<tr>
<td>Malignant neoplasm of lower lip, inner aspect</td>
<td>C00.4</td>
</tr>
<tr>
<td>Malignant neoplasm of lip, unspecified, inner aspect</td>
<td>C00.5</td>
</tr>
<tr>
<td>Malignant neoplasm of commissure of lip</td>
<td>C00.6</td>
</tr>
<tr>
<td>Overlapping malignant lesion of lip</td>
<td>C00.8</td>
</tr>
<tr>
<td>Malignant neoplasm of lip, unspecified</td>
<td>C00.9</td>
</tr>
<tr>
<td>Malignant neoplasm of base of tongue</td>
<td>C01</td>
</tr>
<tr>
<td>Malignant neoplasm of other and unspecified parts of tongue</td>
<td>C02</td>
</tr>
<tr>
<td>Malignant neoplasm of dorsal surface of tongue</td>
<td>C02.0</td>
</tr>
<tr>
<td>Malignant neoplasm of border of tongue</td>
<td>C02.1</td>
</tr>
<tr>
<td>Malignant neoplasm of ventral surface of tongue</td>
<td>C02.2</td>
</tr>
<tr>
<td>Malignant neoplasm of anterior two-thirds of tongue, part unspecified</td>
<td>C02.3</td>
</tr>
<tr>
<td>Malignant neoplasm of lingual tonsil</td>
<td>C02.4</td>
</tr>
<tr>
<td>Malignant neoplasm of overlapping lesion of tongue</td>
<td>C02.8</td>
</tr>
<tr>
<td>Malignant neoplasm of tongue, unspecified</td>
<td>C02.9</td>
</tr>
<tr>
<td>Malignant neoplasm of gum</td>
<td>C03</td>
</tr>
<tr>
<td>Malignant neoplasm of upper gum</td>
<td>C03.0</td>
</tr>
<tr>
<td>Malignant neoplasm of lower gum</td>
<td>C03.1</td>
</tr>
<tr>
<td>Malignant neoplasm of gum, unspecified</td>
<td>C03.9</td>
</tr>
<tr>
<td>Malignant neoplasm of floor of mouth</td>
<td>C04</td>
</tr>
<tr>
<td>Malignant neoplasm of anterior floor of mouth</td>
<td>C04.0</td>
</tr>
<tr>
<td>Malignant neoplasm of lateral floor of mouth</td>
<td>C04.1</td>
</tr>
<tr>
<td>Overlapping malignant lesion of floor of mouth</td>
<td>C04.8</td>
</tr>
<tr>
<td>Malignant neoplasm of floor of mouth, unspecified</td>
<td>C04.9</td>
</tr>
<tr>
<td>Malignant neoplasm of palate</td>
<td>C05</td>
</tr>
<tr>
<td>Malignant neoplasm of hard palate</td>
<td>C05.0</td>
</tr>
<tr>
<td>Malignant neoplasm of soft palate</td>
<td>C05.1</td>
</tr>
<tr>
<td>Malignant neoplasm of uvula</td>
<td>C05.2</td>
</tr>
<tr>
<td>Overlapping malignant lesion of palate</td>
<td>C05.8</td>
</tr>
<tr>
<td>Malignant neoplasm of palate, unspecified</td>
<td>C05.9</td>
</tr>
<tr>
<td>Malignant neoplasm of other and unspecified parts of mouth</td>
<td>C06</td>
</tr>
<tr>
<td>Malignant neoplasm of cheek mucosa</td>
<td>C06.0</td>
</tr>
<tr>
<td>Malignant neoplasm of vestibule of mouth</td>
<td>C06.1</td>
</tr>
<tr>
<td>Malignant neoplasm of retromolar area</td>
<td>C06.2</td>
</tr>
<tr>
<td>Overlapping malignant lesion of other and unspecified parts of mouth</td>
<td>C06.8</td>
</tr>
<tr>
<td>Malignant neoplasm of mouth, unspecified</td>
<td>C06.9</td>
</tr>
<tr>
<td>Malignant neoplasm of parotid gland</td>
<td>C07</td>
</tr>
<tr>
<td>Malignant neoplasm of other and unspecified major salivary glands</td>
<td>C08</td>
</tr>
<tr>
<td>Malignant neoplasm of submandibular gland</td>
<td>C08.0</td>
</tr>
<tr>
<td>Malignant neoplasm of sublingual gland</td>
<td>C08.1</td>
</tr>
</tbody>
</table>
9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overlapping malignant lesion of major salivary glands</td>
<td>C08.8</td>
</tr>
<tr>
<td>Malignant neoplasm of major salivary gland, unspecified</td>
<td>C08.9</td>
</tr>
<tr>
<td>Malignant neoplasm of tonsil</td>
<td>C09</td>
</tr>
<tr>
<td>Malignant neoplasm of tonsillar fossa</td>
<td>C09.0</td>
</tr>
<tr>
<td>Malignant neoplasm of tonsillar piller (anterior)(posterior)</td>
<td>C09.1</td>
</tr>
<tr>
<td>Overlapping malignant lesion of tonsil</td>
<td>C09.8</td>
</tr>
<tr>
<td>Malignant neoplasm of tonsil, unspecified</td>
<td>C09.9</td>
</tr>
<tr>
<td>Malignant neoplasm of oropharynx</td>
<td>C10</td>
</tr>
<tr>
<td>Malignant neoplasm of vallecula</td>
<td>C10.0</td>
</tr>
<tr>
<td>Malignant neoplasm of anterior surface of epiglottis</td>
<td>C10.1</td>
</tr>
<tr>
<td>Malignant neoplasm of lateral wall of oropharynx</td>
<td>C10.2</td>
</tr>
<tr>
<td>Malignant neoplasm of posterior wall of oropharynx</td>
<td>C10.3</td>
</tr>
<tr>
<td>Malignant neoplasm of branchial cleft</td>
<td>C10.4</td>
</tr>
<tr>
<td>Overlapping malignant lesion of oropharynx</td>
<td>C10.8</td>
</tr>
<tr>
<td>Malignant neoplasm of oropharynx, unspecified</td>
<td>C10.9</td>
</tr>
<tr>
<td>Malignant neoplasm of nasopharynx</td>
<td>C11</td>
</tr>
<tr>
<td>Malignant neoplasm of superior wall of nasopharynx</td>
<td>C11.0</td>
</tr>
<tr>
<td>Malignant neoplasm of posterior wall of nasopharynx</td>
<td>C11.1</td>
</tr>
<tr>
<td>Malignant neoplasm of lateral wall of nasopharynx</td>
<td>C11.2</td>
</tr>
<tr>
<td>Malignant neoplasm of anterior wall of nasopharynx</td>
<td>C11.3</td>
</tr>
<tr>
<td>Overlapping malignant lesion of nasopharynx</td>
<td>C11.8</td>
</tr>
<tr>
<td>Malignant neoplasm of nasopharynx, unspecified</td>
<td>C11.9</td>
</tr>
<tr>
<td>Malignant neoplasm of pyriform sinus</td>
<td>C12</td>
</tr>
<tr>
<td>Malignant neoplasm of hypopharynx</td>
<td>C13</td>
</tr>
<tr>
<td>Malignant neoplasm of postericoid region</td>
<td>C13.0</td>
</tr>
<tr>
<td>Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect</td>
<td>C13.1</td>
</tr>
<tr>
<td>Malignant neoplasm of posterior wall of hypopharynx</td>
<td>C13.2</td>
</tr>
<tr>
<td>Overlapping malignant lesion of hypopharynx</td>
<td>C13.8</td>
</tr>
<tr>
<td>Malignant neoplasm of hypopharynx, unspecified</td>
<td>C13.9</td>
</tr>
<tr>
<td>Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx</td>
<td>C14</td>
</tr>
<tr>
<td>Malignant neoplasm of pharynx, unspecified</td>
<td>C14.0</td>
</tr>
<tr>
<td>Malignant neoplasm of Waldeyer ring</td>
<td>C14.2</td>
</tr>
<tr>
<td>Overlapping malignant lesion of lip, oral cavity and pharynx</td>
<td>C14.8</td>
</tr>
<tr>
<td>Malignant neoplasm of oesophagus</td>
<td>C15</td>
</tr>
<tr>
<td>Malignant neoplasm of cervical part of oesophagus</td>
<td>C15.0</td>
</tr>
<tr>
<td>Malignant neoplasm of thoracic part of oesophagus</td>
<td>C15.1</td>
</tr>
<tr>
<td>Malignant neoplasm of abdominal part of oesophagus</td>
<td>C15.2</td>
</tr>
<tr>
<td>Malignant neoplasm of upper third of oesophagus</td>
<td>C15.3</td>
</tr>
<tr>
<td>Malignant neoplasm of middle third of oesophagus</td>
<td>C15.4</td>
</tr>
<tr>
<td>Malignant neoplasm of lower third of oesophagus</td>
<td>C15.5</td>
</tr>
<tr>
<td>Overlapping malignant lesion of oesophagus</td>
<td>C15.8</td>
</tr>
<tr>
<td>Malignant neoplasm of oesophagus, unspecified</td>
<td>C15.9</td>
</tr>
<tr>
<td>Malignant neoplasm of stomach</td>
<td>C16</td>
</tr>
<tr>
<td>Malignant neoplasm of cardia</td>
<td>C16.0</td>
</tr>
<tr>
<td>Malignant neoplasm of fundus of stomach</td>
<td>C16.1</td>
</tr>
<tr>
<td>Malignant neoplasm of body of stomach</td>
<td>C16.2</td>
</tr>
<tr>
<td>Malignant neoplasm of pyloric antrum</td>
<td>C16.3</td>
</tr>
<tr>
<td>Malignant neoplasm of pylorus</td>
<td>C16.4</td>
</tr>
<tr>
<td>Malignant neoplasm of lesser curvature of stomach, unspecified</td>
<td>C16.5</td>
</tr>
<tr>
<td>Malignant neoplasm of greater curvature of stomach, unspecified</td>
<td>C16.6</td>
</tr>
<tr>
<td>Overlapping malignant lesion of stomach</td>
<td>C16.8</td>
</tr>
<tr>
<td>Malignant neoplasm of stomach, unspecified</td>
<td>C16.9</td>
</tr>
<tr>
<td>Malignant neoplasm of small intestine</td>
<td>C17</td>
</tr>
</tbody>
</table>
9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasm of duodenum</td>
<td>C17.0</td>
</tr>
<tr>
<td>Malignant neoplasm of jejunum</td>
<td>C17.1</td>
</tr>
<tr>
<td>Malignant neoplasm of ileum</td>
<td>C17.2</td>
</tr>
<tr>
<td>Malignant neoplasm of Meckel’s diverticulum</td>
<td>C17.3</td>
</tr>
<tr>
<td>Overlapping malignant lesion of small intestine</td>
<td>C17.8</td>
</tr>
<tr>
<td>Malignant neoplasm of small intestine, unspecified</td>
<td>C17.9</td>
</tr>
<tr>
<td>Malignant neoplasm of colon</td>
<td>C18.0</td>
</tr>
<tr>
<td>Malignant neoplasm of caecum</td>
<td>C18.1</td>
</tr>
<tr>
<td>Malignant neoplasm of ascending colon</td>
<td>C18.2</td>
</tr>
<tr>
<td>Malignant neoplasm of hepatic flexure</td>
<td>C18.3</td>
</tr>
<tr>
<td>Malignant neoplasm of transverse colon</td>
<td>C18.4</td>
</tr>
<tr>
<td>Malignant neoplasm of splenic flexure</td>
<td>C18.5</td>
</tr>
<tr>
<td>Malignant neoplasm of descending colon</td>
<td>C18.6</td>
</tr>
<tr>
<td>Malignant neoplasm of sigmoid colon</td>
<td>C18.7</td>
</tr>
<tr>
<td>Overlapping malignant lesion of colon</td>
<td>C18.8</td>
</tr>
<tr>
<td>Malignant neoplasm of colon, unspecified part</td>
<td>C18.9</td>
</tr>
<tr>
<td>Malignant neoplasm of rectosigmoid junction</td>
<td>C19.0</td>
</tr>
<tr>
<td>Malignant neoplasm of rectum</td>
<td>C20.0</td>
</tr>
<tr>
<td>Malignant neoplasm of anus and anal canal</td>
<td>C21.0</td>
</tr>
<tr>
<td>Malignant neoplasm of anus, unspecified</td>
<td>C21.0</td>
</tr>
<tr>
<td>Malignant neoplasm of anal canal</td>
<td>C21.1</td>
</tr>
<tr>
<td>Malignant neoplasm of cloacogenic zone</td>
<td>C21.2</td>
</tr>
<tr>
<td>Overlapping malignant lesion of rectum, anus and anal canal</td>
<td>C21.8</td>
</tr>
<tr>
<td>Malignant neoplasm of liver and intrahepatic bile ducts</td>
<td>C22.0</td>
</tr>
<tr>
<td>Liver cell carcinoma</td>
<td>C22.1</td>
</tr>
<tr>
<td>Intrahepatic bile duct carcinoma</td>
<td>C22.2</td>
</tr>
<tr>
<td>Angiosarcoma of liver</td>
<td>C22.3</td>
</tr>
<tr>
<td>Other sarcomas of liver</td>
<td>C22.4</td>
</tr>
<tr>
<td>Other specified carcinomas of liver</td>
<td>C22.7</td>
</tr>
<tr>
<td>Malignant neoplasm of liver, unspecified</td>
<td>C22.9</td>
</tr>
<tr>
<td>Malignant neoplasm of gallbladder</td>
<td>C23.0</td>
</tr>
<tr>
<td>Malignant neoplasm of other and unspecified parts of biliary tract</td>
<td>C24.0</td>
</tr>
<tr>
<td>Malignant neoplasm of extrahepatic bile duct</td>
<td>C24.1</td>
</tr>
<tr>
<td>Malignant neoplasm of ampulla of Vater</td>
<td>C24.1</td>
</tr>
<tr>
<td>Overlapping malignant lesion of biliary tract</td>
<td>C24.8</td>
</tr>
<tr>
<td>Malignant neoplasm of biliary tract, unspecified</td>
<td>C24.9</td>
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### 9. HEALTH RECORDS AND INFORMATION

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| Subacute leukaemia of unspecified cell type, without mention of remission | C95.20 |
| Subacute leukaemia of unspecified cell type, in remission       | C95.21 |
| Other leukaemia of unspecified cell type                        | C95.7  |
| Other leukaemia of unspecified cell type, without mention of remission | C95.70 |
| Other leukaemia of unspecified cell type, in remission          | C95.71 |
| Leukaemia, unspecified                                         | C95.9  |
| Leukaemia, unspecified, without mention of remission            | C95.90 |
| Leukaemia, unspecified, in remission                           | C95.91 |
| Other and unspecified malignant neoplasms of lymphoid, haematopoietic and related tissue | C96 |</p>
<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letterer-Siwe disease</td>
<td>C96.0</td>
</tr>
<tr>
<td>Malignant histiocytosis</td>
<td>C96.1</td>
</tr>
<tr>
<td>Malignant mast cell tumour</td>
<td>C96.2</td>
</tr>
<tr>
<td>True histiocytic lymphoma</td>
<td>C96.3</td>
</tr>
<tr>
<td>Other specified malignant neoplasms of lymphoid, haematopoietic and related tissue</td>
<td>C96.7</td>
</tr>
<tr>
<td>Malignant neoplasm of lymphoid, haematopoietic and related tissue, unspecified</td>
<td>C96.9</td>
</tr>
<tr>
<td>Malignant neoplasms of independent (primary) multiple sites</td>
<td>C97</td>
</tr>
<tr>
<td>Melanoma in situ</td>
<td>D03</td>
</tr>
<tr>
<td>Melanoma in situ of lip</td>
<td>D03.0</td>
</tr>
<tr>
<td>Melanoma in situ of eyelid, including canthus</td>
<td>D03.1</td>
</tr>
<tr>
<td>Melanoma in situ of ear and external auricular canal</td>
<td>D03.2</td>
</tr>
<tr>
<td>Melanoma in situ of other and unspecified parts of face</td>
<td>D03.3</td>
</tr>
<tr>
<td>Melanoma in situ of scalp and neck</td>
<td>D03.4</td>
</tr>
<tr>
<td>Melanoma in situ of trunk</td>
<td>D03.5</td>
</tr>
<tr>
<td>Melanoma in situ of upper limb, including shoulder</td>
<td>D03.6</td>
</tr>
<tr>
<td>Melanoma in situ of lower limb, including hip</td>
<td>D03.7</td>
</tr>
<tr>
<td>Melanoma in situ of other sites</td>
<td>D03.8</td>
</tr>
<tr>
<td>Melanoma in situ, unspecified</td>
<td>D03.9</td>
</tr>
<tr>
<td>Carcinoma in situ of breast</td>
<td>D05</td>
</tr>
<tr>
<td>Lobular carcinoma in situ of breast</td>
<td>D05.0</td>
</tr>
<tr>
<td>Intraductal carcinoma in situ of breast</td>
<td>D05.1</td>
</tr>
<tr>
<td>Other carcinoma in situ of breast</td>
<td>D05.7</td>
</tr>
<tr>
<td>Carcinoma in situ of breast, unspecified</td>
<td>D05.9</td>
</tr>
<tr>
<td>Polycythaemia vera</td>
<td>D45</td>
</tr>
<tr>
<td>Myelodysplastic syndromes</td>
<td>D46</td>
</tr>
<tr>
<td>Refractory anaemia without sideroblasts, so stated</td>
<td>D46.0</td>
</tr>
<tr>
<td>Refractory anaemia with sideroblasts</td>
<td>D46.1</td>
</tr>
<tr>
<td>Refractory anaemia with excess of blasts</td>
<td>D46.2</td>
</tr>
<tr>
<td>Refractory anaemia with excess of blasts with transformation</td>
<td>D46.3</td>
</tr>
<tr>
<td>Refractory anaemia, unspecified</td>
<td>D46.4</td>
</tr>
<tr>
<td>Other myelodysplastic syndromes</td>
<td>D46.7</td>
</tr>
<tr>
<td>Myelodysplastic syndrome, unspecified</td>
<td>D46.9</td>
</tr>
<tr>
<td>Chronic myeloproliferative disease</td>
<td>D47.1</td>
</tr>
<tr>
<td>Essential (haemorrhagic) thrombocythaemia</td>
<td>D47.3</td>
</tr>
<tr>
<td>Lymphomatoid papulosi</td>
<td>L41.2</td>
</tr>
</tbody>
</table>
Notifiable Cancers which may not be easily recognised as cancer

Below is a list of cancers which are notifiable to the NSW Central Cancer Registry, but which may not be easily recognised as cancer by administrative staff.

- Acute erythremia (acute erythremic myelosis)
- Adamaninoma (malignant)
- Adenocanthoma (malignant)
- Alpha heavy chain disease
- Ameloblastoma/Adamantinoma (malignant)
- Angioendothelioma (malignant)
- Astrocytoma
- Brenner tumour (malignant)
- Burkitt’s tumour
- Carcinoid tumour
- Chloroma
- Chordoma
- Chronic erythremia (chronic erythremic myelosis)
- Di Guglielmo’s disease
- Dysgerminoma
- Endodermal sinus tumour
- Ependymoma
- Epithelioid hemangioendothelioma (malignant)
- Erythremia
- Ewing’s tumour (Ewing’s sarcoma)
- Fibrous histiocytoma (malignant)
- Gamma heavy chain disease (Franklin’s disease)
- Ganglioneuroblastoma
- Germ cell tumours
- Germinoma
- Glioblastoma
- Glioma (malignant)
- Gliomatosis cerebri
- Grawitz tumour
- Hepatoblastoma (embryonal hepatoma)
- Histiocytic medullary reticulosis
- Histiocytosis X (acute, malignant)
- Hodgkin’s disease
- Hutchinson’s Melanotic Freckle
- Immunoproliferative disease
- Krukenberg tumour
- Letterer-Siwe’s disease
- Linitis plastica
- Medulloblastoma
- Merkel cell tumour
- Mesothelioma
- Mullerian mixed tumour
- Mycosis fungoides
- Myelofibrosis (acute, chronic, idiopathic, with myeloid metaplasia, with panmyelosis, as a result of myeloproliferative disease)
9. HEALTH RECORDS AND INFORMATION

- Neuroectodermal tumour
- Nephroblastoma
- Neuroblastoma
- Neuroendocrine tumours
- Paget’s disease, extra mammary
- Phaeochromocytoma (malignant)
- Phyllodes tumour (malignant)
- Pineoblastoma (malignant)
- Plasmacytoma (malignant)
- Polycythaemia vera
- Pseudomyxoma peritonei
- Retinoblastoma
- Richter’s syndrome
- Seminoma
- Sézary disease (syndrome)
- Sympathicoblastoma
- Teratoma (malignant)
- Thecoma (malignant)
- Thymoma (malignant)
- Waldenstrom’s macroglobulinaemia
- Wilm’s tumour
- Yolk sac tumour (malignant)
Appendix 2 Cancer Notification Portal extract layout

The table below shows the format for reporting cancer notifications electronically via the Cancer Notification Portal. This should be used in conjunction with the NSW Central Cancer Registry Data Dictionary. This is available on the Cancer Institute NSW’s website [http://www.cancerinstitute.org.au](http://www.cancerinstitute.org.au)

**NSW Central Cancer Registry: Extract specification for Cancer Notification Portal**

<table>
<thead>
<tr>
<th>Data Record</th>
<th>Size</th>
<th>Start</th>
<th>End</th>
<th>Mandatory?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECORD TYPE</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Yes</td>
<td>Must be “T”</td>
</tr>
<tr>
<td>HOSPITAL_CODE</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>Yes</td>
<td>Facility code (as for header record)</td>
</tr>
<tr>
<td>NUMBER RECORDS</td>
<td>5</td>
<td>6</td>
<td>10</td>
<td>Yes</td>
<td>Number of records following. Right-justified zero-filled (e.g. 00023 = 23)</td>
</tr>
<tr>
<td>PRODUCTION_DATE</td>
<td>8</td>
<td>11</td>
<td>17</td>
<td>No</td>
<td>YYYYYMDD</td>
</tr>
<tr>
<td>SURNAME</td>
<td>24</td>
<td>6</td>
<td>29</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>GIVEN_NAME1</td>
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<td>30</td>
<td>41</td>
<td>Yes</td>
<td>First given name</td>
</tr>
<tr>
<td>GIVEN_NAME2</td>
<td>12</td>
<td>42</td>
<td>53</td>
<td>No</td>
<td>Second given name</td>
</tr>
<tr>
<td>ALIAS1 SURNAME</td>
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<td>54</td>
<td>77</td>
<td>No</td>
<td>Alias 1: Surname (up to 3 aliases may be provided)</td>
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<tr>
<td>ALIAS1 GIVEN_NAME1</td>
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<td>78</td>
<td>89</td>
<td>No</td>
<td>Alias 1: First given name</td>
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<tr>
<td>ALIAS1 GIVEN_NAME2</td>
<td>12</td>
<td>90</td>
<td>101</td>
<td>No</td>
<td>Alias 1: Second given name</td>
</tr>
<tr>
<td>ALIAS2 SURNAME</td>
<td>24</td>
<td>102</td>
<td>125</td>
<td>No</td>
<td>Alias 2: Surname</td>
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<tr>
<td>ALIAS2 GIVEN_NAME1</td>
<td>12</td>
<td>126</td>
<td>137</td>
<td>No</td>
<td>Alias 2: First given name</td>
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<tr>
<td>ALIAS2 GIVEN_NAME2</td>
<td>12</td>
<td>138</td>
<td>149</td>
<td>No</td>
<td>Alias 2: Second given name</td>
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<tr>
<td>ALIAS3 SURNAME</td>
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<td>150</td>
<td>173</td>
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<td>Alias 3: Surname</td>
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<td>ALIAS3 GIVEN_NAME1</td>
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<td>No</td>
<td>Alias 3: Second given name</td>
</tr>
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<td>SEX</td>
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<td>198</td>
<td>198</td>
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<td>Sex</td>
</tr>
<tr>
<td>ABORIGINAL_TSI</td>
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<td>199</td>
<td>199</td>
<td>No</td>
<td>Aboriginal and Torres Strait Islander origin</td>
</tr>
<tr>
<td>MEDICAL_RECORD_NO</td>
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<td>200</td>
<td>206</td>
<td>No</td>
<td>Medical record number. Allocated by Notifying institution</td>
</tr>
<tr>
<td>DATE_BIRTH</td>
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<td>207</td>
<td>214</td>
<td>Yes</td>
<td>Date of birth. Record as YYYYYMDD</td>
</tr>
<tr>
<td>FLAT NO</td>
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<td>215</td>
<td>219</td>
<td>No</td>
<td>Address fields must be split up as indicated: Flat number</td>
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<tr>
<td>STREET NO</td>
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<td>220</td>
<td>223</td>
<td>No</td>
<td>Street number</td>
</tr>
<tr>
<td>STREET_NAME</td>
<td>24</td>
<td>224</td>
<td>247</td>
<td>Yes</td>
<td>Street name</td>
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</table>
### HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>Data Record</th>
<th>Size</th>
<th>Start</th>
<th>End</th>
<th>Mandatory?</th>
<th>Notes</th>
</tr>
</thead>
</table>
| STREET TYPE          | 2    | 248   | 249 | No         | AR = Arcade  
AV = Avenue  
BL = Boulevard  
CC = Circle  
CI = Circuit  
CL = Close  
CR = Crescent  
CT = Court  
DR = Drive  
ES = Esplanade  
GD = Gardens  
GL = Glen  
GR = Grove  
HW = Highway  
JN = Junction  
LN = Lane  
ML = Mall  
MW = Mews  
PD = Parade  
PK = Park  
PL = Place  
PW = Parkway  
PZ = PLAZA  
RD = ROAD  
SQ = SQUARE  
ST = STREET  
TC = TERRACE  
WY = WAY  
XX = N/A |
| LOCALITY             | 24   | 250   | 273 | Yes        | Town/Suburb |
| POSTCODE             | 4    | 274   | 277 | Yes        | Postcode |
| COUNTRY_BIRTH        | 4    | 278   | 281 | No         | Country of birth. Record using the SACC (ABS catalogue no. 1269.0 (Revision 2.03)) |
| MEDICARE_NO          | 10   | 282   | 291 | No         | Medicare number |
| CASE_DOCTOR          | 24   | 292   | 315 | No         | Name of doctor in charge of case (free text) |
| GP                   | 24   | 316   | 339 | No         | Name of GP (or referring doctor if GP not known) (free text) |
| GP_ADDRESS           | 40   | 340   | 379 | No         | Address of GP (or referring doctor if GP not known) (free text) |
| ADMISSION_DATE       | 8    | 380   | 387 | Yes        | Date of admission to hospital. Record as YYYYMMDD  
Note: For non-admitted patients record date of attendance |
| DISCHARGE_DATE       | 8    | 388   | 395 | Yes        | Date of separation from hospital record as YYYYMMDD  
Note: For non-admitted patients leave blank |
| DISCHARGE_STATUS     | 2    | 396   | 397 | Yes        | For PUBLIC notifiers: use Department of Health specification for Mode of separation.  
For PRIVATE notifiers:  
01 = ALIVE  
07 = DEAD  
Note: For non-admitted patients must be 01 |
| GT_ONE_PRIMARY?      | 1    | 398   | 398 | No         | Is there more than one primary cancer?  
1 = YES  
2 = NO |
| DATE_DIAGNOSIS       | 6    | 399   | 404 | Yes        | Date of first diagnosis of this primary cancer. Record as YYYYMM.  
Note: If unknown, record 999901. If only the year is known, record as YYYY99. |
<table>
<thead>
<tr>
<th>Data Record</th>
<th>Size</th>
<th>Start</th>
<th>End</th>
<th>Mandatory?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESIDENCE_AT_DIAG</td>
<td>1</td>
<td>405</td>
<td>405</td>
<td>Yes</td>
<td>State of usual residence at diagnosis: 1 = NSW (incl Jervis Bay) OR Unknown 2 = VIC 3 = QLD 4 = SA 5 = WA (incl Christmas and Cocos Is) 6 = TAS 7 = NT 8 = ACT 9 = Overseas Used for identification of cases of cancer in non-NSW and non-ACT residents</td>
</tr>
<tr>
<td>LATERALITY</td>
<td>1</td>
<td>406</td>
<td>406</td>
<td>No</td>
<td>Cancer of paired organs: 1 = Left 2 = Right 3 = Not applicable 9 = Unknown</td>
</tr>
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<td>PLACE_PATH_DONE</td>
<td>25</td>
<td>407</td>
<td>431</td>
<td>No</td>
<td>Name of Lab where pathology performed (free text) Useful for further inquiries</td>
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<td>BEST BASIS DIAG</td>
<td>1</td>
<td>432</td>
<td>432</td>
<td>Yes</td>
<td>Best basis for diagnosis at this admission: 1 = Histology 2 = Cytology (including blood or bone marrow smear) 3 = Other (clinical imaging, biochemical etc)</td>
</tr>
<tr>
<td>DSPR_THIS_ADMISSION</td>
<td>1</td>
<td>433</td>
<td>433</td>
<td>Yes</td>
<td>Degree of spread of cancer at this admission or attendance: 1 = Localised to tissue of origin 2 = Invasion of adjacent tissue or organs 3 = Regional lymph nodes 4 = Distant metastases 5 = Not applicable 9 = Unknown</td>
</tr>
<tr>
<td>REASON_ADMIT</td>
<td>1</td>
<td>434</td>
<td>434</td>
<td>No</td>
<td>Was this admission for Cancer? 1 = YES 2 = NO</td>
</tr>
<tr>
<td>PRINCIPAL_TOPOGRAPHY</td>
<td>8</td>
<td>435</td>
<td>442</td>
<td>Yes</td>
<td>Valid topography code (ICD-10-AM, Volume 1 Tabular list of diseases) Topography formats: CNN, CNN,N, CNN.NN or (CNNN, CNNNN) Where C = alpha character, N = numeric</td>
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<tr>
<td>PRINCIPAL_MORPHOLOGY</td>
<td>8</td>
<td>443</td>
<td>450</td>
<td>Yes</td>
<td>Valid morphology code (ICD-10-AM, Volume 1 Tabular list of diseases) Morphology formats: MNNNN/N or (MNNNNN) Where M = character “M”, N = numeric</td>
</tr>
<tr>
<td>ADDITIONAL_CODES</td>
<td>8</td>
<td>451</td>
<td>458</td>
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<td>Valid diagnosis code(s) (ICD-10-AM, Volume 1, Tabular list of diseases), formats: CNN, CNN.N, CNN.NN or (CNNN, CNNNNN) Where C = alpha character, N = numeric</td>
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<td>ADDITIONAL_CODES</td>
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<td>459</td>
<td>466</td>
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<tr>
<td>ADDITIONAL_CODES</td>
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<td>467</td>
<td>474</td>
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<td>Valid diagnosis code(s) (ICD-10-AM, Volume 1, Tabular list of diseases), formats: CNN, CNN.N, CNN.NN or (CNNN, CNNNNN) Where C = alpha character, N = numeric</td>
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### 9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Start</th>
<th>Length</th>
<th>Required</th>
<th>Description</th>
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<tr>
<td>ADDITIONAL_CODES</td>
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<td>499</td>
<td>No</td>
<td>Valid diagnosis code(s) (ICD-10-AM, Volume 1, Tabular list of diseases), formats: CNN, CNN.N, CNN.NN or (CNNN, CNNNNN) Where C = alpha character, N = numeric</td>
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<tr>
<td>ADDITIONAL_CODES</td>
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<td>507</td>
<td>No</td>
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<tr>
<td>PRINCIPAL_DIAGNOSIS</td>
<td>8</td>
<td>515</td>
<td>No</td>
<td>Principal diagnosis this admission. Valid diagnosis code (ICD-10-AM, Volume 1, Tabular list of diseases). Formats: CNN, CNN.N, CNN.NN or (CNNN, CNNNNN) Where C = alpha character, N = numeric</td>
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<tr>
<td>PRINCIPAL_PROCEDURE</td>
<td>8</td>
<td>523</td>
<td>No</td>
<td>Valid Procedure code (ICD-10-AM, Volume 3, Tabular list of procedures (ACHI)) NNNNN-N or NNNNNNN Where N = numeric</td>
</tr>
<tr>
<td>FILLER</td>
<td>60</td>
<td>531</td>
<td>Yes</td>
<td>Leave blank</td>
</tr>
</tbody>
</table>

Notes:
1. A Header record must be provided.
2. The file length must be exactly 590 or the file will be rejected by the ‘Cancer Notification Portal’.
9. HEALTH RECORDS AND INFORMATION

CHILD WELLBEING AND CHILD PROTECTION POLICIES AND PROCEDURES FOR NSW HEALTH (PD2013_007)


PURPOSE

This policy articulates the professional and legal responsibilities of all health workers to promote the health, safety, welfare and well-being of children and young people, working collaboratively with interagency partners in the shared system of child protection in NSW. These responsibilities apply whether workers are providing health care directly to children and young people or to adult clients who are parents/carers or are pregnant.

This policy informs Local Health Districts, Specialty Health Networks, other health services and health workers about the tools and resources available and the interagency arrangements in place to assist them to meet their responsibilities and provide a consistent NSW Health response to child protection and wellbeing.

MANDATORY REQUIREMENTS

Every health worker has a responsibility to protect the health, safety, welfare and wellbeing of children or young people with whom they have contact.

The legal responsibilities of health services and health workers are identified in the following legislation:

*Children and Young Persons (Care and Protection) Act 1998*

- Collaborate with interagency partners and comply with information exchange provisions to promote the safety, welfare and wellbeing of children and young people, including taking reasonable steps to coordinate the provision of services with other agencies;
- Meet requirements for mandatory reporting of children and reporting of young people (or classes/groups of children or young people) at suspected risk of significant harm (ROSH);
- Report unborn children where it is suspected they may be at ROSH after their birth;
- Respond to the needs of children and young people after making a report to Community Services or to the NSW Health Child Wellbeing Unit;
- Respond to Community Services’ and Children’s Court requests to provide health services and or Community Services and Police Force requests to provide medical examinations and treatment;
- Assist with Children’s Court proceedings when required.


- Meet requirements to ensure that only people with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years).
Ombudsman Act 1974

- Maintain systems to prevent ‘reportable conduct’ by health workers and for reporting and responding to alleged reportable conduct involving NSW Health employees.

The policy responsibilities of health workers are to:
- Recognise and respond appropriately to the vulnerabilities, risks and needs of families, children and young people when providing any health service;
- Collaborate across NSW Health services and with interagency partners to support and strengthen families and promote child health, safety, welfare and wellbeing;
- Use the Mandatory Reporter Guide and seek assistance from the NSW Health Child Wellbeing Unit to help identify children or young people at suspected risk of significant harm (ROSH);
- Seek assistance from the NSW Health Child Wellbeing Unit and the Family Referral Services to help respond to vulnerable families, children and young people below the ROSH threshold;
- Actively seek feedback from Community Services after making a child protection report and continue to support the child, young person or family consistent with the health worker’s roles and responsibilities;
- Follow the Child Wellbeing and Child Protection - NSW Interagency Guidelines and other agreed interagency procedures when working with children, young people and families, including in relation to information exchange, High Risk Birth Alerts, Prenatal Reporting, escalation of child protection concerns, assumption of care by Community Services and out of home care health assessments;
- Collaborate in joint investigation and response to matters involving alleged child sexual assault or serious child abuse or neglect leading to criminal proceedings; and
- Participate in mandatory and/or other child protection training for NSW Health workers.

IMPLEMENTATION

Chief Executives across the NSW public health system are responsible and accountable for:
1. Ensuring that this policy and the associated Child Wellbeing and Child Protection Fact Sheet for NSW Health Workers are understood and implemented by all health workers; and
2. Enabling frontline staff to operationalise this Policy Statement in accordance with the attached Child Wellbeing and Child Protection Policies and Procedures for NSW Health.

Please go to Child Wellbeing and Child Protection Policies and Procedures for NSW Health to view the above document.
GENERAL RETENTION AND DISPOSAL AUTHORITY – PUBLIC HEALTH SERVICES: PATIENT/CLIENT RECORDS (GDA 17) (IB2004/20)

This Information Bulletin should be read in conjunction with PD2012_069, “Health Care Records – Documentation and Management”.

The attached Authority applies to any organisation, facility or service which is part of the New South Wales public health system and covers records documenting the provision of health care to patients and clients of the public health system and is effective from 19 May 2004. The Authority has been approved by the Board of the State Records Authority in accordance with section 21(3) of the State Records Act 1998 and supersedes the General Disposal Authority – Public Health Services: Patient/Client records (GDA 5) as the legal authority for disposing of records under the State Records Act 1998.

GDA 17 is a more comprehensive authority than the superseded GDA 5 and specifies a substantial number of additional descriptive types of records that will assist users in determining the appropriate retention period. The comprehensive nature of this disposal authority will assist public health organisations to better plan for the management and storage of health care records to meet their operational, regulatory and accountability requirements. Record managers should make themselves fully conversant with the content of the Authority to identify retention periods that are at variance with present practices eg. mental health care, x-ray films.

Public health services are reminded that the authorisations for destruction of records are given in terms of the State Records Act only. A public health service must not destroy any records where they are aware the records may be required as evidence for the purposes of possible legal action or an investigation or inquiry.

General Retention and Disposal Authority
Public Health Services: Patient/Client Records

STATE RECORDS AUTHORITY OF NEW SOUTH WALES
Sydney, Australia

May 2004
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   Patient diagnosis – imaging services
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Part 1: General Retention and Disposal Authority

1.1 Statement of authority

<table>
<thead>
<tr>
<th>GDA No</th>
<th>GDA 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public office</td>
<td>This authority applies to any organisation, facility or service which is part of the New South Wales public health system.</td>
</tr>
<tr>
<td>Scope</td>
<td>This general retention and disposal authority covers records documenting the provision of health care to patients and clients of the public health system.</td>
</tr>
<tr>
<td>Authority</td>
<td>This general retention and disposal authority is issued under section 21(2)(c) of the State Records Act. It has been approved by the Board of the State Records Authority in accordance with section 21(3) of the State Records Act.</td>
</tr>
<tr>
<td>Authorised</td>
<td>19 May 2004</td>
</tr>
</tbody>
</table>

1.2 Scope of patient/client health care records

Patient and client health care records document an individual’s health evaluation, diagnosis, treatment, care, progress and health outcome. These records should be created and maintained in accordance with:

- the principles outlined in PD2012_069 Health Care Records – Documentation and Management
- policies and procedures contained in the Department’s Patient Matters Manual and Health Records and Information Manual for Community Health Facilities
- any guidelines or directives that may be issued by the Department from time to time.

Records relating to the provision of treatment and care to a patient/client include (but are not limited to) records relating to or of a patient’s/client’s:

- admission, including medical and nursing records
- history (medical and social of the patient or their family)
- examination results (physical or other)
- transfer, referral or assessment documentation
- correspondence between the patient or their representative and the health care service
- consultation reports (medical or other)
- principal diagnosis and any other significant diagnosis
- medication or drug orders and medication administered or prescribed (including oral, parenteral and incident reports)
- nursing care (including all versions or revisions of nursing care plans) and clinical pathways observations
- counselling, allied health, social work or other health care professional notes
- allergies or special conditions
- doctor’s or physician’s orders
- all observations and progress notes (including those recorded on separate sheets)
- problem lists (master or other)
- requests for and results or reports of all laboratory, diagnostic or investigative tests or procedures performed (including pathology, X-ray or other medical imaging examinations)
- consent or authority to carry out any treatment, procedure or release of information and certification that consent is informed (including removal or donation of tissue or organs, consent to special procedures etc. See also NSW Health Department PD2005_406 Patient information and consent to medical treatment)
9. HEALTH RECORDS AND INFORMATION

- refusal of treatment or withdrawal of consent
- prenatal, obstetric, newborn and perinatal treatment, care and outcomes (includes newborn records and perinatal morbidity statistics)
- surgical procedure or operation (including pre-operative checklists, anaesthetic records and peri operative nurses reports including instrument and swab count records and post operative observations)
- all therapeutic treatments or procedures (including anti-coagulant, diabetic, dialysis, electric shock therapy (EST) and electro convulsive therapy (ECT))
- statements made for the Police and Coronial Inquest Reports
- discharge (includes final diagnosis, operative procedures, summary or letter of discharge and discharge at own risk or against advice)
- death (includes autopsy or post-mortem reports).

1.3 Quick reference to classes of records covered

<table>
<thead>
<tr>
<th>Records</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT/CLIENT TREATMENT AND CARE</td>
<td>Hospital care</td>
</tr>
<tr>
<td>Community health care</td>
<td>1.2.0</td>
</tr>
<tr>
<td>Oral (dental) health care</td>
<td>1.3.0</td>
</tr>
<tr>
<td>Obstetric/maternity health care</td>
<td>1.4.0</td>
</tr>
<tr>
<td>Psychiatric and mental health care</td>
<td>1.5.0</td>
</tr>
<tr>
<td>Genetic or inherited disorders</td>
<td>1.6.0</td>
</tr>
<tr>
<td>Assisted Reproductive Technology (ART)</td>
<td>1.7.0</td>
</tr>
<tr>
<td>Sexual assault patients</td>
<td>1.8.0</td>
</tr>
<tr>
<td>PANOC Specialist Services</td>
<td>1.9.0</td>
</tr>
<tr>
<td>Radiotherapy treatment</td>
<td>1.10.0</td>
</tr>
<tr>
<td>Electronic health records</td>
<td>1.11.0</td>
</tr>
<tr>
<td>Patient records of significance</td>
<td>1.12.0</td>
</tr>
<tr>
<td>Correspondence</td>
<td>1.13.0</td>
</tr>
<tr>
<td>Legal matters and incident management</td>
<td>1.14.0</td>
</tr>
<tr>
<td>Clinical audits</td>
<td>1.15.0</td>
</tr>
<tr>
<td>Medical certificates</td>
<td>1.16.0</td>
</tr>
<tr>
<td>Sterilisation (instruments)</td>
<td>1.17.0</td>
</tr>
<tr>
<td>Surgical procedures (accountable items)</td>
<td>1.18.0</td>
</tr>
<tr>
<td>PATIENT/CLIENT REGISTRATION AND IDENTIFICATION</td>
<td>Registers and indexes</td>
</tr>
<tr>
<td>Lists and schedules</td>
<td>2.2.0</td>
</tr>
<tr>
<td>Diaries and appointment books or registers</td>
<td>2.3.0</td>
</tr>
<tr>
<td>Censuses and returns</td>
<td>2.4.0</td>
</tr>
<tr>
<td>Ward records</td>
<td>2.5.0</td>
</tr>
<tr>
<td>Electronic patient administration systems</td>
<td>2.6.0</td>
</tr>
<tr>
<td>Health Information Exchange (HIE)</td>
<td>2.7.0</td>
</tr>
<tr>
<td>PATIENT DIAGNOSIS – IMAGING SERVICES</td>
<td>Requests</td>
</tr>
<tr>
<td>Diagnostic reports</td>
<td>3.2.0</td>
</tr>
<tr>
<td>Recordings</td>
<td>3.3.0</td>
</tr>
<tr>
<td>Registers</td>
<td>3.4.0</td>
</tr>
<tr>
<td>Section</td>
<td>Subsection</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PATIENT DIAGNOSIS – PATHOLOGY AND LABORATORY SERVICES</td>
<td>Requests</td>
</tr>
<tr>
<td></td>
<td>Diagnostic results and reports</td>
</tr>
<tr>
<td></td>
<td>Specimens and samples</td>
</tr>
<tr>
<td></td>
<td>Blood bank and blood collection services</td>
</tr>
<tr>
<td></td>
<td>Semen supply</td>
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<tr>
<td></td>
<td>Quality assurance</td>
</tr>
<tr>
<td></td>
<td>Equipment maintenance</td>
</tr>
<tr>
<td></td>
<td>Procedures and methods</td>
</tr>
<tr>
<td>PHARMACEUTICAL SUPPLY AND ADMINISTRATION</td>
<td>Dispensation and supply</td>
</tr>
<tr>
<td>NOTIFICATIONS</td>
<td>Births and deaths</td>
</tr>
<tr>
<td></td>
<td>Health reporting</td>
</tr>
<tr>
<td>PATIENT/CLIENT FINANCE AND PROPERTY MANAGEMENT</td>
<td>Patient property</td>
</tr>
<tr>
<td></td>
<td>Patient/client accounts and finances</td>
</tr>
<tr>
<td></td>
<td>Program of Appliances for Disabled People (PADP)</td>
</tr>
<tr>
<td>RESEARCH MANAGEMENT</td>
<td>Research projects, trials or studies</td>
</tr>
<tr>
<td>RECORDS IMAGING</td>
<td>Records that have been imaged</td>
</tr>
<tr>
<td>PRE 1930 RECORDS</td>
<td></td>
</tr>
</tbody>
</table>
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### 1.4 Retention periods and disposal actions

The following table contains the authorised retention periods and disposal actions applying to the classes of patient and client health care records maintained by public health services.

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
</table>
| 1.0.0 | **PATIENT/CLIENT TREATMENT AND CARE**<sup>19</sup>  
The provision of health assessment, diagnosis, management, treatment and care services and/or advice to individual patients/clients<sup>20</sup>  
- For records created prior to 1930 see **10.0.0**  
- For records relating to:  
  - Assisted Reproductive Technology (ART) see **1.7.0**  
  - genetic or inherited disorders see **1.6.0**  
  - obstetric/maternal health care see **1.4.0**  
  - PANOC Specialist Services patients see **1.9.0**  
  - psychiatric and mental health care see **1.5.0**  
  - radiotherapy treatment see **1.10.0**  
  - sexual assault patients see **1.8.0**  
  - clinical trial participants see **8.0.0**  
- For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning see **9.0.0**  
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 any regulations made under the Act, under which the establishment is licensed. |
| 1.1.0 | **Hospital care**  
Records relating to the provision of treatment and care to individual acute care in-patients, out-patients and accident and emergency patients. |
| 1.1.1 | **Group A Hospitals**<sup>21</sup> (viz Principal Referral Groups A and B, Paediatric Specialist and ungrouped Acute hospitals) - records of discharged or deceased in-patients  
Retain:  
- minimum of 15 years after last attendance or official contact or access by or on behalf of the patient<sup>22</sup>, or  
- until patient attains or would have attained the age of 25 years, whichever is the longer, then destroy |

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<sup>19</sup> See Part 1, section 1.2 above for the scope of records relating to or of a patient’s/client’s treatment and care.

<sup>20</sup> Health care records are to incorporate original observations. Transcribing is not an endorsed practice and should be avoided. Summary records are to be managed in accordance with the purpose for which they were created.

<sup>21</sup> The term ‘teaching’ previously used to categorise hospitals has been replaced with the groups as listed in the NSW Health Department document *NSW Peer Hospital Groups 2001/02*. Hospitals listed under 1.1.1 are groups A1a, A1b, A2 and A3. Hospitals listed under 1.1.2 (Groups B to F) cover all hospitals, nursing homes, rehabilitation facilities, hospices, Multi Purpose Services etc that are not Group A Principal Referral, Paediatric Specialist or ungrouped Acute hospitals. If any further groups are added beyond F they will fall into this category and should retain records in accordance with the minimum retention periods identified for this category.

<sup>22</sup> ‘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’.
### HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.2</td>
<td>Groups B-F Hospitals(^1) - records of discharged or deceased in-patients</td>
<td>Retain: - minimum of 10 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 the longer, then destroy</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>1.1.3</strong> Records of patients attending or presenting to Emergency or Out-Patient Departments not admitted as in-patients – all hospital groups. This includes records of patients who are dead on arrival (DOA) and records maintained as part of the Emergency Department Information System (EDIS).</td>
</tr>
<tr>
<td>1.2.0</td>
<td><strong>Community health care</strong> Records relating to clients of community health services or centres. This includes records of unregistered clients, clients who are only ‘visitors’, clients who are screened without follow up, potential clients or clients who are referred elsewhere. <strong>See 1.3.0</strong> for records relating to oral (dental) health care</td>
<td>Retain: - minimum of 7 years after last attendance or official contact or access by or on behalf of the client, or - until client attains or would have attained the age of 25 years, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Client health records. Records documenting the provision of health care, assessment or screening services to registered or unregistered clients, including records relating to confidential referrals or temporary records of transfers or ‘visitors’. This includes records of deceased clients, ie records relating to clients where the facility has been officially notified of the death of the client, and sensitive or registered records documenting or reporting instances of abuse, family disharmony, developmental disorders, pregnancy etc. <strong>See 1.8.0 and 1.9.0</strong> for records relating to instances of sexual assault and PANOC Specialist Services patients/clients</td>
<td>Retain: - minimum of 7 years after date of immunisation or after last official contact or access by or on behalf of the client, then destroy</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Immunisation records not maintained as part of the main client record and where there is no adverse or other reaction</td>
<td>Retain minimum of 7 years after date of immunisation or after last official contact or access by or on behalf of the client, then destroy</td>
</tr>
<tr>
<td>1.2.3</td>
<td>Immunisation records not maintained as part of the main client record and where there is an adverse or other reaction</td>
<td>Retain: - minimum of 7 years after last official contact or access by or on behalf of the client, or - until client attains or would have attained the age of 25 years, whichever is the longer, then destroy</td>
</tr>
</tbody>
</table>
### 9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.4</td>
<td>Child/baby health care screening records documenting the screening and monitoring of the health of infants from birth to 4-5 years where there is no abnormality detected. This includes progress notes, centile charts, immunisation schedule etc.</td>
<td>Retain until child attains or would have attained the age of 6 years, then destroy</td>
</tr>
<tr>
<td>1.2.5</td>
<td>Child/baby health care screening records where there is an abnormality detected or with possible legal implications. This includes sensitive or registered records documenting or reporting instances of abuse, family disharmony, developmental disorders etc. See 1.8.0 and 1.9.0 for records relating to instances of sexual assault and PANOC Specialist Services patients/clients</td>
<td>Retain: - minimum of 7 years after last official contact or access by or on behalf of the client, or - until client attains or would have attained the age of 25 years, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>1.2.6</td>
<td>School screening records documenting the screening and monitoring of the health of pre-primary, primary and secondary school students where there is no abnormality detected</td>
<td>Retain until student completes either primary or secondary school in which the screening was undertaken, then destroy</td>
</tr>
<tr>
<td>1.2.7</td>
<td>School screening records where there is an abnormality detected or with possible legal implications. This includes sensitive or registered records documenting or reporting instances of abuse, family disharmony, developmental disorders, pregnancy etc. See 1.8.0 and 1.9.0 for records relating to instances of sexual assault and PANOC Specialist Services patients/clients</td>
<td>Retain: - minimum of 7 years after last official contact or access by or on behalf of the client, or - until client attains or would have attained the age of 25 years, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>1.2.8</td>
<td>Criminal histories held on files of clients under the Magistrates Early Referral into Treatment (MERIT) Program</td>
<td>Retain until the conclusion of the client’s active involvement in the program, then destroy</td>
</tr>
<tr>
<td>1.3.0</td>
<td><strong>Oral (dental) health care</strong></td>
<td></td>
</tr>
<tr>
<td>1.3.1</td>
<td>Records relating to the examination, assessment and treatment of patients/clients. This includes dental charts, x-rays etc for both adults and minors.</td>
<td>Retain: - minimum of 7 years after last attendance or official contact or access by or on behalf of the patient/client, or - until patient/client attains or would have attained the age of 25 years, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>1.3.2</td>
<td>School dental risk assessment consent forms</td>
<td>Retain minimum of 2 years from date of consent, then destroy</td>
</tr>
</tbody>
</table>

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23 If an abnormality is detected then the record should be incorporated into the main Community Health client record system.
9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4.0</td>
<td>Obstetric/maternal health care</td>
<td></td>
</tr>
<tr>
<td>1.4.1</td>
<td>Records documenting birth episodes</td>
<td>These records are currently required to be retained indefinitely by the organisation responsible for their management</td>
</tr>
<tr>
<td>1.4.2</td>
<td>Social work records relating to instances of arrangements for adoptions</td>
<td>These records are currently required to be retained indefinitely by the organisation responsible for their management</td>
</tr>
<tr>
<td>1.5.0</td>
<td>Psychiatric and mental health care</td>
<td></td>
</tr>
<tr>
<td>1.5.1</td>
<td>Records of patients/clients of former Crown operated/5th Schedule psychiatric hospitals where the records were wholly or partly created prior to 1960</td>
<td>Required as State archives</td>
</tr>
</tbody>
</table>
| 1.5.2 | Records of patients/clients receiving psychiatric treatment and care and/or treatment and care (including community health care) under the Mental Health Act. This includes records of deceased patients/clients (ie records of patients receiving treatment and care under the Mental Health Act who die while in or receiving treatment from a facility or where the facility has been officially notified of death). Records relating to the treatment and care of patients not covered by the Mental Health Act who have mental disorders are to be retained in accordance with 1.1.0 or 1.2.0 | 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 the longer, then destroy |
| 1.6.0 | Genetic or inherited disorders                           |                                                                                  |
| 1.6.1 | Records documenting the diagnosis of a genetic or inherited disorder24 | These records are currently required to be retained indefinitely by the organisation responsible for their management |
| 1.6.2 | Records relating to the management of patients with genetic or inherited disorders | To be retained and disposed of in accordance with the requirements for the type of patient/client records they comprise eg hospital or community health care |

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24 Where possible these records should be filed, maintained and stored separately from the main (unit) patient record. Diagnostic results held in other departments should be returned to the genetics department. Where records are maintained as part of the individual’s main (unit) patient record the records must be maintained for the minimum retention period specified in this section.
## 9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.7.0</td>
<td><strong>Assisted Reproductive Technology (ART)</strong>&lt;sup&gt;25&lt;/sup&gt;</td>
<td>Records relating to ART procedures (including In Vitro Fertilisation (IVF), gamete intrafallopian transfer (GIFT) and artificial insemination). This includes case records of each individual person or family unit, consent to ART procedures, donation and use of semen, ova, embryos and the withdrawal of consent for such procedures or processes.</td>
</tr>
<tr>
<td>1.7.1</td>
<td>Records relating to ART patients/clients where a child is born or, if it is not known whether a child is born, where a pregnancy is achieved</td>
<td>Retain minimum of 75 years from date of birth (or estimated date of birth if not known), then destroy</td>
</tr>
<tr>
<td>1.7.2</td>
<td>Records relating to any other ART patients/clients</td>
<td>Retain minimum of 15 years after last attendance or last official contact with the service or after last access by or on behalf of the patient, then destroy</td>
</tr>
<tr>
<td>1.8.0</td>
<td><strong>Sexual assault patients</strong></td>
<td></td>
</tr>
<tr>
<td>1.8.1</td>
<td>Records relating to instances of sexual assault</td>
<td>Retain minimum of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 30 years after any legal action is completed and resolved (where known) or after last contact for legal access, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 30 years after the individual attains or would have attained the age of 18, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>1.9.0</td>
<td><strong>Physical Abuse and Neglect of Children (PANOC) Specialist Services</strong></td>
<td></td>
</tr>
<tr>
<td>1.9.1</td>
<td>Client records of PANOC Specialist Services</td>
<td>Retain minimum of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 30 years after any legal action is completed and resolved (where known) or after last contact for legal access, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 30 years after the individual attains or would have attained the age of 18, whichever is the longer, then destroy</td>
</tr>
</tbody>
</table>

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<sup>25</sup> Where possible these records should be filed, maintained and stored separately from the main (unit) patient record. Where records are maintained as part of the individual’s main (unit) patient record the records must be maintained for the minimum retention period specified in this section. For further information concerning recordkeeping requirements for the accreditation of Reproductive Medicine Units refer to NSW Department of Health GL 2006_011 and the National Health and Medical Research Council (NHMRC) Ethical Guidelines on Assisted Reproductive Technology.
<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.10.0</td>
<td>Radiotherapy treatment</td>
<td>Retain minimum of:</td>
</tr>
</tbody>
</table>
| 1.10.1 | Records documenting radiation dose delivery in respect to patients (admitted and non-admitted) who have undergone radiotherapy treatment. (These records are generally maintained in Radiotherapy Departments.) | - 10 years after patient would have attained the age of 70 or after last attendance, whichever is the longer, or  
- where the service has received notification of the date of death,  
10 years after date of death, then destroy |
| 1.11.0 | Electronic health records                                                          | Retain until no longer required for administrative purposes, then review, if no longer required, then destroy                                                                                               |
| 1.11.1 | Extract summary data created to facilitate the making of treatment decisions where the source records still exist and are retrievable for and at any particular point in time |                                                                                                                                                                                                               |
| 1.11.2 | Extract summary data created to facilitate the making of treatment decisions where the source records are not retrievable or no longer exist | To be retained and disposed of in accordance with the requirements for the type of patient/client records they comprise eg hospital or community health care |
| 1.11.3 | Original data where the electronic record is the only record                       | To be retained and disposed of in accordance with the requirements for the type of patient/client records they comprise eg hospital or community health care |
| 1.12.0 | Collections or samples of patient records of significance                            |                                                                                                                                                                                                               |
|        | **See** section 2.3 of Part 2 of this Authority for guidance on the identification of these records |                                                                                                                                                                                                               |
|        | **See also** 10.0.0 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 | Required as State archives                                                                                                                                                                                   |
| 1.13.0 | Correspondence                                                                     |                                                                                                                                                                                                               |
### Classes of records

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
</table>
| 1.13.1 | Routine correspondence with individual patients/clients, or others on behalf of patients/clients, of a health care facility or service. Correspondence includes records of telephone contact and a record of any medical advice given is to be retained. 26 | Retain:  
- minimum of 7 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 the longer, then destroy |
| 1.13.2 | Correspondence logs or registers                                                  | Retain minimum of 7 years after last entry, then destroy                         |
| 1.13.3 | Copies of requests or referrals for other services, eg diagnostic, where the medical record does not incorporate details or where the patient did not attend the service for which the referral was provided. This includes private patient referrals/requests. 27 | Retain minimum of 3 years after last action, then destroy                        |
| 1.14.0 | **Legal matters and incident management**                                         |                                                                                  |
| 1.14.1 | Records relating to issues, claims or case matters:  
- of major public interest or controversy, or  
- which are precedent setting in nature, or  
- which result in significant changes to the service’s or facility’s policy or procedures | Required as State archives                                                      |
| 1.14.2 | Records relating to other issues, claims or case matters involving legal action    | Retain minimum of 15 years after legal action is completed and resolved (where known) or after last contact for legal access purposes, then destroy |
| 1.14.3 | Records relating to complaints and incidents not involving legal action            | Retain for minimum of 7 years after last action, then destroy                     |

26 Where possible these records should be filed and maintained as part of the main (unit) patient/client record and retained accordingly. If there is no record of the patient, note receipt of the correspondence in the correspondence log book or register and return to sender.

27 Where possible a copy of any request/referral form is to be filed and maintained as part of the main (unit) patient/client record and retained accordingly. This retention period encompasses Health Insurance Commission requirements to retain private patient referrals/requests for at least 18 months.

28 A copy of any incident report or notification is to be filed and maintained as part of the main (unit) patient/client record and retained accordingly. Correspondence and associated records relating to the handling of these matters should be filed and maintained separately from the individual patient record.

29 Records of an investigation into or analysis of the cause of an incident (Root Cause Analysis) are to be appropriately managed and retained in accordance with the retention periods identified in this section.
### Classes of records

<table>
<thead>
<tr>
<th>No.</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.14.4</td>
<td>Subpoenas and discovery orders relating to legal action involving the health service or facility. Records covered by this class are records of correspondence etc concerning the service’s or facility’s receipt of and compliance with a subpoena or discovery order. It does not apply to the records that are the subject of the subpoena or discovery order.</td>
<td>Retain minimum of 7 years after finalisation of legal proceedings (where known) or after last contact for legal access purposes, then destroy.</td>
</tr>
<tr>
<td>1.14.5</td>
<td>Subpoenas and discovery orders relating to other litigation not directly involving the health service or facility. Records covered by this class are records of correspondence etc concerning the service’s or facility’s receipt of and compliance with a subpoena or discovery order where the service or facility is not a respondent or plaintiff to the litigation. It does not apply to the records that are the subject of the subpoena or discovery order.</td>
<td>Retain minimum of 2 years after finalisation of legal proceedings (where known) or after last contact for legal access purposes, then destroy.</td>
</tr>
<tr>
<td>1.14.6</td>
<td>Registers of patient injuries</td>
<td>Retain minimum of 30 years after last entry, then destroy.</td>
</tr>
<tr>
<td>1.15.0</td>
<td>Clinical audits</td>
<td></td>
</tr>
<tr>
<td>1.15.1</td>
<td>Records relating to the conduct of clinical audits for the purposes of evidence based quality management eg an audit of the outcome of pain management treatment</td>
<td>Retain minimum of 5 years after completion of the audit, then destroy.</td>
</tr>
<tr>
<td>1.16.0</td>
<td>Medical certificates</td>
<td></td>
</tr>
<tr>
<td>1.16.1</td>
<td>Copies of medical certificates issued to patients detailing dates of attendance and where appropriate reason for attendance not maintained as part of the main (unit) patient/client record.</td>
<td>Retain minimum of 7 years after date of issue, then destroy.</td>
</tr>
<tr>
<td>1.17.0</td>
<td>Sterilisation (instruments)</td>
<td></td>
</tr>
<tr>
<td>1.17.1</td>
<td>Records relating to the sterilisation of surgical instruments and equipment used in procedures</td>
<td>Retain minimum of 15 years after date of printout, then destroy.</td>
</tr>
<tr>
<td>1.17.2</td>
<td>Sterilisation print-outs</td>
<td>Retain minimum of 15 years after last entry, then destroy.</td>
</tr>
<tr>
<td>1.18.0</td>
<td>Surgical procedures (accountable items)</td>
<td></td>
</tr>
<tr>
<td>1.18.1</td>
<td>Duplicates of records of accountable items (MR18) used in operating theatres eg instruments and swab counts. (The original is required to be placed on the patient’s file.)</td>
<td>If used as a Register of surgically implanted devices see 2.1.11, otherwise retain minimum of 1 year after date of completion, then destroy.</td>
</tr>
</tbody>
</table>
### 2.0.0 Patient/Client Registration and Identification

Management of the identification, registration, admission, transfer and discharge of new or readmitted patients/clients and the treatments or procedures performed on them. For records created prior to 1930 see 10.0.0. For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning see 9.0.0.

### 2.1.0 Registers and Indexes

Summary and control records relating to patient admission, identification, diagnosis, treatment and discharge. See 3.4.0 and 4.3.0 for registers of diagnostic services and 5.1.0 for drug registers. 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 any regulations made under the Act, under which the establishment is licensed.

#### 2.1.1 Patient Master Index (PMI), Number register (eg card register) or equivalent

This includes records relating to the names and medical record numbers of clients or admitted patients of hospitals, health care facilities and services. In addition to the patient’s name and medical record number, details recorded may also include date of birth, sex, address and other relevant details to assist patient identification. Where the PMI or its equivalent maintains a record of summary patient admission and discharge registration details not recorded elsewhere see 2.1.4.

- Retain until no longer required for administrative purposes, then destroy.

#### 2.1.2 Disease and operation index

Recording for each disease, condition, operation or procedure code number the details of each in-patient having that diagnosis or having undergone that operation or procedure. Required as State archives.

---

32 Records relating to the registration, identification, admission, discharge, transfer etc of patients/clients maintained in electronic formats must be maintained in a readily accessible format for as long as they are required to be retained in accordance with the identified minimum retention period for the class of record they constitute.

33 Services are required to create and maintain these records. The PMI or Number register is the key to locating an individual’s patient record in the medical records filing system as it provides a link between the name of the patient and the facility’s medical record number.

34 The index or register will need to 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 required to be retained indefinitely.

35 Services are required to create and maintain these records. In addition to the patient’s name, medical record number and disease/condition and operation/procedure codes relevant to each episode of care, details recorded may also include age, sex, date of admission, length of stay, discharge status and destination, responsible doctor or unit (name or code identifier), ward.
## 9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.3</td>
<td>Physicians index</td>
<td>Retain minimum of 15 years after date of last entry, then destroy</td>
</tr>
<tr>
<td></td>
<td>A record for each medical practitioner with admitting rights of the details of each patient attended by the practitioner during the period covered by the index. In addition to the patient’s name, medical record number and all disease, condition, operation and procedure codes relating to each patient attended, details recorded may also include age, sex, date of admission, length of stay, discharge status and destination.</td>
<td></td>
</tr>
<tr>
<td>2.1.4</td>
<td>Admission and discharge registers</td>
<td>Required as State archives</td>
</tr>
<tr>
<td></td>
<td>In addition to the details of the patient’s date of admission and discharge, details recorded may also include time of admission, patient’s medical record number, address, sex, date of birth, next of kin, admitting diagnosis, discharge diagnosis and length of stay. Where the details recorded in the discharge register are duplicated in the admission register see 2.1.13</td>
<td></td>
</tr>
<tr>
<td>2.1.5</td>
<td>Register of births(^{36})</td>
<td>Required as State archives</td>
</tr>
<tr>
<td></td>
<td>A record of each birth occurring in the service or facility. This includes Birth and Labour Ward registers, confinement books or their equivalent.</td>
<td></td>
</tr>
<tr>
<td>2.1.6</td>
<td>Death register(^{37})</td>
<td>Required as State archives</td>
</tr>
<tr>
<td></td>
<td>A record of each death occurring in the hospital or facility, including deaths on arrival (DOA’s).</td>
<td>See 6.1.2 for death certificates</td>
</tr>
<tr>
<td>2.1.7</td>
<td>Emergency Department register</td>
<td>Required as State archives</td>
</tr>
<tr>
<td></td>
<td>In addition to date of attendance and name of patient, details recorded may also include patient’s medical record number, address, sex, date of birth, reason for attendance and outcome of any follow up arrangements.</td>
<td></td>
</tr>
<tr>
<td>2.1.8</td>
<td>Surgical procedures, Operation or Theatre register(^{38})</td>
<td>Required as State archives</td>
</tr>
<tr>
<td></td>
<td>A record of each operation or surgical procedure carried out.</td>
<td></td>
</tr>
<tr>
<td>2.1.9</td>
<td>Community health registers</td>
<td>Retain:</td>
</tr>
<tr>
<td></td>
<td>A record of details of individual client contact, demographics, presenting problem, transfers in and out etc. This includes Baby health registers.</td>
<td>- minimum of 15 years after date of last entry, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- until youngest child in the register attains the age of 25 years, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>2.1.10</td>
<td>Ward register</td>
<td>Retain minimum of 7 years after date of last entry, then destroy</td>
</tr>
<tr>
<td></td>
<td>A record of dates of reception of individual patients into a ward. Information recorded should include date of reception and name of individual patient.</td>
<td></td>
</tr>
</tbody>
</table>

\(^{36}\) Services are required to create and maintain these records. Information recorded should include date and time of birth, mother’s name, sex of child and names of medical and nursing staff in attendance. Details recorded may also include mother’s medical record number, age and address.

\(^{37}\) Services are required to maintain this register in accordance with PD2007_094 Client Registration Policy.

\(^{38}\) Services are required to maintain this register in accordance with NSW Department of Health PD2014_049 Register of surgical operations.
### 9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
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</tr>
</thead>
</table>
| 2.1.11 | Register of surgically implanted devices\(^{39}\)  
A record of details of any surgically implanted prostheses or devices. | These records are currently required to be retained indefinitely by the organisation responsible for their management. |
| 2.1.12 | Electro Convulsive Therapy (ECT)\(^{40}\), Sedation\(^{41}\) and Seclusion\(^{41}\) registers and Rapid tranquillisation journals | Retain minimum of 15 years after date of last entry, then destroy. |
| 2.1.13 | Duplicate registration and index records. This applies to records in hard copy or electronic format that duplicate details or information recorded in and accessible from a centrally maintained or alternate registration system. | Retain until no longer required for administrative or reference purposes\(^{42}\), then destroy. |
| 2.2.1 | In-patient admission, transfer, discharge or death lists  
Where the admission, discharge or death register does not exist sentence in accordance with 2.1.4 or 2.1.6, otherwise retain minimum of 2 years after date of last entry or list, then destroy. | |
| 2.2.2 | Operation/theatre lists or schedules eg theatre bookings | Retain minimum of 2 years after list or schedule completed, then destroy. |
| 2.2.3 | Clinical lists. This includes out-patient lists, attendance books etc  
See 2.3.1 for records of client contact not recorded elsewhere | Retain minimum of 1 year after date of last entry or list, then destroy. |
| 2.2.4 | Waiting lists - quarterly waiting list surveys (Form A’s) | Retain minimum of 1 year after date of survey, then destroy. |
| 2.2.5 | Waiting lists - clerical audit reports | Retain minimum of 3 years after audit, then destroy. |
| 2.2.6 | Recommendation for admission forms where the patient did not attend and no medical record was created | Retain minimum of 3 years after creation, then destroy. |
| 2.3.1 | Personal/work diaries or appointment books/registers recording details of appointments and client contact or attendance not recorded elsewhere | Retain minimum of 7 years after date of last entry, then destroy. |

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\(^{39}\) Services are required to create and maintain these records for the purposes of product recall. If details of surgically implanted devices are retained in a form other than a register it is to be ensured that such details are retained and recoverable in accordance with the requirements of this section.

\(^{40}\) A Register of Electro Convulsive Therapy is required to be maintained under s.196 of the Mental Health Act 1990 and in accordance with the form prescribed by the Mental Health Regulation 2000.

\(^{41}\) Services are required to maintain this register in accordance with NSW Ministry of Health PD2012_035, Aggression, Seclusion & Restraint in Mental Health Facilities in NSW and GL2012_005, Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline focused Upon Older People Seclusion Practices in Psychiatric Facilities.

\(^{42}\) Where records are created and used for the purposes of data entry the determination of appropriate retention periods must allow adequate time for data verification and audit requirements.
<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.2</td>
<td>Personal/work diaries or appointment books used to record basic information or details such as dates and times of meetings and appointments</td>
<td>Retain until no longer required for administrative or reference purposes, then destroy</td>
</tr>
<tr>
<td>2.4.0</td>
<td><strong>Censuses and returns</strong>&lt;br&gt;See 6.2.0 for records relating to the reporting of notifiable diseases etc.</td>
<td>Retain until no longer required for administrative or reference purposes, then destroy</td>
</tr>
<tr>
<td>2.4.1</td>
<td>Records reporting numbers of patients admitted or transferred, eg bed returns or daily in-patient census</td>
<td>Retain minimum of 1 year after date of creation or until completion of audit, if sooner, then destroy</td>
</tr>
<tr>
<td>2.4.2</td>
<td>Originals of data collection forms, returns etc held by the Department of Health. This includes data related to sexual assault, brain injury, admitted patient statistics, midwife data collection etc.</td>
<td>Retain until no longer required for administrative or reference purposes, then destroy</td>
</tr>
<tr>
<td>2.4.3</td>
<td>Copies of data collection records/returns held by public health organisations</td>
<td>Retain minimum of 1 year after date of submission, then destroy</td>
</tr>
<tr>
<td>2.5.0</td>
<td><strong>Ward records</strong>&lt;br&gt;See 5.1.3 for drug registers maintained on the ward</td>
<td></td>
</tr>
<tr>
<td>2.5.1</td>
<td>Records relating to the management, treatment and care of patients on the ward not incorporated into the main (unit) patient record eg ward reports, report books and related records</td>
<td>Retain minimum of 7 years after date of last entry or action, then destroy</td>
</tr>
<tr>
<td>2.6.0</td>
<td><strong>Electronic patient administration systems</strong>&lt;sup&gt;45&lt;/sup&gt;</td>
<td>To be retained and disposed of in accordance with the requirements for the type of records they comprise</td>
</tr>
<tr>
<td>2.6.1</td>
<td>Systems (eg Cerner/I Soft systems) that consist of and manage patient personal (PMI), admission, transfer and separation (ATS) and disease index (DI) details</td>
<td></td>
</tr>
<tr>
<td>2.7.0</td>
<td><strong>Health Information Exchange (HIE)</strong></td>
<td></td>
</tr>
<tr>
<td>2.7.1</td>
<td>Extracted electronic data from existing source systems which is aggregated for reporting, analysis and service planning purposes</td>
<td>Retain until no longer required for administrative or reference purposes, then review, if no longer required, then destroy</td>
</tr>
<tr>
<td>3.0.0</td>
<td><strong>PATIENT DIAGNOSIS - IMAGING SERVICES</strong>&lt;br&gt;Imaging procedures and tests performed for the purposes of patient/client diagnosis. This includes diagnostic radiology, tomography, nuclear medicine, ultrasound, magnetic resonance imaging and related diagnostic digital imaging procedures. For records created prior to 1930 see 10.0.0 For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning see 9.0.0</td>
<td></td>
</tr>
</tbody>
</table>

<sup>45</sup> Records maintained within these systems are to be sentenced in accordance with entries 2.1.1 to 2.2.6. Organisations should have in place strategies for managing the deletion of records from the system when they are no longer required and for the ongoing maintenance of access to patient registration details that are required to be retained permanently as State archives.
<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.0</td>
<td>Requests[^44] Medical officer’s requests for diagnostic imaging procedures</td>
<td></td>
</tr>
<tr>
<td>3.1.1</td>
<td>Diagnostic service copy of requests for imaging procedures</td>
<td>Retain minimum of 3 years after receipt of the request[^45], then destroy</td>
</tr>
<tr>
<td>3.2.0</td>
<td>Diagnostic reports[^46] Records and reports documenting findings based on an analysis, evaluation or interpretation of recordings or procedures</td>
<td></td>
</tr>
<tr>
<td>3.2.1</td>
<td>Patient record copy See 1.0.0 for patient health care records</td>
<td>To be retained and disposed of in accordance with the type of patient record they comprise</td>
</tr>
<tr>
<td>3.2.2</td>
<td>Diagnostic service copy (that is originals or copies of diagnostic reports or findings maintained by the diagnostic service)</td>
<td>Retain minimum of 3 years after date of report, then destroy</td>
</tr>
<tr>
<td>3.3.0</td>
<td>Recordings[^47] Recordings produced for or created as a result of diagnostic processes</td>
<td></td>
</tr>
<tr>
<td>3.3.1</td>
<td>Diagnostic visual, image or pictorial recordings. This includes x-rays, videotapes, films, photographs or equivalent image recordings</td>
<td>Release to patient upon request[^48] or retain: - minimum of 7 years after last attendance for diagnostic procedure, or - until patient attains or would have attained the age of 25 years, whichever is the longer, then recycle or destroy[^49]</td>
</tr>
</tbody>
</table>

[^44]: Details of requests for diagnostic procedures or tests should be recorded and maintained as part of the main (unit) patient record, ie as part of the progress notes or a copy of the request is attached to the file, and retained accordingly.

[^45]: This retention period encompasses Health Insurance Commission requirements to retain private patient referrals/requests for at least 18 months.

[^46]: The original or a copy of any diagnostic report should also be maintained as part of the main (unit) patient record and retained accordingly.

[^47]: Recordings produced by diagnostic services should be retained in the originating department or area, for example radiographic films or diagnostically equivalent recordings should be retained in the Radiography/Radiology Department. If recordings are digitally stored the retention periods specified in this section are the minimum retention requirements for the records.

[^48]: If a patient requests a diagnostic recording and the recording is not required for possible future treatment or other requirements, for example litigation, then the recording can be released subsequent to the patient signing for its release.

[^49]: If it is known that the recordings could possibly be required for legal action or compensation claims, the recordings should be retained for appropriate time periods, that is at least until the legal action has been completed. If it is known that an adverse event has occurred the visual recording associated with that event should be retained until the matter has been resolved or for the minimum retention period as specified, whichever is the longer.
### Classes of records

<table>
<thead>
<tr>
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<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.2</td>
<td>Diagnostic graphical recordings, that is recordings or tracings of a graphical nature created via diagnostic measuring processes eg electroencephalograms, electrocardiograms, electromyograms or cardiotocograms, where there is an abnormality detected</td>
<td>Retain: - minimum of 7 years after last attendance for diagnostic procedure, or - until patient attains or would have attained the age of 25 years, whichever is the longer, then recycle or destroy</td>
</tr>
<tr>
<td>3.3.3</td>
<td>Diagnostic graphical recordings where there is no abnormality detected</td>
<td>Subject to results being noted in the patient’s record, retain until no longer required for administrative purposes, then destroy</td>
</tr>
<tr>
<td>3.4.0</td>
<td>Registers</td>
<td>Retain until no longer required for administrative purposes, then destroy</td>
</tr>
<tr>
<td>3.4.0.1</td>
<td>Registers or associated control records maintained for the purposes of identifying or locating diagnostic recordings and reports</td>
<td>Retain until no longer required for administrative purposes, then destroy</td>
</tr>
<tr>
<td>4.0.0</td>
<td>PATIENT DIAGNOSIS - PATHOLOGY AND LABORATORY SERVICES</td>
<td></td>
</tr>
<tr>
<td>4.1.0</td>
<td>Requests</td>
<td></td>
</tr>
<tr>
<td>4.1.1</td>
<td>Diagnostic service copy of requests for tests or procedures</td>
<td>Retain minimum of 3 years after receipt of the request, then destroy</td>
</tr>
<tr>
<td>4.2.0</td>
<td>Diagnostic results and reports</td>
<td></td>
</tr>
</tbody>
</table>

### Notes

50. The records 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.

51. Retention periods for these records reflect current minimum standards considered acceptable for good laboratory practice in relation to the retention of laboratory records and diagnostic material established by the National Pathology Accreditation Advisory Council (NPAAC) *Retention of Laboratory Records and Diagnostic Material*, 3rd edition, 2002. Laboratories involved in biochemical, molecular genetics or newborn screening should refer to current NPAAC standards for details of specific requirements applying to them.

52. Details of requests for diagnostic procedures or tests should be recorded and maintained as part of the main (unit) patient record, ie as part of the progress notes or a copy of the request is attached to the file, and retained accordingly.

53. This retention period encompasses Health Insurance Commission requirements to retain private patient referrals/requests for at least 18 months.

54. The original or a copy of any diagnostic report, including autopsy/post-mortem reports, should also be maintained as part of the main (unit) patient record and retained accordingly.
<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2.1</td>
<td>Anatomical pathology, cytology (exfoliate and non exfoliate) and autopsy or post-mortem reports/records, registers, diagrams and copies of any representative images prepared</td>
<td>Retain minimum of 20 years from date of report, then destroy</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Histopathology and bone marrow reports/records</td>
<td>Retain minimum of 20 years from date of report, then destroy</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Blood alcohol reports/records. This includes medical practitioner declarations.</td>
<td>Retain minimum of 3 years from date of report or declaration, then destroy 55</td>
</tr>
<tr>
<td>4.2.4</td>
<td>Haematology, clinical chemistry/chemical pathology, microbiology and immunology records</td>
<td>Retain minimum of 3 years from date of report, then destroy</td>
</tr>
<tr>
<td>4.2.5</td>
<td>Genetics reports/records. This includes karyotypes and digital images. See also 1.6.0 for records documenting the diagnosis of genetic or inherited disorders</td>
<td>These records are currently required to be retained indefinitely by the organisation responsible for their management</td>
</tr>
<tr>
<td>4.2.6</td>
<td>Neonatal screening (Guthrie) cards</td>
<td>Retain: - until child attains or would have attained the age of 25 years, or - minimum of 7 years after last action, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>4.2.7</td>
<td>Reports documenting diagnostic findings (including autopsy/post-mortem reports) - patient record copy See 1.0.0 for patient health care records</td>
<td>To be retained and disposed of in accordance with the type of patient record they comprise.</td>
</tr>
<tr>
<td>4.3.0</td>
<td><strong>Specimens and samples</strong> 56</td>
<td></td>
</tr>
<tr>
<td>4.3.1</td>
<td>Bodily specimens, samples or materials examined in a diagnostic pathology procedure. This includes slides, films, blocks, cultures and related material.</td>
<td>To be retained in accordance with current NPAAC minimum standards for the retention of diagnostic material</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Registers or equivalent records of specimens collected and received. This includes laboratory information management systems.</td>
<td>Retain until no longer required for administrative purposes 57, then destroy</td>
</tr>
<tr>
<td>4.3.3</td>
<td>Extract summary data from the register used to undertake management activities (eg printouts of reports to facilitate the tracking or monitoring of testing completion) and where no additional data or actions are noted on that extract data</td>
<td>Retain until no longer required for administrative purposes, then destroy</td>
</tr>
<tr>
<td>4.3.4</td>
<td>Extract summary data from the register used to undertake management activities and where additional data or actions are noted on the extract data and not recorded on the main register (that is the extract data in effect becomes a unique record containing information not recorded elsewhere)</td>
<td>Retain minimum of 1 year after action is completed, then destroy</td>
</tr>
</tbody>
</table>

55 Regard should be had to potential retention requirements for legal purposes. See 1.14.0
56 Bodily specimens and samples do not constitute ‘recorded information’ for the purposes of the State Records Act.
57 Retention periods should be in accordance with the minimum retention periods required for the type/s of specimens recorded in the register, see 4.3.1, and, where these 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.
9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3.5</td>
<td>Retained human tissue records. Records associated with the management of and consents to the retention of human tissue. This includes records of statutory declarations, registers, consent forms and clinical information about the deceased etc.</td>
<td>Retain minimum of 20 years after tissue disposed of, then destroy.</td>
</tr>
<tr>
<td>4.4.0</td>
<td><strong>Blood bank and blood collection services</strong> (autologous and homologous)</td>
<td></td>
</tr>
<tr>
<td>4.4.1</td>
<td>Diagnostic results and reports</td>
<td>Retain:</td>
</tr>
<tr>
<td></td>
<td>58 Records associated with the management of and consents to the retention of human tissue. This includes records of statutory declarations, registers, consent forms and clinical information about the deceased etc.</td>
<td>- minimum of 10 years after last action, or</td>
</tr>
<tr>
<td></td>
<td>59 These records should be created and maintained in accordance with the requirements of the Human Tissue Act 1983, Human Tissue and Anatomy Legislation Amendment Act 2003, Human Tissue Regulation 2000 and the Therapeutic Goods Administration (TGA) Australian Code of Good Manufacturing Practice (GMP) for Therapeutic Goods: Blood and Blood Products. The retention periods identified for these records reflect current minimum standards established by the GMP code and NPAAC.</td>
<td>- until donor attains or would have attained the age of 30 years, whichever is the longer, then destroy.</td>
</tr>
<tr>
<td>4.4.2</td>
<td>Laboratory records of blood donations and administration of blood and blood products</td>
<td>Retain:</td>
</tr>
<tr>
<td></td>
<td>60 Records associated with the management of and consents to the retention of human tissue. This includes records of statutory declarations, registers, consent forms and clinical information about the deceased etc.</td>
<td>- minimum of 20 years after last action, or</td>
</tr>
<tr>
<td></td>
<td>61 These records should be created and maintained in accordance with the requirements of the Human Tissue Act 1983, Human Tissue and Anatomy Legislation Amendment Act 2003, Human Tissue Regulation 2000 and the Therapeutic Goods Administration (TGA) Australian Code of Good Manufacturing Practice (GMP) for Therapeutic Goods: Blood and Blood Products. The retention periods identified for these records reflect current minimum standards established by the GMP code and NPAAC.</td>
<td>- until donor attains or would have attained the age of 30 years, whichever is the longer, then destroy.</td>
</tr>
<tr>
<td>4.4.3</td>
<td>Registers of blood products. Recorded details of fresh and pooled blood products.</td>
<td>Retain minimum of 20 years after date of last entry, then destroy.</td>
</tr>
<tr>
<td>4.4.4</td>
<td>Statements by persons intending to donate blood. This includes records of consents, questionnaires and associated donor records.</td>
<td>Retain:</td>
</tr>
<tr>
<td></td>
<td>62 These records should be created and maintained in accordance with the requirements of the Human Tissue Act 1983, Human Tissue and Anatomy Legislation Amendment Act 2003, Human Tissue Regulation 2000 and the Therapeutic Goods Administration (TGA) Australian Code of Good Manufacturing Practice (GMP) for Therapeutic Goods: Blood and Blood Products. The retention periods identified for these records reflect current minimum standards established by the GMP code and NPAAC.</td>
<td>- minimum of 20 years after last action, or</td>
</tr>
<tr>
<td></td>
<td>63 These records should be created and maintained in accordance with the requirements of the Human Tissue Act 1983, Human Tissue and Anatomy Legislation Amendment Act 2003, Human Tissue Regulation 2000 and the Therapeutic Goods Administration (TGA) Australian Code of Good Manufacturing Practice (GMP) for Therapeutic Goods: Blood and Blood Products. The retention periods identified for these records reflect current minimum standards established by the GMP code and NPAAC.</td>
<td>- until donor attains or would have attained the age of 30 years, whichever is the longer, then destroy.</td>
</tr>
</tbody>
</table>

58 Where any tissue, organ or body part is retained for purposes (eg teaching or research) other than for which originally taken or examined (eg for the purposes of treatment, diagnosis, autopsy or post-mortem) then the provisions of the Human Tissue and Anatomy Legislation Amendment Act 2003 apply.

59 These records should be created and maintained in accordance with the requirements of the Human Tissue Act 1983, Human Tissue and Anatomy Legislation Amendment Act 2003, Human Tissue Regulation 2000 and the Therapeutic Goods Administration (TGA) Australian Code of Good Manufacturing Practice (GMP) for Therapeutic Goods: Blood and Blood Products. The retention periods identified for these records reflect current minimum standards established by the GMP code and NPAAC.

60 See Human Tissue Regulation 2000 Schedule 3 for full details of recordkeeping requirements.

61 Details recorded should include date of receipt, identification number of donation or batch/s, including the quantity in each batch, date of transfusion, date of issue to ward and blood group of product if applicable.

62 See Human Tissue Regulation 2000 Schedule 3 for full details of recordkeeping requirements.

63 See Human Tissue Regulation 2000 Schedule 4 for full details of recordkeeping requirements.
### 9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5.1</td>
<td>Records relating to the business of semen supply. This includes records of: • full name and date of birth of donor • donor’s written consent • the results of tests and identification of all details • the name of the medical practitioner to whom semen supplied</td>
<td>Retain: - minimum of 10 years after last action, or - until donor attains or would have attained the age of 30 years, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>4.6.0</td>
<td>Quality assurance</td>
<td>Retain minimum of 3 years from date of review, then destroy</td>
</tr>
<tr>
<td>4.7.0</td>
<td>Equipment maintenance</td>
<td>Retain minimum of 3 years after the equipment has been replaced or disposed of, then destroy</td>
</tr>
<tr>
<td>4.8.0</td>
<td>Procedures and methods</td>
<td>Retain minimum of 3 years after methods/procedures superseded, then destroy</td>
</tr>
</tbody>
</table>
| 5.0.0| **PHARMACEUTICAL SUPPLY AND ADMINISTRATION**

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

For records created prior to 1930 see **10.0.0**
For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning see **9.0.0**

| 5.1.0| **Dispensation and supply**

Records relating to the supply and dispensation of pharmaceuticals. This includes requisitions, prescriptions, records of medication chart orders, records of supply other than on prescription and receipts/records of delivery. | Retain minimum of 2 years after date of supply, then destroy |
| 5.1.2| Medication charts and incident reports

See **1.0.0** for patient health care records | To be retained and disposed of in accordance with the type of patient record they comprise |
| 5.1.3| Registers. This includes Registers of drugs of addiction (H31, H32) held in the Pharmacy Department, Ward or other department. | Retain minimum of 7 years after date of last entry, then destroy |

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64 The Poisons and Therapeutic Goods Act 1966 and the Poisons and Therapeutic Goods Regulation 2002 require certain records to be created and maintained by those responsible for the control, storage and supply of certain substances and drugs of addiction. These records should be maintained by the relevant area, department or ward of the service, for example pharmacy records should be maintained in the Pharmacy Department, ward records in the ward. The minimum retention periods for these records incorporate current minimum retention requirements in accordance with the Regulation. The National Health Act 1953 (C’wth) also regulates the retention of prescription and order forms.

65 Requisitions, prescriptions, orders etc for drugs of addiction, pentazocine or drugs listed in the Poisons and Therapeutic Goods Regulation 2002 PD2013_043 Medication Handling in NSW Public Health Facilities.

66 Drug or medication charts comprising the medication orders written by medical staff and records of administration written by nursing or medical staff should be filed and maintained as part of the main (unit) patient record and retained accordingly.

67 Services should note that this is longer than the 2 year period required by the Regulation.
### 9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.4</td>
<td>Stock and inventory control records. This includes requisitions and orders for pharmaceutical products or substances and receipts/records of delivery.</td>
<td>Retain minimum of 2 years after date of last entry or action, then destroy</td>
</tr>
<tr>
<td>5.1.5</td>
<td>Section 100 (highly specialised) drugs. This includes prescriptions and declaration forms signed by the prescriber.</td>
<td>Retain minimum of 7 years after date of receipt, then destroy</td>
</tr>
<tr>
<td>5.1.6</td>
<td>Special Access Scheme (SAS) drugs consent forms for non-admitted patients</td>
<td>Retain: - minimum of 7 years after last action, or - until child attains or would have attained the age of 25 years, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>5.1.7</td>
<td>Therapeutic Drugs Administration (TGA) application forms, e.g., form no. 2949 (0105), where only copies are held by the public health organisation</td>
<td>Retain minimum of 7 years after last action, then destroy</td>
</tr>
<tr>
<td>5.1.8</td>
<td>Records relating to applications to prescribe drugs of addiction for persons. This includes Methadone or Buprenorphine Program records, medical reports, authorities, treatment proposals, correspondence etc.</td>
<td>Retain minimum of 7 years after date of last entry, then destroy</td>
</tr>
<tr>
<td>5.1.9</td>
<td>Records relating to reports of lost or stolen drugs or lost or stolen drug registers</td>
<td>Retain minimum of 10 years after action completed, then destroy</td>
</tr>
</tbody>
</table>

#### 6.0.0 NOTIFICATIONS
- Notification and reporting to prescribed bodies regarding patient medical conditions, instances or episodes in accordance with statutory or other requirements.
- For records created prior to 1930 see 10.0.0
- For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning see 9.0.0

#### 6.1.0 Births and deaths
- Copies of birth registration forms
  - To be retained and disposed of in accordance with the type of patient record they comprise. See 1.0.0 for patient health care records
- Copies of death certificates retained separately from the main patient record
  - Retain minimum of 1 year after date of notification, then destroy

#### 6.2.0 Health reporting

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68 See NSW Ministry of Health PD2013_055 Accreditation of Community Prescribers - Highly Specialised Drugs for HIV, Hepatitis B & Hepatitis C.
69 Consent forms for admitted patients are to be placed on the main patient (unit) record and retained and disposed of in accordance with the type of patient record they comprise. See 1.0.0 for patient health care records
70 These records are held by the NSW Health Pharmaceutical Services Branch.
71 A copy of the birth registration form is given to the parents and where possible a copy is to be filed and maintained as part of the main (unit) patient record.
72 Where possible a copy of the death certificate is to be filed and maintained as part of the main (unit) patient record and retained accordingly.
### 9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2.1</td>
<td>Records of notification maintained by hospitals, community health services etc fulfilling obligations to report notifiable diseases etc under the <em>Public Health Act 1991</em>[^73]</td>
<td>Retain: - minimum of 15 years after last attendance, date of death or still birth or after last 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 the longer, then destroy</td>
</tr>
<tr>
<td>6.2.2</td>
<td>Records relating to the initial report of an incidence of a notifiable disease maintained by Public Health Units</td>
<td>Retain minimum of 7 years after receipt of the notification, then destroy</td>
</tr>
<tr>
<td>6.2.3</td>
<td>Duplicate records of notifications received by Public Health Units subsequent to the initial notification</td>
<td>Retain until no longer required for administrative or reference purposes, then destroy</td>
</tr>
</tbody>
</table>

### 7.0.0 PATIENT/CLIENT FINANCE AND PROPERTY MANAGEMENT

Management of patient/client finances and property during their admission to a facility or service

For records created prior to 1930 see 10.0.0

For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning see 9.0.0

<table>
<thead>
<tr>
<th>7.1.0</th>
<th>Patient property</th>
<th>Records relating to the management of patient property</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.1</td>
<td>Patient Property and Wearing Apparel books</td>
<td>Retain minimum of 6 years after date of last entry, then destroy</td>
</tr>
<tr>
<td>7.1.2</td>
<td>Patient Money and Valuables register</td>
<td>Retain minimum of 6 years after date of last entry, then destroy</td>
</tr>
<tr>
<td>7.1.3</td>
<td>Patient Money and Valuables register where a copy page from the register is maintained in the main (unit) patient record and the copy page is used to record the movement and disposal of property and money to the patient etc[^74]</td>
<td>Retain minimum of 1 year after date of last entry, then destroy</td>
</tr>
<tr>
<td>7.1.4</td>
<td>Patient/client authorities to make payment or transfer property</td>
<td>Retain minimum of 6 years after date of last entry, then destroy</td>
</tr>
</tbody>
</table>

### 7.2.0 Patient/client accounts and finances

Records relating to the management of patient finances including accounts, benefits and claims

| 7.2.1 | Assigned Benefits Claim books | Retain minimum of 1 year after last completed entry, then destroy |

[^73]: Notification requirements are outlined in NSW Department of Health IB2013_010 Notification of diseases under the *Public Health Act 1991*. Documents maintained as part of the patient record are to be retained and disposed of in accordance with the type of patient record they comprise. For the retention and disposal of cancer notification forms and registers, including the PAP Test Register, maintained by the NSW Department of Health see Disposal Authority DA25, entry 7.2.0 re data collections.

[^74]: Services or facilities must have in place a system to be able to undertake an inventory of items held at any time.
### Classes of records

<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2.2</td>
<td>Hospital Private Patient Claim and Assignment form (HC21) and Patient Election forms</td>
<td>Retain minimum of 6 years after action completed, then destroy</td>
</tr>
<tr>
<td>7.2.3</td>
<td>Register of Patient Admission and Account forms</td>
<td>Retain minimum of 6 years after date of last entry, then destroy</td>
</tr>
<tr>
<td>7.3.0</td>
<td>Program of Appliances for Disabled People (PADP)</td>
<td>Retain minimum of 6 years</td>
</tr>
<tr>
<td>7.3.1</td>
<td>Applications for PADP aids, appliances and services</td>
<td>Retain minimum of 3 years after last contact with or use of service, then destroy</td>
</tr>
<tr>
<td>7.3.2</td>
<td>Records relating to the provision and maintenance of PADP services</td>
<td>Retain minimum of 5 years after action completed, then destroy</td>
</tr>
</tbody>
</table>

### RESEARCH MANAGEMENT

Management of the conduct 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 (eg Research Ethics Committees)

- For records created prior to 1930 see 10.0.0
- For records that have been duplicated by means of imaging technologies such as microfilming or digital scanning see 9.0.0

<table>
<thead>
<tr>
<th>8.1.0</th>
<th>Research projects, trials or studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1.1</td>
<td>Records relating to the conduct of clinical research. This includes records or documentation relating to the recruitment and consent of research participants, the collection and analysis of data, preliminary findings, surveys, and results.</td>
</tr>
<tr>
<td>8.1.2</td>
<td>Records relating to the conduct of non clinical research or research not involving humans. This includes records or documentation relating to the recruitment and consent of research participants, the collection and analysis of data, preliminary findings, surveys and results.</td>
</tr>
<tr>
<td>8.1.3</td>
<td>Records of requests to access records for approved clinical research purposes where the research proceeds</td>
</tr>
</tbody>
</table>

---

75 Regard should be had to the expected life span of the equipment before destruction of records proceeds.

76 Retention periods are based on recommendations for the retention of research data in Section 2.3 of the Joint National Health and Medical Research Council (NHMRC)/Australian Vice-Chancellor’s Committee (AVCC) Statement and Guidelines on Research Practice (May 1977). See also the International Committee for Harmonisation (ICH) Guidelines for Good Clinical Practice, sections 4.9.4 and 4.9.5 and the NHMRC National Statement on Ethical Conduct in Research Involving Humans (1999).

77 NHMRC guidelines recommend that where materials of a biological origin are being used in a clinical trial or research project records should be retained for appropriate periods of time to monitor effects and trace all participants in the event that late or long term effects emerge. Where the data is crucial to the substantiation of research findings and cannot readily be duplicated elsewhere, longer retention periods may also be appropriate.

78 Where possible requests to access records for research purposes should be maintained as part of the main (unit) patient record and retained accordingly.
<table>
<thead>
<tr>
<th>No</th>
<th>Classes of records</th>
<th>Disposal Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1.4</td>
<td>Records of requests to access records for approved non-clinical research purposes</td>
<td>Retain minimum of 5 years after the expected research completion date or date of termination of the study, then destroy</td>
</tr>
<tr>
<td></td>
<td>where the research proceeds</td>
<td></td>
</tr>
<tr>
<td>8.1.5</td>
<td>Records of requests relating to projects where the research does not proceed</td>
<td>Retain minimum of 3 years after last action, then destroy</td>
</tr>
<tr>
<td>9.0.0</td>
<td><strong>RECORDS IMAGING</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duplication of records by means of imaging technologies for storage, access,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>reference or related management purposes</td>
<td></td>
</tr>
<tr>
<td>9.1.0</td>
<td><strong>Records that have been imaged</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This refers to records identified in the previous sections which have been subject</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to processes resulting in the creation of authentic, complete and accessible copies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of the records in digital or microform format and which are not required as State</td>
<td></td>
</tr>
<tr>
<td></td>
<td>archives.<strong>79</strong></td>
<td></td>
</tr>
<tr>
<td>9.1.1</td>
<td>Originals of records that have been imaged and that are not required as State</td>
<td>Retain until all requirements for the retention of the originals have been fulfilled, then destroy</td>
</tr>
<tr>
<td></td>
<td>archives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See section 2.4 of Part 2 of this Authority for additional conditions relating to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the destruction of originals.</td>
<td></td>
</tr>
<tr>
<td>9.1.2</td>
<td>Master copies of imaged records</td>
<td>Retain in accordance with the retention period and disposal action that applied to the original record</td>
</tr>
<tr>
<td>9.1.3</td>
<td>Reference, working or superseded copies of imaged records</td>
<td>Retain until no longer required for reference purposes, then destroy</td>
</tr>
<tr>
<td>9.1.4</td>
<td>Affidavits and documentation relating to records authenticity</td>
<td>Retain until the master copy of the records to which they relate is destroyed or superseded, then destroy</td>
</tr>
<tr>
<td>10.0.0</td>
<td><strong>PRE 1930 RECORDS</strong></td>
<td></td>
</tr>
<tr>
<td>10.1.0</td>
<td>Patient/client records created prior to 1930. This refers to records identified in</td>
<td>Required as State archives</td>
</tr>
<tr>
<td></td>
<td>the previous sections created wholly or in part prior to 1930.</td>
<td></td>
</tr>
</tbody>
</table>

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79 Originals of records required as State archives that have been imaged are not to be destroyed.

80 The determination of appropriate retention periods for the originals of records that have been imaged must allow adequate time for data verification and audit requirements. Originals of records that have been imaged or duplicated in a way that does not comply with the requirements of the *Evidence Act 1995* will need to be retained and disposed of in accordance with the requirements for the type of records they comprise.
9. HEALTH RECORDS AND INFORMATION

Part 2: Understanding and using the authority

1.1 Overview

Purpose
The purpose of issuing the *General Retention and Disposal Authority - Public Health Services: Patient/Client records* is to permit public health services and facilities to destroy certain health care records of patients and clients, after appropriate minimum retention periods have been met, and to identify which patient/client records are required as State archives.

Previous disposal authorisations superseded

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

<table>
<thead>
<tr>
<th>General Disposal Authority</th>
<th>Parts superseded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Services: Patient/Client Records (GDA5) 1999</td>
<td>Whole</td>
</tr>
</tbody>
</table>

Changes to retention periods to note:

<table>
<thead>
<tr>
<th>Assisted Reproductive Technology</th>
<th>see 1.7.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic recordings, including x-rays, graphical recordings etc</td>
<td>see 1.3.1 and 3.3.0</td>
</tr>
<tr>
<td>Diagnostic results and reports maintained by pathology or laboratory services</td>
<td>see 4.2.0</td>
</tr>
<tr>
<td>Drugs registers</td>
<td>see 5.1.3</td>
</tr>
</tbody>
</table>

What records does this 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
- patient administration registers, systems and databases used to record summary information about patients and clients
- records relating to diagnostic imaging and pathology and laboratory services
- 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

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 also 2.3 below). 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. Services should consult the following for disposal authorisation.
9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>For records relating to the function or activity of:</th>
<th>Use the following General Retention and Disposal Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>General administration (ie not health sector specific)</td>
<td>General Retention and Disposal Authority – Administrative records</td>
</tr>
<tr>
<td>Personnel</td>
<td>General Retention and Disposal Authority – Personnel records</td>
</tr>
<tr>
<td>Financial management</td>
<td>General Retention and Disposal Authority – Finance and Accounting records</td>
</tr>
</tbody>
</table>

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 State Records.

Providing feedback
To suggest amendments or alterations to this authority please contact us via email disposal@records.nsw.gov.au or phone (02) 8247 8636.

Further assistance
To obtain assistance in the interpretation or implementation of this authority, or any of our general retention and disposal authorities, contact us via email disposal@records.nsw.gov.au or phone (02) 8247 8636.

2.2 Guidelines for implementation

Introduction
Comprehensive information about implementation of disposal authorities is found in State Records’ guideline on sentencing records, guideline on destruction of records and procedures for transferring records as State archives.

Minimum retention periods
The authority specifies minimum retention periods for all records not required as State archives. A Service must not destroy or otherwise dispose of records before the minimum retention period has expired. Services may retain records for longer periods of time, subject to organisational need, without further reference to State Records. Reasons for longer retention can include legal requirements, administrative need, on-going research use or government directives.

Retention of electronic records
Electronic records must be protected and readily accessible for the specified minimum retention period. See Future Proof: Ensuring the accessibility of equipment/technology dependent records for information relating to managing the accessibility of electronic and other technology dependent records.

Destroying records
When the authorised minimum retention period has been reached, appropriate arrangements for the destruction of records may be undertaken without further reference to State Records, unless otherwise advised. Persons using the Authority should apply it with caution, bearing in mind that the authorisations for disposal are given in terms of the State Records Act only. It is the responsibility of the public office to ensure that all legal and other organisational requirements for retention of records have been met before disposing of any of its records. A public office must not destroy any records where the public office is aware of possible legal action, investigation or inquiry where the records may be required as evidence.
9. HEALTH RECORDS AND INFORMATION

Transferring records required as State archives
Records identified in the Authority as being required as State archives should be prepared for transfer to State Record’s custody and/or control only when they are no longer required for ongoing business use.

Transfer of ownership must be authorised
Regardless of whether a record has been authorised 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 State Records.

2.3 Records required as State archives

Introduction
Records which are to be retained as State archives are identified with the disposal action Required as State archives.

Pre 1930 records
Patient/client records listed in this authority created wholly or in part prior to 1930 are required as State archives (for example a file started in 1913 and ending shortly after 1930). Prior to proposing to transfer pre 1930 records as State archives services should contact State Records to discuss the condition, types, content and quantities of records involved. Some records may be subject to further appraisal and review if State Records does not consider their retention as State archives is warranted.

Identifying significant and unique collections of records
The provisions relating to significant or unique collections of patient records (see 1.12.0 in the table of authorised disposal actions) are included for special exceptions that may arise from time to time. Individual services may identify exemplary or significant collections or samples of records amongst their holdings that warrant ongoing retention as State archives. This may be because 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

This may encompass records relating to a particular time period or to the treatment of a particular illness or condition or records of a specific service, facility or research project.

Services that think that they hold records of significance should contact State Records.
2.4 Records that have been imaged

This authority authorises the destruction of original health care records that have been imaged provided that the following conditions have been met:

- the records are not identified in the authority as State archives
- all requirements for retaining the originals have been assessed and fulfilled
- copies are made which are authentic, complete and accessible for the authorised minimum retention period

See *Future Proof: Ensuring the accessibility of equipment/technology dependent records* for information relating to managing the accessibility of technology dependent records and *Digital Imaging and Recordkeeping* for guidance concerning the use of imaging technologies.

Part 3: Acknowledgements and sources

Introduction
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- School of Health Services Management, University of NSW
- South Western Pathology Services


*Health Administration Act 1982*
*Health Services Act 1997*
*Human Tissue Act 1983*
*Human Tissue and Anatomy Legislation Amendment Act 2003*
*Human Tissue Regulation 2000*
*Mental Health Act 1990*
*Mental Health Regulation 2000*
*Poisons and Therapeutic Goods Act 1966*
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*Public Health Act 1991*
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National Pathology Accreditation Advisory Council (NPAAC) *Retention of Laboratory Records and Diagnostic Material*, 3rd edition, 2002
NSW Department of Health *Circul ars*
NSW Department of Health *Health Records and Information Manual for Community Health Facilities*
NSW Department of Health *Patient Matters Manual*
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The following index is provided to enable easy reference to records covered by the “General Retention and Disposal Authority - Public Health Services: Patient/Client Records.”

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  patient record copy ........................................................................................ 1.0.0
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  electronic health records .................................................. 1.11.0
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GENERAL RETENTION AND DISPOSAL AUTHORITY – ORIGINAL OR SOURCE RECORDS THAT HAVE BEEN COPIED (GA 45) (IB2015_052)


PURPOSE

To notify the Health system that State Records Authority General Retention and Disposal Authority: *Original or source records that have been copied (GA 45)* has been issued to replace General Retention and Disposal Authority: *Imaged records (GA36)*.

GA 45 provides for the authorised destruction of original or source records that have been copied, provided that certain conditions are met.

KEY INFORMATION

GA 45 provides for the authorised disposal of certain State records which have been successfully copied using microfilming or digital imaging processes. In particular, it describes the circumstances and conditions under which the destruction of certain original or source records is permitted under the provisions of the *State Records Act 1998* after they have been copied.

Whereas GA36 established the conditions under which original records that had been microfilmed or imaged could be destroyed, it primarily applied to paper and excluded records identified as State archives or those required to be retained where created prior to 2000.

The main changes from GA36 to GA45 are:

- Records that are required as State archives or required to be retained in agency may now be destroyed after copying (if the conditions have been met and they do not fall within the exclusions categories) if they were created after 1980, rather than 2000.
- The scope of the authority was widened from original records copied using microfilming or digital imaging processes, to original or source records that have been copied.
- The requirement to assess all requirements for retaining originals was removed, as this condition has become less relevant due to digital copies of paper records being widely accepted.
- Additional exclusions have been included in GA 45 to cover State archives on loan from State Records and records that have high personal value to individuals who were subject to Government control.

Further information on GA45 can be accessed on the State Records website:

http://www.records.nsw.gov.au/recordkeeping/rules/retention-and-disposal-authorities/general-retention-and-disposal-authorities/original-or-source-records-that-have-been-copied-1/frequently-asked-questions-re-original-or-source-records-that-have-been-copied

To download the GDA please go to


251(10/09/15)
The Board of the State Records Authority approved under the provisions of the State Records Act 1998 on 20 October 2004 the attached “General Retention and Disposal Authority – Departments of Forensic Medicine (Public Health System) as the legal authority for disposing of records retained by Departments of Forensic Medicine in the Public Health System.

Public health services are reminded that the authorisations for destruction of records are given in terms of the State Records Act only. A public health service must not destroy any records where they are aware the records may be required as evidence for the purposes of possible legal action or an investigation or enquiry.

<table>
<thead>
<tr>
<th>GDA no</th>
<th>GDA19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public office</td>
<td>Departments of Forensic Medicine (Public Health System).</td>
</tr>
<tr>
<td>Scope</td>
<td>This general retention and disposal authority covers records created by public health system Departments of Forensic Medicine since 1963.</td>
</tr>
<tr>
<td>Authority</td>
<td>This general retention and disposal authority is issued under section 21(2)(c) of the State Records Act. It has been approved by the Board of the State Records Authority in accordance with section 21(3) of the State Records Act.</td>
</tr>
<tr>
<td>Authorised</td>
<td>David Roberts Director State Records Authority of New South Wales 20/10/2004</td>
</tr>
</tbody>
</table>

How to use the General Retention and Disposal Authority

The disposal process

Disposing of State records involves assessing the value of records for future use, identifying those State records that have continuing value as State archives and identifying how soon the remainder can be destroyed or otherwise disposed of. Disposal can also involve transfer of ownership or custody of records and the alteration of records.

This general retention and disposal authority is issued 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 State 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 State Records does not disapprove. Advice on the State Records Act can be obtained from State Records.

Purpose of the authority

This general retention and disposal authority authorises the destruction or other disposal of State records as required by the State Records Act.
9. HEALTH RECORDS AND INFORMATION

Using 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 is to be used to sentence records. Sentencing is the examination of records in order to identify the disposal class to which they belong. This process enables the sentencing officer to determine the appropriate disposal action for the records. Advice on sentencing can be obtained from State Records.

Where the format of records has changed (for example, from paper-based to electronic) this does not prevent the disposal classes from being used to sentence records which perform the same function. The information 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 also the General Disposal Authority – Records of short term value that have been imaged). Public offices will need to ensure that any software, hardware or documentation required to gain continuing access to technologically dependent records is available for the periods prescribed.

Disposal action

Records that are identified as being required as State archives should be stored in controlled environmental conditions. Control of these records should be transferred to State Records when they cease to be in use for official purposes.

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

In some cases State Records may withhold authorisation for the disposal of a particular disposal class or possibly a whole function or activity. This would be used where records have been identified as having some immediate short term requirements for retention such as pending legal action. These records will need to be re-appraised at the end of a designated period. This re-appraisal process is necessary as the circumstances which instigate the need for the records to be retained for a longer period may also affect the ‘value’ of the records.

Regardless of whether a record has been authorised 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 authorisation of State Records.

Amendment and review of this authority

State Records must approve any amendment to this authority. Public offices that use the authority should advise State Records of any proposed changes or amendments to the authority.

State Records recommends a review of this authority after five years to establish whether its provisions are still appropriate. State Records may propose a review of the authority at any other time, particularly in the case of change of administrative arrangements or procedures which are likely to affect the value of the records covered by this authority.
In all cases the process of review will involve consultation between State Records and the public offices. If the process of review reveals that this authority requires amendment, the necessary amendments will be made and authorised.

Contact Information

State Records
PO Box 516 Kingswood NSW 2747
Telephone: (02) 8247 8627
Facsimile: (02) 8247 8626
E-mail: govrec@records.nsw.gov.au

<table>
<thead>
<tr>
<th>1.0.0</th>
<th>Forensic pathology and Laboratory Services</th>
<th>The function of delivering forensic pathology and laboratory services. Includes developing, implementing and evaluating pathology policy and practice strategies, conducting autopsies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.0</td>
<td>Autopsy</td>
<td>The activity of conducting autopsies for coronial and non coronial purposes. Includes preliminary screenings and ancillary services. Includes testing of samples.</td>
</tr>
<tr>
<td>1.1.1</td>
<td>Summary and control records of autopsies performed and samples tested. Includes examination registers and indexes. See below 1.1.3 for the disposal of the post mortem report.</td>
<td>Required as State archives</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Records relating to directions by the Coroner regarding the autopsy process.</td>
<td>Required as State archives</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Records relating to post mortem reports (coronial and non-coronial). Includes post mortem report, radiography images, x-rays, neuropathology results, sample test results, case sheets, photographs. Also includes consents for approval to conduct research for scientific and medical purposes and consents to conduct non-coronial autopsies.</td>
<td>Required as State archives</td>
</tr>
<tr>
<td>1.2.0</td>
<td>Body control</td>
<td>The activity of controlling the movement and storage of bodies. Includes admission, storage, transportation, release and transfer.</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Records relating to admission and release or transfer of bodies.</td>
<td>Retain minimum of 20 years after last action, then destroy</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Records relating to the storage of bodies including sealing of body bags.</td>
<td>Retain minimum of 20 years after last action, then destroy</td>
</tr>
<tr>
<td>1.2.3</td>
<td>Records relating to management of deceased’s clothing and possessions.</td>
<td>Retain minimum of 20 years after last action, then destroy</td>
</tr>
<tr>
<td>1.2.4</td>
<td>Records relating to approved body carriers.</td>
<td>Retain minimum of 6 years after termination of contract, then destroy</td>
</tr>
<tr>
<td>1.3.0</td>
<td>Body identification</td>
<td>The activity of identifying deceased persons or skeletal remains through forensic anthropology and odontology. Includes determining cause of death of skeletal remains.</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>Retention</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>-----------</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Records relating to identification of deceased persons or skeletal remains, including dental x-rays.</td>
<td>Required as State archives</td>
</tr>
<tr>
<td>1.4.0</td>
<td>Body screening</td>
<td>The use of tissue samples to screen bodies for infectious/contagious disease prior to autopsy.</td>
</tr>
<tr>
<td>1.4.1</td>
<td>Records relating to the screening of bodies for infectious/contagious disease.</td>
<td>Retain minimum of 20 years after last action, then destroy</td>
</tr>
<tr>
<td>1.5.0</td>
<td>Compliance</td>
<td>The activity of complying with applicable legislation and standards. Includes obtaining and complying with licences and accreditation.</td>
</tr>
<tr>
<td>1.5.1</td>
<td>Records relating to licences and accreditation to conduct pathology and laboratory services.</td>
<td>Required as State archives</td>
</tr>
<tr>
<td>1.6.0</td>
<td>Counselling</td>
<td>The activity of counselling next of kin.</td>
</tr>
<tr>
<td>1.6.1</td>
<td>Records relating to management of next of kin support groups.</td>
<td>Retain minimum of 10 years after last action, then destroy</td>
</tr>
<tr>
<td>1.6.2</td>
<td>Records relating to individual cases of grief counselling. Includes case running sheets and correspondence with next of kin or relevant parties.</td>
<td>Retain minimum of 10 years after last action, then destroy</td>
</tr>
<tr>
<td>1.7.0</td>
<td>Education and training</td>
<td>The activity of providing education and training in autopsy related matters. Includes visits and lectures.</td>
</tr>
<tr>
<td>1.7.1</td>
<td>Records relating to development and delivery of training, visits, lectures in autopsy related matters. Includes lecture notes.</td>
<td>Retain minimum of 10 years after last action, then destroy</td>
</tr>
<tr>
<td>1.7.2</td>
<td>Records relating to arrangements for training, visits and lectures.</td>
<td>Retain minimum of 2 years after last action, then destroy</td>
</tr>
<tr>
<td>1.8.0</td>
<td>Forensic research</td>
<td>The activity of conducting research.</td>
</tr>
<tr>
<td>1.8.1</td>
<td>Records relating to ethics approvals to conduct research.</td>
<td>Required as State archives</td>
</tr>
<tr>
<td>1.8.2</td>
<td>Records relating to original research projects where the research data is unique and not able to be easily replicated.</td>
<td>Required as State archives</td>
</tr>
<tr>
<td>1.8.3</td>
<td>Records relating to research projects where the data is collected and collated from other sources and could be replicated.</td>
<td>Retain minimum of 20 years after last action, then destroy</td>
</tr>
<tr>
<td>1.9.0</td>
<td>Liaison</td>
<td>The activity of liaising with the NSW Police, Department of Health, individual hospitals and other forensic medicine bodies.</td>
</tr>
<tr>
<td>1.9.1</td>
<td>Records relating to requests for hospital records and their subsequent return to the respective hospital.</td>
<td>Retain minimum of 10 years after last action, then destroy</td>
</tr>
<tr>
<td>1.9.2</td>
<td>Copies of hospital records.</td>
<td>Retain maximum of 1 month, then return to hospital of origin</td>
</tr>
<tr>
<td>1.9.3</td>
<td>Records relating to liaison with NSW police regarding a case.</td>
<td>Retain minimum of 10 years after last action, then destroy</td>
</tr>
<tr>
<td>1.9.4</td>
<td>Records relating to requests and correspondence with other forensic medicine bodies including those interstate and overseas.</td>
<td>Retain minimum of 20 years after last action, then destroy</td>
</tr>
<tr>
<td>1.10.0</td>
<td>Medico-legal opinions</td>
<td>The activity of providing medico-legal opinions to external persons or organisations. Includes case studies. See Autopsy for post mortem reports.</td>
</tr>
<tr>
<td>1.10.1</td>
<td>Records relating to the provision of medico-legal opinions by forensic pathologists.</td>
<td>Required as State archives</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>1.11.0</td>
<td>Policy and procedures The activity of developing policy and procedures with regard to pathology and laboratory services. Includes procedures for dealing with emergencies and disasters and policy and procedures for management of samples.</td>
<td></td>
</tr>
<tr>
<td>1.11.1</td>
<td>Records relating to development and implementation of autopsy policy and procedures.</td>
<td>Required as State archives</td>
</tr>
<tr>
<td>1.12.0</td>
<td>Sample control The activity of controlling the movement, management and disposal of body samples. *Note: Samples of blood, bone, tissue, fluids, etc are not State records and should be disposed of in accordance with relevant standards and policies.</td>
<td></td>
</tr>
<tr>
<td>1.12.1</td>
<td>Records relating to the movement, management and disposal of body samples.</td>
<td>Retain minimum of 20 years after last action, or until samples are disposed of, whichever is the longer, then destroy</td>
</tr>
<tr>
<td>1.12.2</td>
<td>Copies of records relating to retention of tissue.</td>
<td>Retain until no further use, then destroy</td>
</tr>
<tr>
<td>1.13.0</td>
<td>Waste control The activity of controlling waste from pathology and laboratory processes.</td>
<td></td>
</tr>
<tr>
<td>1.13.1</td>
<td>Records relating to waste water discharge and recycling of chemicals.</td>
<td>Retain minimum of 10 years after last action, then destroy</td>
</tr>
</tbody>
</table>
9. HEALTH RECORDS AND INFORMATION

CHILD DEATH REVIEW TEAM - ACCESS TO RECORDS (IB2014_028)


PURPOSE

The NSW Child Death Review Team (CDRT) reviews the deaths of children in NSW. The purpose of the CDRT is to prevent and reduce child deaths.

The purpose of this information bulletin is to provide advice to the NSW Health system regarding the requirements of current legislation in relation to the CDRT’s access to medical/health records.

KEY INFORMATION

Amendments to the Community Services (Complaints, Reviews and Monitoring) Act 1993 No 2 were made in 2011\(^1\) in response to the Special Commission of Inquiry into Child Protection Services in NSW which was led by the Hon James Wood AO QC in 2008.

These changes had no ostensible impact on the existing requirements for NSW Health agencies in relation to providing full and unrestricted access to records reasonably required for the CDRT to perform its functions. One notable change however, was the transfer of responsibility for support and assistance of the CDRT from the then Commission for Children and Young People to the office of the NSW Ombudsman, and made the Ombudsman the Convenor of the CDRT.

Legislation providing for the Ombudsman to be the Convenor of the CDRT came into effect on 16 November 2011. Under the Children and Young Persons (Care and Protection) Act 1998 and Section 38 of the Community Services (Complaints, Reviews and Monitoring) Act 1993, there are provisions for the exchange of information about children and young people who have died. The Ombudsman can request full and unrestricted access to NSW Health records when investigating a reviewable death or a death reviewable by the CDRT.

Under Part 5A of the Community Services (Complaints, Reviews and Monitoring) Act 1993, the CDRT’s functions include:

- Maintaining the register of child deaths occurring in NSW.
- Classifying those deaths according to cause, demographic criteria and other relevant factors.
- Data analysis to identify relevant patterns and trends.
- Undertake research to prevent or reduce the likelihood of child deaths.
- Make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths.
- Identify further research required by the CDRT or other agencies or persons.

The following persons are required under Section 34K to provide the CDRT with full and unrestricted access to records reasonably required for the purpose of the CDRT exercising its functions:

- The Director-General, the Department Head, Chief Executive Officer or senior member of any department of the government, statutory body or local authority.
- The Commissioner of Police.
- The State Coroner.
- A medical practitioner or health care professional who, or the head of a body which, delivers health services to children.
- A person who, or the head of a body which, delivers welfare services to children (including family support services, children’s services, foster care or residential out-of-home care, and disability services).
- The principal of a non-government school (within the meaning of the Education Act 1990).

\(^1\) Children Legislation Amendment (Child Death Review Team) Act 2011 No 60
This includes the right to inspect and, on request, to be provided with copies of, any record referred to in that subsection and to inspect any non-documentary evidence associated with any such record. In the legislation, ‘record’ means any document or other source of information compiled, recorded or stored in written form or on film, or by electronic process, or in any other manner or by any other means.

The legislation also details the requirements of the CDRT related persons in relation to maintaining confidentiality of any information acquired for the purposes of the CDRT.

Each Local Health District must ensure requests for information by the CDRT are met as required, and should implement protocols to facilitate this.

It is noted that:

• Any request from the CDRT should be in writing and reference the legislative provisions relied upon by the CDRT for the release of patient information, namely section 34K of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (“the Act”). The release must be required for the purpose of the CDRT exercising its functions pursuant to section 34D of the Act.

• Any request from the Ombudsman should be in writing and reference the legislative provisions relied upon for the release of patient information, namely section 38 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (“the Act”). The release must be required for the purpose of the Ombudsman’s functions pursuant to section 36 of “the Act.”

NSW privacy legislation allows the release of personal and/or health information in circumstances where the organisation (a Local Health District for example) is lawfully authorised to disclose the information; as outlined above.

Where information requested by the Ombudsman or the CDRT contains any reference to reports of Risk of Significant Harm (ROSH), the Health service or health worker handling the request should confirm whether details of the reporter’s identity and/or the ROSH report itself are required. If not, de-identified information should be provided. Refer to section 29 of the *Children and Young Persons (Care and Protection) Act 1998* for further information regarding the protection of reporter identity and legal exceptions. Also see PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health Section 9.1.2 for legal and policy advice on the protection of a reporter’s identity.
NOTIFIABLE CONDITIONS DATA SECURITY AND CONFIDENTIALITY (PD2012_047)


PURPOSE

The purpose of this policy is to provide guidance for NSW Health staff to manage the security and confidentiality of Notifiable Conditions data in any form, either unit records or aggregated form. This includes:
- Paper notification records;
- Electronic notification records;
- The Notifiable Conditions Information Management System (NCIMS);
- The Secure Analytics for Population Health Research and Intelligence (SAPHaRI); and/or
- Any other form of data that has not been approved for release in the public domain.

MANDATORY REQUIREMENTS

All NSW Health and Local Health District staff must comply with this policy when accessing, managing or analysing notifiable conditions data.

Prior to accessing notifiable conditions data, NSW Health staff must sign each page of the Notifiable Conditions Data Security and Confidentiality Policy Directive, to confirm that they have read, understood and agreed to comply with the policies, procedures and conditions set out in it.

Release of notifiable conditions data must be managed according to section 4 – Data and information release.

IMPLEMENTATION

This policy directive should be distributed to all NSW Health staff. Staff with access to notifiable conditions data must follow the procedure set out in this policy directive.

All staff with access to notifiable conditions data in any form must sign the Notifiable Conditions Data - Confidentiality and Security Agreement at Appendix 1.

1. INTRODUCTION

1.1 About this document

Notifications of Scheduled Medical Conditions made under the Public Health Act include highly confidential information. NSW Health staff from Local Health Districts and the NSW Ministry of Health with access to such information should always protect the security and confidentiality of this information.

1.2 Key definitions

This policy refers to the security and confidentiality of Notifiable Conditions data in any form, either unit records or aggregated data. This includes paper or electronic notifications, the Notifiable Conditions Information Management System (NCIMS), the Secure Analytics for Population Health Research and Intelligence (SAPHaRI), or any other form that has not been approved for release in the public domain.
2. LEGAL AND LEGISLATIVE CONTEXT

The conditions and procedures set out in this document are supplemental and subordinate to any State or Commonwealth statutes, legislation or regulations and any NSW Health policies or guidelines subsequently issued by the Director-General which relate to confidentiality and data security.

Specifically, management of confidential notification data are referred to in the following legislation:

- NSW Public Health Act 2010
- Health Administration Act 1982

NSW Health Employees with access to notifiable conditions data must also acquaint themselves with the NSW Health Records and Information Privacy Act 2002 and the Privacy Manual for Health Information (March 2015).

3. ACCESS TO SCHEDULED MEDICAL CONDITIONS DATA

3.1 Personnel

Access to notifiable conditions data for NSW Health Staff should be limited to the minimum level required to fulfil the functions of their position. Individuals requesting access to scheduled medical conditions data (and their managers) must:

- Be aware of their responsibilities with regard to information privacy.
- Undertake training on the operation of any databases or systems which they will operate to record or access personal health information in relation to notifiable conditions data.
- Complete the Confidentiality Agreement (Appendix 1) and identify the appropriate level of access according to their position and role.

3.2 Security

3.2.1 Password Security

NSW Health staff with access to databases containing information on notifiable conditions must observe the following measures in order to maintain security:

- Each individual is assigned a unique username. Access to the data will be controlled by a password. The password must be known only to the individual.

---

Notifiable Condition | A medical condition listed under Schedule 1, 2 or 3 in the NSW Public Health Act (excluding category 1 conditions and cancer).
Unit record data | For the purpose of this policy directive, ‘unit record data’ are line listed electronic records of information that relate to the health of an individual which are held by NSW state data collections and owned by NSW Health.
Identifiable data | Information that allows identification of a specific individual.
De-identified data | Information from which identifiers have been permanently removed, or where identifiers have never been included. De-identified information cannot be re-identified.
Aggregate data | Summary data from analysis of unit record data by broad categories (such age group, sex or geographic location) so that it is not possible to identify the individual.
Disclosure | Communication or transfer of information outside NSW Health or Local Health District to Universities, and all other organisations or individuals.
Data custodian | The person with responsibility and administrative control over the ongoing development, data collection, maintenance, review of the data collection and granting access to data.
9. HEALTH RECORDS AND INFORMATION

- Passwords are required to be a minimum 6 and maximum 12 characters and contain at least one numeric and at least one text character.
- The individual must not record their password in any file or other electronic document, no matter where or how such a file or document is stored.
- Individuals must change their passwords when requested by system administrators.

3.2.2 Electronic Security

- Access to notifiable conditions data through the NCIMS web based application is to be through individual login passwords only.
- When an individual’s access to the notifiable conditions data is no longer required (i.e. the role of the staff member changes, or their employment by the organisation at which they worked when the Confidentiality Agreement was signed), the staff member and/or manager must notify the System Administrators of their changed circumstance, so that role changes can be made or logins disabled.
- System administrators will undertake an audit of NSW Health staff with access at least twice annually.

3.2.3 Physical Security and Storage of Data

- Electronic notifiable conditions data should be password protected and stored on secured networks with appropriately restricted access, not standalone PCs.
- Where access to notifiable conditions data through the NCIMS application is required externally (outside the usual work environment), individuals must ensure that information is not downloaded or saved to a PC.
- Network hardware and any back up or copies of notifiable conditions data must be password protected and stored in a secure location.
- Hard copies of identifiable notifiable conditions data related to scheduled medical conditions should be stored in locked cabinets in a secure location.
- Secure document disposal facilities must be available.
- Secure printers and faxes must be available for confidential data management.

3.2.4 Workstation Security

- Care must be taken not to leave documents containing personal health information related to notifiable conditions data on work benches or anywhere they may be visible to unauthorised people.
- Personal health information should be unloaded from computer monitors (or the screen locked) if the monitor is to be left unattended.
- These requirements also apply where notifiable conditions data is handled externally (outside the physical confines of the usual work environment).

3.3 Acceptable use of notifiable conditions data

Notifiable conditions data must only be used for official NSW Health/Local Health District business related to notification or public health action, unless authorised in writing by an appropriate officer (see section 4 - Data and Information Release).

Notifiable conditions data should not be used for personal study. Use of the data for research purposes is subject to the NSW policy directive PD2015_037: ‘Data Collections - Disclosure of Unit Record Data Held for Research or Management of Health Services’ referred to in section 4 - Data and Information Release. Where an individual holds external organisation (e.g. academic) and NSW Health/Local Health District appointments, access to notifiable conditions data must not be used for any academic or teaching purposes without prior approval.
4. DATA AND INFORMATION RELEASE

4.1 Legal context for release of data

This section should be read in conjunction with ‘Data Collections - Disclosure of Unit Record Data Held for Research or Management of Health Services’ (PD2015_037).

NSW Health staff with access to notifiable conditions data must not release, pass on or otherwise make available to third parties (where the first party is NSW Health and the second party is the notifiable conditions data user) any data, subset of data or any tables, graphs or other aggregations or manipulations of data obtained or derived from notifiable conditions data where this data or information allows the identification of individual persons, institutions, communities or organisations by any means.

NSW Health staff with access to notifiable conditions data should note that identification of individuals, communities or organisations may occur through the release of specific identifying information such as addresses, or by inference from the combination of multiple non specific or less specific data items (such date of birth plus postcode).

The authority to disclose notifiable conditions data is vested in:

a) the Director General or his/her delegate (for identified unit record data) under the Health Administration Act 1982 and the Health Administration Regulation 2012 (subject to the conditions of that Act and Regulation).

b) The Chief Health Officer (for epidemiological data) under the Public Health Act 2010 and Health Administration Act and Health Administration Regulation (subject to the conditions of those Acts and Regulation).

There are no delegations relating to the disclosure of identified unit record notifiable conditions data under the Public Health Act.

The delegations under the Health Administration Act 1982 can be found in section 10 of the Combined Delegations Manual at http://www.health.nsw.gov.au/policies/manuals/Pages/combined-delegations.aspx

Other persons are not authorised to disclose notifiable conditions data.

4.2 Applications for release of data

Applications for release of notifiable conditions data should be made through the relevant data custodian using the appropriate form and will be assessed in accordance with PD2015_037 (Appendix 2).

Applications for the release of identified unit record notifiable conditions data for research or management of health service should be submitted to the NSW Population and Health Services Research Ethics Committee for consideration as per policy directive PD2010_055 Ethical & Scientific Review of Human Research in NSW Public Health Organisations. Available at: www.health.nsw.gov.au/policies/pd/2010/PD2010_055.html

Specific guidelines for the release of Aboriginal health information related to notifiable conditions data are required to protect Aboriginal people from the risk of identification as individuals or communities. Disclosure of Aboriginal health information must comply with the NSW Aboriginal Health Information Guidelines.
4.3 Exceptions for release of identifying data

Under the Public Health Act 2010 (Section 130), it is an offence to disclose information obtained in connection with the Act unless the disclosure is made:

- with the consent of the person whom the information was obtained;
- in connection with the administration or execution of the Act or regulations;
- for the purposes of legal proceedings arising out of the Act or the regulations, of a report of any such legal proceedings;
- with the approval of the Chief Health Officer, or a person authorised by the Chief Health Officer, to a person specified in the approval and the information consists of epidemiological data specified in the approval;
- in any other prescribed circumstances; or
- with other lawful excuse.

4.4 Acknowledgement of use of data in publications

Where notifiable conditions data is approved for release in research or management of health services, all approvals must include a condition that data recipients agree to include a written acknowledgement of the role of NSW Health and the Centre for Health Protection in the fulfilment of any data requests and in the preparation of any report, scientific paper or on-line document (such as a World-Wide Web page). Typically the acknowledgement will appear in the covering letter, foreword or, in the case of electronic documents, as part of the introductory or top-level pages.

The source of notifiable conditions data should be attributed to the underlying data collection. For example, a graph which displays notifiable disease information derived from Notifiable conditions data should have the following attribution: “Source: Notifiable Conditions Information Management System, NSW Health”.

Where data is accessed via a secondary interface, such as SAPHaRI, the underlying data collection should be referenced along with the method of extraction: “Source: Notifiable Conditions Information Management System (Secure Analytics for Population Health Research and Intelligence), NSW Health”.

5. DURATION OF THIS AGREEMENT

The applicant agrees to be bound by the conditions of this Agreement indefinitely or until they sign a new Confidentiality and Data Security Agreement which supersedes this agreement.

The applicant is bound by this Agreement regardless of whether they continue to be an active user of the notifiable conditions data or database system and regardless of whether they remain an employee of or associated with the NSW Health or Local Health District.

6. LIST OF ATTACHMENTS

1. Notifiable conditions Confidentiality and Security Agreement
2. Data request template
Appendix 1

Notifiable Conditions Data - Confidentiality and Security Agreement

I, [Full name of applicant], ____________________________

[Work phone number] ______________________ [work e-mail address] ______________________

[Employed as Position]: ____________________________

By [Name of business unit employing the person] ____________________________

Agree to abide by the confidentiality and data security conditions and procedures set out in this document.

By signing this document and each page of the Notifiable Conditions Data Security and Confidentiality Policy Directive, I confirm that I have read, understood and have agreed to comply with the policies, procedures and conditions set out in it.

I undertake not to knowingly access any personal health information unless such information is essential for me to properly and efficiently perform my duties. I undertake strictly to preserve the confidentiality of this information and I understand that a breach of this undertaking will result in disciplinary action.

I acknowledge my statutory duty under Section 22 and Section 23 of the NSW Health Administration Act 1983 and Section 150 of the NSW Public Health Act 2010, in relation to the disclosure of information. In order to fulfil this undertaking, I will not divulge any identifying, personal or health information regarding individual persons, except to authorised staff of the NSW Ministry of Health, Local Health District or other staff who require such information to carry out their medical or public health duties.

I further undertake to inform my supervisor immediately if I become aware of any breach of privacy or security relating to the information which I access in the course of my duties.

Signature of applicant: ____________________________ Date: ____________________________

Position Title: ____________________________

Witnessed by [Name of witness]: ____________________________

Signature of witness: ____________________________ Date: ____________________________

To be completed by Unit manager employing the applicant:

I confirm that, to properly fulfil the functions of their position, the above signed has reasonable need for access to notifiable conditions data. I also confirm that, in order to properly undertake the business of NSW Health or Local Health District, the business unit has a valid requirement for access to this data.

Manager’s Name: ____________________________

Signature: ____________________________ Date: ____________________________

Position Title: ____________________________

Business Unit Name: ____________________________ Local Health District ____________________________

For access to notifiable conditions data through the NCIMS application - please tick all that apply

<table>
<thead>
<tr>
<th>Applicant position</th>
<th>Intended role</th>
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<tbody>
<tr>
<td>Administration</td>
<td>Administration</td>
</tr>
<tr>
<td>Immunisation staff</td>
<td>Data entry</td>
</tr>
<tr>
<td>Project Officer</td>
<td>Data cleaning/analysis</td>
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<tr>
<td>Public Health Nurse</td>
<td>Epidemiological analysis</td>
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<tr>
<td>Surveillance Officer</td>
<td>Outbreak response</td>
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<tr>
<td>Tuberculosis Nurse</td>
<td>Surge Capacity</td>
</tr>
<tr>
<td>Other (describe)</td>
<td>Other (describe)</td>
</tr>
</tbody>
</table>

End of Agreement

161(16/08/12)
Appendix 2

Request for Release of Notifiable Conditions Data

Request for release of notifiable conditions data by requesters external to NSW Health or Local Health District.

To be completed by person making the request

1. Person and/or agency making request:

2. Purpose for which data is sought:

3. □ Epidemiological/aggregate data □ Unit record data
   Where unit record data are sought, please provide a copy of the NSW Population and Health Services Research Ethics Committee approval (according to PD 2012_030)

4. Description of data requested (disease/condition, fields of interest, & time period of interest)

5. What (if any) publication of data is intended?

6. Date data requested by: (allow up to 6 weeks from the date of request) ______ / ______ / ______

7. Person taking responsibility for appropriate use of data:
   Name: __________________________ Position: __________________________
   Organisation name: ____________________________________________________
   Phone: __________________________ Email: __________________________
   Signature: __________________________ Date: __________________________

Fax this form to the Surveillance Manager, Communicable Diseases Branch on 02 9391 9189

NSW Health reserves the right of comment on use of data and interpretation prior to publication.

Request Received: __________________________ Request Approved: __________________________
Date request completed: ______ / ______ / _____ Data prepared by: __________________________

161(16/08/12)
NSW DEPARTMENT OF HEALTH – POLICY ON INTELLECTUAL PROPERTY ARISING FROM HEALTH RESEARCH (PD2005_370)

Mandatory Policy

This document states the Department’s policy in relation to intellectual property arising from health research. Compliance with this policy is mandatory. The Minister for Science and Medical Research supports the policy. The policy may be amended or revoked from time to time.

Application

The policy applies to all public health organisations, Area Health Services, Statutory Health Corporations and Affiliated Health Corporations in respect of their recognised establishments and recognised services. Health research means laboratory, pre-clinical and clinical research and development in all its forms.

This policy does not apply to intellectual property which arises in the course of any other endeavour. It does not apply to commissioned works, that is, work that is specifically commissioned or contracted by public health organisations for a fee.

The main points of this policy are as follows:

- It requires public health organisations to establish intellectual property (IP) committees to manage their IP interests;
- It requires employees to notify any IP they create in the course of their employment to the committee;
- It sets up structures to deal with managing IP created by visitors (including visiting practitioners and conjoint employees such as clinical academics);
- It allows for the proceeds of the commercialisation to be shared between the creator(s) of the IP, the department or section of the public health organisation which originated the IP, and the public health organisation on a 1/3, 1/3, 1/3 basis.
NSW DEPARTMENT OF HEALTH

POLICY ON INTELLECTUAL PROPERTY

ARISING FROM HEALTH RESEARCH IN

PUBLIC HEALTH ORGANISATIONS

July 2004
9. HEALTH RECORDS AND INFORMATION

NSW DEPARTMENT OF HEALTH POLICY ON INTELLECTUAL PROPERTY ARISING FROM HEALTH RESEARCH IN PUBLIC HEALTH ORGANISATIONS

1. Introduction

1.1 This policy recognises the value of health research undertaken within public health organisations. It recognises that the acquisition and dissemination of knowledge and skills in the area of research and clinical practice is of major public benefit and a primary role of public health organisations. Occasionally, the outcomes of health research may have a significant commercial value. The objectives of this policy are to:

- encourage health research in the public health system and the acquisition and dissemination of knowledge and skills;
- manage intellectual property with a potential commercial value in a manner which benefits the public health system as a whole;
- foster an environment within which intellectual property issues can be identified and developed; and
- recognise and reward innovation by staff of public health organisations.

2. Definitions

2.1 Intellectual property as it should be understood in this policy is the legally recognised outcome of creative effort and economic investment in creative effort. IP rights are rights to:

- the protection of intellectual activity or the protection of ideas and information that have been created;
- control the distribution of such activity, ideas or information;
- receive benefits from such activities, ideas or information by way of exploitation and commercialisation;
- recognition and acknowledgement.

Intellectual property in a broad sense includes:

- inventions, and patents granted in respect of such inventions and applications for such patents;
- unpatented know-how, which comprise an invention or a way of doing something which is not public knowledge;
- confidential information and trade secrets;
- registered and unregistered designs and applications for registered designs;
- copyright;
- circuit layout rights;
- registered and unregistered trademarks and applications for registration of trademarks;
- get-up and trade dress associated with products and services;
- plant variety rights;
- all other rights resulting from intellectual activity in the scientific, industrial, literary or artistic fields; and
- any contractual rights to use or exploit any of these rights.

A brief description of some forms of intellectual property and the nature of intellectual property rights is to be found at Attachment A.

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2.2 This policy also uses other defined terms set out below.

“Health research” means laboratory, pre-clinical and clinical research and development in all its forms. This includes:
• development of treatment procedures and methods;
• development of equipment or other goods which may have application in a clinical setting or a public health application;
• biomedical research;
• research and development of pharmaceuticals; and
• epidemiological and research methods.

“Committee” means an Intellectual Property Committee constituted in accordance with section 4 of this policy.

“Creator” in relation to any intellectual property means an employee(s) who made a significant contribution to the creation or invention of the subject matter (eg the work, product or process) in which the intellectual property subsists, or a visitor(s) or student(s) who made a significant contribution to the creation or invention of the subject matter (eg the work, product or process) in which the intellectual property subsists and assigned his or her rights and interests in the intellectual property to the public health organisation.

“Establishment costs” in relation to intellectual property means any costs paid by the public health organisation to establish and develop the intellectual property for protection or commercialisation, once it has been determined by the public health organisation that commercialisation of the intellectual property should take place. Establishment costs do not include costs that the public health organisation would normally have incurred in carrying out the research as its core function, for example, the costs of employing/retaining the creators in their regular capacity or providing infrastructure for medical research. Examples of establishment costs would include:
• any costs paid to consultants or other professionals for advice on commercialisation or further development of the intellectual property for the purposes of commercialisation;
• any costs incurred in setting up a commercial vehicle for the purposes of developing or commercialising the intellectual property, or any costs paid to third parties for the purposes of commercialising the intellectual property, or further developing the intellectual property for commercialisation;
• legal costs incurred in relation to the intellectual property or its commercialisation, for example, in drafting joint venture agreements, licence agreements or assignments, or providing advice on the commercialisation of the intellectual property; and
• any taxes, or similar outgoings to third parties.

“Gross commercialisation proceeds” means all amounts receivable in consideration of the assignment or licensing of intellectual property rights. These amounts may be lump sum payments made up-front or periodically, or may be in the nature of royalties payable on the happening of future events such as product sales.

“Net commercialisation proceeds” means gross commercialisation proceeds received by the public health organisation, less establishment costs and protection costs.

“Protection costs” in relation to intellectual property means any costs incurred in taking any step towards obtaining registration or protection of the intellectual property including fees for preparing and filing patent applications, renewals, extensions, taxes, stamp duty, and legal and patent attorney’s fees expended in the course of obtaining protection.
“Visitor” means:
- any person providing services at a public health organisation other than as an employee in either a remunerated or honorary position (for example, visiting practitioners, visiting medical officers, honorary medical officers);
- any person (other than a student) not employed by a public health organisation who utilises the resources of a public health organisation at any time (for example, a visiting researcher).

3. Application

3.1 This policy applies to all public health organisations within the meaning of the Health Services Act 1997 (Area Health Services set out in Schedule 1 of the Act, statutory health corporations set out in Schedule 2 of the Act, and affiliated health organisations in respect of their recognised establishments and recognised services set out in Schedule 3 of the Act).

3.2 This policy applies to intellectual property which arises, or may arise, from health research. It does not apply to intellectual property which arises in the course of any other endeavour.

3.3 This policy does not apply to commissioned works, that is, any intellectual property arising from work specifically commissioned or contracted by the public health organisation for a fee. The intellectual property in such work is governed by the terms of the commissioning agreement.

3.4 All public health organisations which are involved in health research must have an intellectual property policy which is consistent with this policy. A public health organisation is involved in health research if:
- any of its employees or visitors carry out health research; or
- it is a party to any agreements, arrangements or collaborations with other bodies to carry out health research.

3.5 A copy of the intellectual property policy of the public health organisation must be provided to:
- all current employees and visitors who are, or may be, engaged in health research; or
- all new employees who will be, or may be, engaged in health research, at the commencement of their employment;
- all visitors and students who will be, or may be, engaged in health research at the commencement of their association with the public health organisation.

The policy which is provided to the individuals listed above, must contain a clear statement to the effect that any or all of the provisions contained in the policy, including provisions relating to the sharing of any proceeds from the commercialisation of intellectual property, may be amended or revoked at anytime.

4. Intellectual Property Committee

4.1 Establishment

Each public health organisation involved in health research shall have an Intellectual Property Committee. Some public health organisations which do not undertake a significant amount of health research may:
- agree to utilise the Committee of another public health organisation;
- may constitute an ad hoc committee from time to time; or
9. HEALTH RECORDS AND INFORMATION

- utilise an existing committee to carry out the IP Committee’s functions, such as the research committee, provided that the membership of such a committee is in accordance with this policy.

4.2 Composition

4.2.1 The composition of a Committee is a matter for the public health organisation and may include co-opted members appropriate to the matter under consideration. However, the standing membership is to include:

- the Chief Executive Officer or a senior executive nominated by the Chief Executive Officer;
- the Director Finance of the organisation or senior financial employee nominated by the Director Finance;
- a senior officer in charge of research within the organisation (except that such a senior officer shall not participate in the making of recommendations in relation to research in which he or she is directly involved or has an interest); and
- a person designated by the CEO of the public health organisation.

4.2.2 Specialist legal advice should be available to the Committee, either by having a legal adviser as a member, or by seeking advice as appropriate. Public health organisations may wish to include members with expertise in commercialising intellectual property.

4.2.3 The Committee shall have a secretariat or responsible officer who is available to coordinate the business of the Committee when it is not sitting, and to receive notifications.

4.2.4 Public health organisations may also have staff who are responsible for intellectual property matters within the organisation, such as IP identification, education, encouragement etc. Such staff may be members of the Committee.

4.3 Functions

The functions of the Committee shall include the receipt and consideration of notifications, the provision of advice, and the making of recommendations to the CEO of the public health organisation as set out in this policy. The Committee shall also act as a resource for staff on intellectual property matters, particularly in relation to the provision of advice on prior disclosure (see section 13).

4.3.2 The Committee may delegate any of its functions, except the function of making recommendations to the CEO of the public health organisation regarding protection and commercialisation of intellectual property.

4.4 Records

4.4.1 The proceedings of the Committee, and any records of those proceedings, shall be treated as commercial in confidence, in so far as they relate to the organisation’s intellectual property interests. See section 13 on prior disclosure.
5. **Intellectual property created by employees**

5.1 *Ownership of intellectual property created by employees.*

5.1.1 As is the case under the general law, this policy mandates that all intellectual property created by employees of a public health organisation in the course of their employment, is owned by the public health organisation.

5.1.2 For the purposes of this policy, intellectual property which is created by an employee through any significant utilisation of the resources of the organisation (eg, funding, other employees, laboratory facilities, equipment, existing intellectual property of the organisation) is taken to be intellectual property created in the course of the employee’s employment. This shall be the case unless the employee has the prior written agreement of the Chief Executive Officer to utilise the organisation’s resources outside the course of his or her employment to perform the work in the course of which the intellectual property was created.

5.1.3 Public health organisations are not to assert ownership of any intellectual property in scholarly books, articles, audiovisuals, lectures or other such scholarly works (unless commissioned by the public health organisation). However, public health organisations may reserve the right to use such works or subject matter generated by employees.

5.1.4 Nothing in this policy shall be taken to detract from the moral rights conferred on creators under Part X of the *Copyright Act 1968.*

5.2 *Notification by employees of intellectual property*

5.2.1 An employee of a public health organisation is to notify the Committee as early as possible of the creation, or anticipated imminent creation, of any work, product or process as a result of, or in the course of, health research undertaken in the course of the employee’s employment which may have, or which the employee believes may have, commercial application.

5.2.2 Each notification must be in writing marked “confidential” and must identify:

- the work, product or process in detail;
- each person involved in the creation of the work, product or process;
- the period in which the work, product or process was created;
- the research project or program in the course of which the work, product or process was created; and
- any known details as to the likely commercial significance of the work, product or process.

5.2.3 Notifications are to occur whether the employee is carrying out the research alone or with other employees, or as part of a collaborative research project with *visitors* or persons from other organisations.

5.2.4 Only one notification need be made where the research is being carried out by more than one employee, or by employees from different areas of the organisation, provided the notification covers the whole of the research and identifies all employees and other persons involved in the research.

5.2.5 In no case is an employee to take steps to apply for any registration of intellectual property created in the course of their employment in his or her own name (eg file a patent application, or lodge an application for registration of a design etc), unless the intellectual property has been assigned to him or her by the public health organisation in accordance with this policy (see paragraph 5.3.7).
5.3 Role of the Committee on notification

5.3.1 The Committee shall examine and consider all notifications under paragraph 5.2. If a notification does not contain sufficient information about the work, product or process for the Committee to properly consider the notification, the notifying employee shall provide to the Committee such further information as the Committee requests.

5.3.2 After consideration of each notification, the Committee shall make a recommendation to the CEO of the public health organisation as to whether any steps toward protection and/or commercialisation of intellectual property notified to it should be undertaken. Such recommendation should be made in a timely manner without undue delay. Recommendations as to protection and commercialisation may not be made at the same time, or be decided upon at the same time. A recommendation may be made to take steps to protect the intellectual property, pending a later consideration and recommendation as to commercialisation.

5.3.3 The public health organisation’s approval is not required for every step of the commercialisation process. The public health organisation may approve a general commercialisation strategy, with details of the strategy to be implemented by the public health organisation (or persons engaged by them for that purpose).

5.3.4 Where protection and/or commercialisation is to proceed, the Committee shall consult the creators in relation to appropriate protection and commercialisation strategies.

5.3.5 Prior to taking any step toward protection or commercialisation, the Committee is to ensure that all relevant creators have been identified.

5.3.6 Where there is more than one creator the Committee shall elicit as soon as possible a written agreement from each creator as to the relative contribution of each of them to the creation of the intellectual property.

5.3.7 If the public health organisation determines that no steps be taken toward protection and/or commercialisation of the intellectual property, the Committee is to consider making a further recommendation to the public health organisation that:
   • the intellectual property be assigned to the creator(s) on appropriate terms and conditions (including any retention by the public health organisation of a share of the net proceeds of commercialisation appropriately reflecting the effort and risk taken by the creator in such commercialisation); OR
   • the intellectual property be retained by the public health organisation, but that the creator(s) be allowed to act as agent for the public health organisation solely for the purpose of seeking commercial partners, with the public health organisation agreeing to participate in negotiations with such commercial partners (if found) regarding commercialisation.

5.3.8 The appropriate recommendation will depend upon the circumstances of the case and the creator should be consulted in this regard.

5.4 Distribution of proceeds of commercialisation

5.4.1 Where intellectual property developed by an employee is commercialised by, or on behalf of, a public health organisation, and such commercialisation gives rise to income or other benefits to the public health organisation, the benefits to the public health organisation shall be dealt with as outlined in section 5.5.
9. HEALTH RECORDS AND INFORMATION

5.5 Formula for distributing proceeds of commercialisation

5.5.1 The public health organisation shall deduct all establishment costs and protection costs expended by the public health organisation as a first call on all gross commercialisation proceeds.

5.5.2 Following deduction by the public health organisation of establishment costs and protection costs any net commercialisation proceeds will be distributed as follows:

• one third to the creator(s) of the intellectual property;
• one third to the department or section of the public health organisation which originated the intellectual property; and
• one third to the public health organisation.

5.5.3 The public health organisation shall divide the one third share of net commercialisation proceeds payable to the creators amongst the individual creators in accordance with the contributions identified by them in the agreement referred to in paragraph 5.3.6. If no such agreement has been made, the public health organisation shall distribute the one third share in accordance with its own reasonable estimate of the relative contributions of each creator. In making such an estimate, consideration should be given to the role of any creators who have left the employ of the public health organisation. The estimate of the Committee shall be final and binding on the creators until such time as an agreement has been reached between them. This must be noted in the deed of release which is required by paragraph 9.1.

5.5.4 Monies paid to employees under this policy shall be paid as income.

5.5.5 The eligibility of an employee under section 6 is conditional upon the employee having acted in good faith in accordance with the requirements of the intellectual property policy of the public health organisation.

6. Clinical academics and joint teaching hospital/University facilities

6.1 Significant issues arise in relation to intellectual property created by clinical academics, who work in both the University sector and the public hospital sector. Both the relevant university and the public health organisation are likely to have contributed significantly to the remuneration of the clinical academic, as well as providing the clinical academic with resources, support and infrastructure. It will not always be possible to determine which resources were utilised in the creation of intellectual property by clinical academics.

6.2 Similar issues arise in relation to joint teaching hospital/University facilities, where health research may be undertaken jointly by a mixture of University and hospital staff.

6.3 It is in the interests of both universities and public health organisations that issues regarding intellectual property created by clinical academics and at joint facilities be clarified as early as possible in the identification/protection/commercialisation process.

6.4 Public health organisations which have affiliations with universities are encouraged to negotiate fair and equitable agreements as to the rights of respective parties to the intellectual property created in joint facilities or by clinical academics. Such agreements should take into account the rights of creators as set out in both this policy and the university policy, and the equitable contributions of all parties to the creation of the intellectual property.
9. HEALTH RECORDS AND INFORMATION

7. Intellectual property created by visitors

7.1 Ownership of intellectual property created by visitors

7.1.1 The ownership of intellectual property created by visitors will depend upon the terms of any agreements between the visitor (or the visitor’s employer) and the public health organisation. In general, however, intellectual property created by visitors is owned by the visitor or his or her employer (subject to any applicable agreements).

7.2 Agreements with visitors regarding intellectual property

7.2.1 Where a visitor is to use the resources of a public health organisation to carry out research which may result in the creation of commercially valuable intellectual property, it is appropriate for a prior written agreement to be reached regarding the basis upon which those resources are used. Where the visitor is an employee of another body (for example, an independent research institute or a practice company) the agreement will need to be between the public health organisation and that body. Heads of clinical and research departments of public health organisations should ensure that, where visitors are utilising the resources of their department to create potentially valuable intellectual property, the issue of an appropriate agreement is raised with the visitor and referred to the Committee at the earliest opportunity.

7.2.2 The Committee shall provide advice to the CEO of the public health organisation on appropriate agreements between the public health organisation and visitors who utilise the resources of the public health organisation to conduct health research.

7.2.3 Appropriate agreements may include an assignment of intellectual property by the visitor to the public health organisation on certain terms and conditions, or may include terms under which the public health organisation receives a share of the income of commercialisation of the intellectual property. Whether such terms are appropriate will depend upon a number of factors, including:
   • the extent and nature of the research;
   • the use of the resources of the public health organisation;
   • the source of funding of the research;
   • the involvement of other public health organisation staff; and
   • any other relevant factors.

7.2.4 The visitor (and his or her employer, if any) is to be fully informed and consulted by the Committee when it considers these issues. Before entering into any agreements with a public health organisation regarding intellectual property, visitors should be given an opportunity to seek their own legal advice.

8. Intellectual property created by students

8.1 Students may be involved in health research utilising a range of resources of the public health organisation. Generally, public health organisations should not claim ownership over intellectual property created by students. However, it may be appropriate for public health organisations to assert rights over intellectual property created by students in the following circumstances:
   • the intellectual property has been created utilising substantial resources of the public health organisation;
   • the intellectual property is created as a result of pre-existing intellectual property owned by the public health organisation;
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- the intellectual property has been created by a team of which the student is a member;
- the intellectual property has been created as a result of funding provided by or obtained by, the public health organisation.

8.2 Heads of research departments should be cognisant of any students undertaking health research within their department that may lead to the creation of valuable intellectual property. Appropriate agreements as to ownership should be concluded at that time, considering the same matters as set out in paragraph 7.2.3.

8.3 Where the student is a student of a University with which the public health organisation has an arrangement under paragraph 6.4, the public health organisation and the University may come to an agreement on how to equitably deal with the intellectual property of students, bearing in mind any claims the students may have under this Policy and the intellectual property policy of the University.

9. **Payment of monies under this policy.**

Where a share in the proceeds of commercialisation of intellectual property is to be paid to creators under this policy, no monies shall be paid unless the creator first signs a written agreement with the public health organisation acknowledging:

- that the creators’ rights to receive monies under the agreement is in full and final satisfaction of any rights or entitlement that the creator has in respect of the commercialisation of the intellectual property;
- his or her responsibility for any taxation obligations which may flow from the receipt of those monies; and
- that he or she has had the opportunity to seek his or her own advice in relation to the agreement.

9.2 Such agreements should not be signed or accepted by the public health organisation unless it appears to the public health organisation that the creator has been given an opportunity to seek his or her own advice in relation to the agreement.

10. **Independent research institutes funded by public health organisations**

10.1 **Ownership of intellectual property created by independent research organisations.**

10.1.1 Public health organisations may house, or be associated with, independent research institutes which carry out health research. Public health organisations may support or resource the development of health research by such institutes in a number of ways, including through the provision of research and administrative staff, infrastructure and equipment, or direct funding. Where such institutes are independent legal entities, they will, generally speaking, be the owners of any intellectual property created by their employees (subject to the terms of the Institute’s constitution and any applicable agreements).

10.2 **Agreements with independent research institutes**

10.2.1 Public health organisations which provide substantial resources to independent research institutes should have in place agreements with the institute which make appropriate arrangements regarding the rights of the public health organisation in relation to intellectual property created by the institute, utilising the resources of the public health organisation.
10.2.2 Such agreements should ensure that the benefits of research undertaken by such institutes and funded or resourced by the public health organisation are preserved for the public health system. This may be achieved in a variety of ways including (but not limited to):

- provisions whereby the public health organisation is the owner of intellectual property generated by the institute utilising the resources provided by the public health organisation; or
- obtaining for the public health organisation a share of the proceeds flowing from the commercialisation of any intellectual property created by the institute utilising resources provided by the public health organisation; or
- ensuring that all proceeds flowing to the institute from the commercialisation of intellectual property are preserved for the continuing research of the institute.

10.2.3 The advice of the Committee may be sought in relation to such agreements.

11. Collaborative research, joint ventures, arrangements with third parties

11.1 Public health organisations may create intellectual property in conjunction with other organisations in the public or private sector, for example, under collaborative research projects or joint venture arrangements for specific research and development projects. The ownership of intellectual property which arises from such ventures will depend upon the contractual arrangements between the parties.

11.2 Where public health organisations enter into collaborative research activities, joint ventures, or similar arrangements with third parties, the public health organisation should ensure that there is a written agreement between the parties which sets out:

- the rights (if any) of each party to use the intellectual property which the other party brings to the project;
- the ownership of any intellectual property created by the research partners, both individually and jointly;
- where valuable intellectual property may arise, the rights and obligations of the parties regarding the protection and commercialisation of the intellectual property;
- the benefits flowing back to each of the parties with respect to any proceeds of commercialisation.

11.3 Any such agreement should protect the interests of the public health organisation proportionately to its contribution to the research project.

11.4 The public health organisation should obtain legal advice regarding proposed agreements on joint ventures and collaborative research projects.

11.5 The requirements of the Public Authorities (Financial Arrangements) Act 1987 in relation to joint ventures must be complied with (including the requirement that joint venture arrangements have the Treasurer’s approval).

12. Commercialisation by outside bodies

12.1 It is recognised that public health organisations may not have the expertise to undertake commercialisation of their intellectual property, and will contract with a third party to do so on their behalf.
12.2 Arrangements of this kind will vary in their terms and conditions, and may or may not involve
the following aspects:

• Assignment of the intellectual property to the commercialising entity;
• Provisions for profit sharing with creators (rather than relying on the intellectual property
policy of the public health organisation).

12.3 Where such arrangements are entered into, the public health organisation should ensure that the
return to the organisation is equitable, and that any profit sharing arrangements with employees
do not disadvantage employees by providing a lesser entitlement than that envisaged by this
policy. The advice of the Committee may be sought in relation to such arrangements.

13. Need for confidentiality – prior disclosure

13.1 Much health research does not, and is not intended to, lead to commercial application.
Researchers, however, should be cognisant of the possibility of research leading to a
commercial application. Where a researcher is in doubt as to whether research may lead to a
commercial application or have any possible commercial value, the advice of the Committee
should be sought at the earliest opportunity.

13.2 The confidentiality provisions set out below do not apply to research which does not have a
potential commercial application or commercial value. This policy is not intended to
unnecessarily restrict the flow of information in the course of collaboration and communication
between researchers and practitioners which this policy recognises is essential in health
research.

13.3 Where it is considered that commercially valuable intellectual property has been created (in
particular, patentable innovations, know-how or other secret information) it is critical that no
disclosure, or publication of such innovation be made to any third party outside the public
health organisation, until appropriate steps have been taken to secure statutory protection.
Disclosure within the public health organisation should be kept on a “need to know” basis, and
all Committees must have procedures in place to ensure that the confidentiality of information
presented to them is preserved.

13.4 Prior publication of an innovation can be fatal to the ability to obtain a patent, as it may lead to
the loss of “novelty” of an invention, a prerequisite for the granting of a patent. Prior
publication can be fatal to a patent, whether the publication is made in Australia or overseas.
Prior publication may include verbal and written disclosures made in any forum. The
presentation of papers at scientific conferences, the publications of papers in peer journals, and
the discussion of the innovation or aspects of it with colleagues who are not under obligations of
confidentiality will generally constitute prior publication.

13.5 Where a creator wishes to make disclosure relating to an innovation which has potential
commercial value (e.g., a publication or a presentation at a scientific conference), the creator
must first seek the permission of the Committee. The Committee can obtain legal advice as to
whether the nature of the publication will jeopardise patent or other intellectual property rights,
and advise the creator appropriately regarding what disclosures may and may not be made.
This advice may include appropriate amendments to the proposed publication or presentation.
Researchers should ensure that the advice of the Committee is sought a reasonable time prior to
the planned publication or presentation date.

13.6 Public health organisations must ensure that advice on prior disclosure is provided in a timely
manner, so as not to unnecessarily prejudice appropriate publication of research results.
Students should not be prevented from publishing a thesis under this policy for a period greater
than two years.
14. Miscellaneous

14.1 Taxation matters

14.1.1 Public health organisations should ensure that they comply with any relevant taxation obligations which may flow from the commercialisation of intellectual property. Relevant taxation advice may be required in this respect.

14.1.2 Public health organisations should inform employees or visitors who receive a share in the proceeds of commercialisation of intellectual property under this policy that taxation obligations which flow as a result of the receipt of such money are a matter for them and that they should obtain their own taxation advice.

14.2 Audit matters

14.2.1 The audit treatment of any monies received as a result of the commercialisation of intellectual property (either by the Area alone, or as a result of a joint venture or similar arrangement) must be undertaken in accordance with the Department’s Accounts and Audit Determination for Area Health Services and Public Hospitals.

14.3 Risk Management

- In commercialising intellectual property, public health organisations are not to incur undue risk of liabilities to the public health system. Legal and risk management advice must be obtained as part of the commercialisation process. Approval for incurring any risks as part of the commercialisation process must be obtained from the Department’s Chief Financial Officer prior to the commercialisation being commenced. No monies shall be paid by a public health organisation to creators of intellectual property where there are any extant risks outstanding to the public health organisation, unless the Chief Financial Officer has given approval in writing. Such approval shall only be given on the basis that the risks have been appropriately managed.

14.4 Variations from this policy

- Any arrangements in relation to intellectual property which depart from this policy must be approved in writing by the Director-General (or delegate). Such variations include:
- Any profit sharing arrangement which involves employees sharing in commercialisation other than by payment of monies (eg through equity in a start-up company);
- Any profit sharing arrangement that involves creators sharing the proceeds of commercialisation in greater share than envisaged in Para 5.5.2.

14.5 Dispute resolution

Public health organisations should agree on an appropriate dispute resolution process for disputes arising under this policy. Where public health organisations enter into individual agreements for the commercialisation of health research it is recommended that appropriate dispute resolution procedures are included in the agreement.

15. Review of this policy

15.1 It is proposed that this policy be reviewed within a reasonable period after its implementation by the Department of Health. Comments on the operation of this policy by public health organisations are encouraged.
ATTACHMENT A: DESCRIPTIONS OF INTELLECTUAL PROPERTY

This guide is designed to provide a simple outline of some types of intellectual property. It is not intended to be a comprehensive legal guide. The advice of the Committee should be sought for a more detailed understanding.

1. Copyright

There are three categories of protection under the Commonwealth Copyright Act 1968 being:

a) literary, musical, dramatic and artistic works, including adaptations and arrangements of works;
b) films, sound recordings, television broadcasts, radio broadcasts, published editions;
c) performers’ protection (not strictly copyright but included in Copyright Act).

Copyright protection is automatic on the creation of a work. It gives the owner the exclusive right to do various acts in relation to the work, including reproducing the work.

There is no copyright in an “idea”. Copyright protects the author’s particular way of expressing an idea. An example of a work created through health research which may attract copyright would be a manual developed explaining a particular product or process, or diagrams and charts explaining a product or process. It is the expression of the product or process which is protected by copyright law, not the product or the process itself. Copyright law only gives protection against the copying of the work and does not protect against the independent creation of a similar work.

Moral rights also exist in relation to literary, musical, dramatic and artistic works and in relation to cinematograph films. Moral rights seek to protect the individual creator’s honour and reputation.

2. Patents

A patent is a right granted in respect of a method, process, device or substance that is new, inventive and useful. Patents are regulated by the Commonwealth Patents Act 1990. If it can be shown that the invention was already known publicly or that it was the subject of an earlier patent, a patent will not be granted. A patent gives the owner the exclusive right to commercially exploit the invention. Unlike copyright, a patent must be applied for and protection is not automatic.

Patent rights are extremely fragile and can easily be lost if the nature of the invention is disclosed, published, sold or otherwise commercialised before a patent is applied for.

3. Registered Designs

Industrial designs can be protected by registration under the Commonwealth Designs Act 1906. The visual appearance of articles is protected – a distinctive shape, configuration, ornamentation or pattern. This protection may protect a design in relation to all sorts of items eg computer keyboards, furniture, toys and spare parts. A design must be new or original in order to be registered. It will not be possible to obtain a registration where there has been prior publication or use of the design. A design registration gives the exclusive right to apply the design to the article in respect of which the design is registered.

4. Trade Marks

The relevant legislation is the Commonwealth Trade Marks Act 1995. A trade mark is a sign used to distinguish goods or services dealt with or provided in the course of trade by a person from goods or services so dealt with or provided by any other person. Trademarks include letters, words, names,
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Signatures, numerals, devices, brands, headings, labels, tickets, aspects of packaging, shape, colour, sound, scent or any combinations, eg “Vegemite”. Registration can be applied for under the Trade Marks Act. A registered trade mark gives the exclusive right to use the trade mark for the goods or services for which it is registered.

5. Trade Secrets

The protection of trade secrets is an aspect of the law of confidential information and this law tends to be used when traditional areas of intellectual property provide no relief. Trade secrets include manufacturing techniques, customer lists, engineering designs, marketing procedures and some government information.

Employees owe a duty of confidentiality to their employer. This does not mean that information cannot be transferred from one scientist or researcher to another. However, if the information is particularly sensitive or relates to potentially valuable intellectual property, the secrecy of the information can be maintained and protected by confidentiality agreements. Confidentiality is an important concept and is useful in research and development. It can be used to assist the flow of scientific or medical information while maintaining legal secrecy and safeguarding patenting rights.

6. Circuit Layout Rights

Circuit layout rights protect original layout designs for computer chips and integrated circuits. The owner of an original circuit layout has the exclusive right to copy and commercially exploit the layout in Australia. Protection is automatic.
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STATE HEALTH FORMS (PD2009_072)

PURPOSE

This policy and attached procedures define the processes for the creation and management of State Health Record Forms incorporated in Health Care Records.

The scope of the policy is to have clinical statewide forms filed in the Health Care Record and the standardisation of the physical Health Care/Medical Record Cover as well as other health record documents such as labels and dividers. This policy includes but is not limited to Inpatient facilities, Community Health Centres and outpatient clinics/areas.

MANDATORY REQUIREMENTS

Health services are required to use standardised forms developed by the NSW Health State Forms Management Committee.

All State Health Record Forms for inclusion (or potential for inclusion) in the Health Care Record must be approved by the NSW Health State Forms Management Committee (SFMC) or Health Service forms for use only within the Health Service must be endorsed by the local forms committee. Health Services must establish:

• A functional health service Health Records Forms Committee.
• Processes to ensure all line managers are accountable for the effective implementation of standard health record forms across the health service, including Directors of Clinical Operations, Clinical Governance and Nursing and Midwifery Services, Health Information Management units and facility based Health Information services.

All NSW Health State Record forms can only be obtained from the State Print and Print Management contracted supplier.

IMPLEMENTATION

The Health Service Chief Executive is responsible for:

• Establishing a functional health service Health Records Forms Committee, a member of which must act as representative to the NSW Health State Forms Management Committee (SFMC).
• Establishing processes to ensure all line managers are accountable for the effective implementation of standard health record forms across the health service, including Directors of Clinical Operations, Clinical Governance and Nursing and Midwifery Services, Health Information Management units and facility based Health Information services.

The Health Service Records Forms Committee is responsible for:

• Reviewing clinical forms intended for statewide use.
• Approving all clinical forms to be used by its Health Service.
• Ensuring all clinical forms meet the requirements of relevant Australian Standards (e.g. AS2828), NSW Health Policy Directives, a Health Service and State Health Records Forms templates.
• Working with the NSW Health, appointed Print and Print Management Services contracted provider, to facilitate Statewide implementation of the Policy.
• To standardise clinical forms across their health service where possible.
• To provide a formalised communication network between Health Service forms users, Executive, the contracted Print Management Services provider and the SFMC.
• To make recommendations for ongoing introduction/amendment/deletion of forms.

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- Ensuring that the terms of reference includes a requirement that direct clinical contribution is obtained as required.

The custodians and authors of Health Records Forms (including the NSW Department of Health) are responsible for:
- Ensuring all steps in the health record forms development processes adhere to policy.
- Submitting relevant forms through their health service representative to the SFMC for review and endorsement.
- If NSW Health Policy Directive or Guideline requires a Health Record form to be used or created in order to comply with that policy or guideline the form must be submitted directly to and processed through the NSW Health SFMC and form a part of that Policy Directive or Guideline before it is distributed for implementation.

Health Support is responsible for:
- Monitoring and Reporting:
  - Supplier (Print and Print Management Services) performance
  - Quality issues (product, artwork and supply)
  - Health Service usage and expenditure
  - Health Records Forms gallery
- Management and support of the SFMC.
- Implementation of a Communication Plan.
- Collaboration with Health Item Master File program.
- Maintenance of the State Health Record Forms and bar-code number allocation register.
- Management of print supplier contract and meeting costs associated with contract, (e.g. destruction of obsolete forms etc).

Persons undertaking the evaluation of forms are responsible for:
- Confirming that the form is compliant with the current Australian Standards on Hospital Medical Records (AS2828).
- Ensuring the form has a consistent format and template.
- Ensuring that the form meets the criteria as per stated throughout the Appendices to this policy.
- There is clear evaluation criteria against which the form is to be evaluated.
- A diverse group is selected to evaluate where applicable and possible and that consultation with any Health Service which is taking part in the evaluation has been consulted with at the highest level.
- Evaluation report is clearly documented and that any changes made to a form are within the boundaries of any policy directive which the form maybe written from.
- That any change which is outside a policy within which the form has been written from is referred back to the content owners for approval.
- That the form is in and remains in State Forms Management Committee State forms template.

BACKGROUND

About this document

In line with the strategic reform initiative, NSW Department of Health has instructed Health Support Services to include forms rationalisation and print management across NSW Health. This project will ultimately cover all forms however initially health records rationalisation is being addressed.
It is estimated that there are approximately 15,000 commercially printed health record forms being used across NSW Health. There is not a common Statewide process to develop or review health (clinical) record forms. Not all forms comply with current Australian standards (e.g. AS2828). NSW Department of Health develops policies and guidelines with health records forms incorporated for implementation across NSW Health without always making provision for:

- A co-coordinated implementation plan across all Health Services and agencies
- Compliance with the current Australian Standards (i.e. for paper-based health care records - AS2828)
- Review of the printing and distribution requirements and impact across all Health Services and agencies.

Key definitions

**Health Record Form:** A record of the provision of care, assessment, diagnosis, management and/or professional advice given to a person. This term is used interchangeably with clinical form. A Health Record Form is a Clinical form that is endorsed by Health Service Forms Committee for use within the area/service.

**State Health Record Form is considered to be a:**

- Clinical Form that is mandated by NSW Department of Health for statewide usage. See appendix 3 for the Statewide forms templates.
- Clinical Form that Health Services have devised for health service or agency use.
- Clinical Form that has undergone a NSW Health State Forms Management Committee (SFMC) approval process.

**Health Care Record:** A Health Care Record is a documented account of a patient’s/client’s health evaluation, diagnosis, illness, treatment, care, progress and health outcome that provides a means of communication for all health care personnel during each visit or stay at a health service. It is the primary repository of all information regarding patient/client care.

The record is used to care for the patient/client during an episode of care but may also be used for future episodes of care, communication with external health care providers and regulatory bodies, planning, research, education, financial reimbursement, quality improvement and public health. The health care record may also become an important piece of evidence in protecting the legal interests of a patient/client, clinician or Health Service.

The health care record may be in hard copy, electronic or other form, and unless otherwise indicated, the provisions of this policy directive apply equally to all health care records regardless of the media in which they are kept.

**Health Service:** a Health Service within the boundaries of the Health Service Act 1997 (which includes Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Public Hospitals)

**SFMC:** NSW Health State Forms Management Committee.

**Site:** Physical facility or service e.g. Hospital, Community Health Centre, Renal Service, Justice Health site.

**Location:** Ward, Oral Health, Clinic, Unit e.g. ICU, ED
Rationale

The introduction of statewide health records forms will assist in:
- Promoting quality processes through
  - Consistent business practices when designing and implementing clinical forms across NSW Health.
  - Statewide standardised document control for all Health Record Forms included in NSW Health Policies.
- Health Services and agencies transferring to electronic medical records systems.
- Streamlining the implementation of NSW Health Policy and forms at the Health Service and agency level.
- Supporting scanning of health care records, including a standardised bar-coding system and the maintenance of a State Health Record Forms Register.
- Promoting effective and efficient work practice by:
  - Decreasing the workload at Health Services and Agencies, who are currently responsible for the implementation of forms incorporated in NSW Health policies and guidelines.
  - Standardising information and formatting to assist staff across NSW Health to accurately and consistently collect patient information, regardless of the health care facility or service.

1. NSW Health State Forms Management Committee

1.1 Terms of Reference

The Committee has the following Terms of Reference:
- Co-ordinate the development of State Health Record Forms and documents.
- Standardise State Health Record Forms and documents and across the whole of NSW Health where possible.
- Ensure compliance with relevant Australian Standards where appropriate.
- Ensure liaison and co-ordination with the Electronic Medical Records Project (eMR) and other related electronic information systems.
- Provide a formalised communication network between form users, NSW Department of Health, Health Support and the contracted Print and Print Management Services Supplier.
- Disseminate forms and related information across NSW Health.
- Approve statewide health record forms and allocate a unique form number.
- Oversee the maintenance of the State Health Record Forms Register.
- Ensure actions and issues are assigned to the appropriate personnel either within Health Support, Health Services/Agencies, NSW Department of Health or the contracted Print and Print Management Services Supplier.
- Regularly review the statewide electronic forms web-site, when developed, for accuracy and initiate remedial action as required.
- Make recommendations for ongoing introduction/amendment/deletion of forms.
- To complement existing Health Service Forms Committees to ensure only endorsed approved (local or state) health record forms are produced for filing in the Health Care Record.

1.2 Governance

The Committee will be responsible to the Deputy Director-General, Health System Support.
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1.3 Representation

NSW Health Services (NSCCAHS/HNEAHS/SESIAHS/SSWAHS/SWAHS/GSAHS/GWAHS/NCAHS/CHW and Justice Health)

Health Support
By Invitation as required
• Standards Australia representative
• NSW Department of Health representative
• eMR Project Team representative
• Ambulance Service NSW representative
• MH-OAT representative
• Print and Print Management Services Contractor representative
• Other persons involved with special projects involving clinical forms and health records

3. Development of Statewide Health Record Forms

3.1 Identification of need for new or revised health record forms

Sources for identifying the need for the development or revision of a State Health record form include, but are not limited to:
• State executive sources including legislative requirements, NSW Health Policy Directives, Guidelines, Australian Standards and specific industry requirements, better practice or research evidence
• Service reviews, Incident Information Management System (IIMS), complaints, root cause analysis (RCAs) and peer review
• Internal and External audit reports

3.2 Development Stage

Custodians and authors of proposed State Health Record forms are required to:
• Search for an existing or similar form.
• Source relevant documentation where possible and ensure forms comply with Best Practice, both in forms design and clinical practice.
• Ensure compliance with NSW Health policy directives, guidelines and information bulletins.
• Ensure there is endorsement from Health Services and supply confirmation of this in writing to the SFMC.
• Ensure that the form utilises the SFMC Forms Template.
• Contact relevant Health Service Forms Committee to identify which form is to be replaced and provide reasons for replacement
• Through their SFMC representative, send an electronic version of the form and completed application package for approval to the SFMC – see appendix 7 for application checklist
• Consider usage when stock numbers are being established.
• Specify colour, print and other specifications at the time of form submission.
• Comply with relevant Australian Standards (e.g. AS2828)
• Ensure forms are developed in liaison with appropriate clinical representation at both State and Area level.
• Ensure forms meet medico-legal requirements.
• Ensure relevant stakeholders are alerted to form development.
• Ensure training and/or implementation guidelines and materials are developed and distributed to appropriate Area representatives prior to the introduction of the form.
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- The AHS is to establish a single line of communication with the SFMC; and the process for submission to the SFMC should confirm the above has been undertaken and the proposal endorsed at an Area Health Service level, prior to submission.

3.3 Considerations

The impact of creating new Health Record forms is to be considered. This impact may include:

- Increased staff workload due to staff completing the form and Medical Record/Clinical/Health Information Department filing the form.
- Increased size of medical records, which may impact on storage space and have potential OH&S issues due to the weight
- Costs – for example the colour of form or print, NCR paper, A3 size and booklets.

Instructions/protocols/checklists should not, as a general rule, be included on the back of forms. Rather, alternate approaches should be explored to minimize interference with clinical documentation and unnecessary space requirements in the health care record. For example, instructions can be laminated and placed in an obvious area when introducing the form and/or be included in a procedure.

Only Health Record forms endorsed by the SFMC (or Health Service Forms endorsed by the local Forms Committee) will be filed in the Health Care Record. If a Health Record form is released for use without an authorized form number and bar-code identifier when one is required, then it will be deemed ineligible to be filed into the Health Care Record.

Revised forms, once approved, will be printed for use when the current supply is depleted. If a form is deemed to pose a clinical risk it is to be destroyed at the contracted printers and the artwork removed.

Photocopying of blank State Health Record forms for use and filing in the Health Care Record is not permitted.

3.4 Validation Stage

The NSW Health State Forms Management Committee (SFMC) will review the proposed Health Record form based on the following criteria:

- Form must comply with NSW Health State templates and current Health Record Standards (e.g. AS2828).
- A unique form number must be allocated from the State Forms Register.
- A bar code identifier must be allocated based on the determined state form number.
- Working with the NSW Health contracted Print and Print Management supplier, to manage printing of the form using the approved SFMC template.
- Informing author or custodian of approval or non-approval
- Managing the gallery of State Health Record Forms.
- Provide support to authors in design and concepts (e.g. colours of print, paper, scanning requirements).

3.5 Consultation Phase

A consultation phase will occur for a two week period from the time the form is released to the AHS’s or relevant Health Bodies for comments to be received back.
3.6 Evaluation Criteria

All Health Record Forms will be evaluated on:

- best practice through
  - Consistent format and standardised template.
  - Compliance with current Australian Standards on Hospital Medical Records (AS2828)
- provision of supporting policy and guidelines
- current clinical policy
- clinical work flow
- financial resources
- implementation requirements and the provision of training materials
- decrease in duplication of data items
- decrease in space requirements of health records i.e. storage requirements.

The evaluation process shall include consultation with the Health Services.

3.7 Transition Period

Implementation

High usage clinical forms will be identified for standardisation into the NSW Health statewide template. It is expected that this is where the greatest impact should be gained for cost saving and standard work practice. Examples of these forms are; Medical record covers, Progress notes, Fluid Balance charts, etc.

Phased Transition

The SFMC will determine based on usage and/or clinical criteria the priority for the standardisation of Statewide forms. If more than one form exists then there will need to be consultation with the key stakeholders via the members of the SFMC about the design of the most clinically functional and cost effective solution.

Once the SFMC has developed a new form the Print Management Services vendor will be advised not to replace current stock of previous old forms. When the stock is low or no longer available the “Flag” on the Print Management Services vendor’s web site will direct users to the NSW Health Statewide standardised form that must be used.

The replacement Statewide form must be available on the Print Management Services vendor’s web site before old stock is depleted to ensure continuity of supply.

If old stock is still available after 6 months the Print Management Services vendor will identify this issue with the SFMC for a decision to either:

- Contact the owner of the form and advise them of “The option to write off old stock”
- Make the stock redundant
- Discuss with the relevant Health Service to determine who will bear this cost.

The Option to Write Off Old Stock

If a Health Service or NSW Department of Health Division needs to write off excess “old” stock (in order to introduce “new” stock rapidly), they must be advised that:
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a. The Service Level Agreement Contract allows that the Print Management Services vendor is responsible for the (write off) cost of the first 3 months of stock held,
b. The Health Service would be responsible for the cost of the remaining (unused) “old” stock, and the costs of destruction.
c. Where there is stock held which has not moved in the last 12 months, the Print Management Services contractor would notify the owner of the stock of their intent to write off and destroy (noting the above incurred costs), unless advised otherwise within 2 months time
d. If no response or advice is given after that period, then the stock will be written off and the entire cost of the stock and destruction costs will be invoiced to the initiating source.

**State Mandated Forms (those included in a NSW Health Policy Directive)**

a. If the form is Print on Demand (POD), it can be transitioned to the NSW State Forms Template immediately as there is no stock on hand.
b. If the form is warehoused existing stock will be run out and the form transitioned into the NSW State Forms Template ready to be printed on the next reprint.
c. New forms required by Policy Directives in the process of formulation will follow the requirements of this policy elsewhere described.

3.8 **Health Record forms that require a trial**

The following guidelines are to be followed for introduction of a new State Health Record Forms which are not available in the NSW Health Print and Print Management Contractor’s State Health Record Forms Library:

a. Complete the request and forward it to the Health Service Forms Committee Representative advising of the need to develop/introduce a State Health Record Form. See Appendix 7 for the Application Checklist.
b. The Health Service or agency Forms Representative is to advise the NSW Health State Forms Management Committee (SFMC) Convenor of the proposed form.
c. The SFMC is to formulate the appropriate Working Party who will be responsible for co-ordinating, providing education and supervising the form trial.
d. The time period required for the trial of a form will be dependent on the usage of form. For forms that have a high usage, a minimum trial period of up to 3 months may be required, whilst forms that have a low usage may require up to a 12 month trial period.
e. During the trial period, stocks of the “old” form (if a revised form) must be withdrawn from circulation, to enable a true and accurate trial of the “new” form to occur.
f. All trial forms to adopt the State Forms Template and to be allocated a ‘Trial State Forms Number category and barcode’.
g. At the end of the trial period, the outcome of the trial must be evaluated to determine whether the new form has been accepted by users (results of a compliance audit). If the trial is unsuccessful the current version should be deleted from the State Health Record Forms website as a State form or re-designed. If a local area wishes to continue using the trial form they must give it a local form number.
h. The final form to be registered with State Forms Number, category and barcode.

3.9 **Low Usage Forms**

Those forms that are identified by the SFMC as extremely low usage can be made available via the relevant website (primarily the NSW Health authorised Print and Print Management suppliers’ website). These forms can be viewed and printed direct from the website. These forms must adhere to this policy including usage of the approved NSW Health clinical forms artwork and must be approved by the NSW Health SFMC. As identified by the SFMC by usage at the present time this is expected to be in the realm of 100 per annum per site.
9. HEALTH RECORDS AND INFORMATION

4. REFERENCES

4.1 External

Australian Standard AS2828 - Paper Based Health Care Records

4.2 Internal

Electronic Information Security Policy – NSW Health (PD2013_033)
Health Care Records – Documentation and Management (PD2012_069)
NSW Health Patient Matters Manual
Privacy Manual for Health Information (March 2015)

4.3 Glossary

SFMC = NSW Health Statewide Forms Management Committee
HIMS = Health Information Managers
HS = Health Service
PD = NSW Health Policy Directive
POD = Print On Demand
HSS = Health Support
MHOAT = Mental Health Outcomes Assessment Tool

4.4 Appendices

Appendix 1 - Forms Committee Process and Procedure
  a – State Health Care Record Form Process – New Form Process
  b – State Health Care Record Form Process – Targeted Form standardisation
Appendix 2 - Health Forms Design
Appendix 3 - State Forms Templates
Appendix 4 - State Health Care Record Cover Artwork
Appendix 5 - Terminal Digit Colours for Health Care Record Covers
Appendix 6 - Strip Colours and Patterns
Appendix 7 - NSW Health State Health Record Form Design Checklist
ABORIGINAL AND TORRES STRAIT ISLANDER ORIGIN – RECORDING OF INFORMATION OF PATIENTS AND CLIENTS (PD2012_042)

PD2012_042 rescinds PD2005_547.

PURPOSE

The policy directive and the associated procedures document outlines the requirements for collecting and recording accurate information on whether clients of NSW Health services are Aboriginal and/or Torres Strait Islander. Aboriginal and Torres Strait Islander people are under-reported in many health related data collections in NSW. Self-report in response to the standard Australian Bureau of Statistics question about a person’s Aboriginality is the most accurate means of ascertaining whether a client is Aboriginal and/or Torres Strait Islander. The standard question must be asked of all clients of NSW Health services, and the information needs to be recorded accurately according to national standards.

MANDATORY REQUIREMENTS

1. All NSW Health services are required to collect consistent and comprehensive data on Aboriginal and Torres Strait Islander health.

2. The Aboriginal and Torres Strait Islander Origin – Recording of Information of Patients and Clients: Procedures document describes the standards required for the accurate collection and recording of data.

3. The standard question seeking information about a person’s Aboriginality should be asked of all clients of NSW Health services to establish whether they are Aboriginal and/or Torres Strait Islander:
   ‘Are you (is the person) of Aboriginal or Torres Strait Islander origin?”

4. These standard response options should be provided to the clients to answer the questions (either verbally or on a written form):
   □ No
   □ Yes, Aboriginal
   □ Yes, Torres Strait Islander
   □ Yes, both Aboriginal and Torres Strait Islander

5. Asking the question:
   • Staff responsible for registering a client should ask the standard question when the client is first registered with the service.
   • The question should be asked of all clients irrespective of appearance, country of birth, or whether or not the staff know the client or their family background.
   • Clients may be asked the question directly, or asked to complete a form with the question included, and the client should answer this question themselves.
   • Specific situations related to asking the question are described in Section 2 and Section 4 of the Procedures document.

6. Recording the Information:
   • Information systems should record whether a client is Aboriginal or Torres Strait Islander using the standard categories, which are outlined in Section 3 in the Procedures document.
   • Responses to the standard questions should be coded as described in Section 3 in the Procedures document.
9. HEALTH RECORDS AND INFORMATION

- A response to the standard question should be a mandatory requirement when registering or entering client details in electronic recording systems.
- Local data management systems must be able to identify those records that are coded as not stated/inadequately described which require follow-up.

7. Training in the correct and consistent recording of whether a client is Aboriginal and/or Torres Strait Islander must be delivered to all staff. See Section 5 in the Procedures document.

8. Data quality assurance and validation activities must be undertaken at the local level (Section 6 Procedures document) and by NSW Ministry of Health (Section 7 Procedures document).

IMPLEMENTATION

1. Roles and Responsibilities of NSW Health agencies:
   - Chief Executives, Health Service Executives, and Managers are responsible for the implementation of this policy and procedures at the local level.
   - All NSW Health employees are responsible for the accurate recording of Aboriginality when ever this is part of their role.

2. Roles and Responsibilities of NSW Ministry of Health:
   - NSW Ministry of Health is responsible for providing the mandatory requirements and procedures, and to support the implementation and evaluation of this policy.

3. Activity Based Funding
   With the implementation of activity based funding in July 2012, accurate and consistent recording of Aboriginality is essential for the effective application of associated weighting and will enable LHDs/SHNs to:
   - Monitor expenditure on health care against funding for Aboriginal clients.
   - Enable clinicians and managers to understand the factors contributing to cost variations including the extent to which these relate to patient complexity or differences in the way services are delivered to Aboriginal clients.
   - Make decisions about where to invest additional resources to meet increasing demand in the most cost effective way for Aboriginal clients.
   - Contribute information about costs to the national “price setter”, the Independent Hospital Pricing Authority.
   - Be appropriately funded according to the efficient pricing for treating Aboriginal patients.

1. BACKGROUND

1.1 About this document

This Policy Directive replaces Policy Directive PD2005_547 ‘Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients’. This policy directive revises and updates the previous policy.

1.2 Legal and legislative framework

The ‘National best practice guidelines for collecting Indigenous status in health data sets’ (AIHW, 2010) documents the national approach for collecting and recording accurate information on whether a client is Aboriginal and/or Torres Strait Islander.
9. HEALTH RECORDS AND INFORMATION

The Council of Australian Governments (COAG) National Indigenous Reform Agreement requires all jurisdictions, including NSW, to implement the National Best Practice Guidelines.

This policy and procedures document incorporate the activities outlined in the National Best Practice Guidelines. The implementation of these will ensure NSW meets their National Indigenous Reform Agreement obligations in relation to identification of Aboriginal and Torres Strait Islander people.

2. ASKING THE QUESTION

2.1 The Standard Aboriginal and Torres Strait Islander Origin Question

The following question should be asked of all clients to establish whether they are Aboriginal and/or Torres Strait Islander:

‘Are you (is the person) of Aboriginal or Torres Strait Islander origin?’

2.2 The standard response options

2.2.1 Three standard response options should be provided to the clients to answer the questions (either verbally or on a written form):

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander
- Yes, both Aboriginal and Torres Strait Islander

2.2.2 If the question has not been completed on a returned form, this should be followed up and confirmed with the client.

2.3 How to ask the question

2.3.1 Staff responsible for registering a client should ask the standard question seeking information about a person’s Aboriginality when the client is first registered with the service.

2.3.2 The question should be asked of all clients irrespective of appearance, country of birth, or whether the staff know of the client or their family background

2.3.3 The question should be placed within the context of other questions related to cultural background, such as country of birth and main language spoken.

2.3.4 Clients may be asked the question directly, or asked to complete a form with the question included, and the client should answer this question themselves.

2.3.5 In some situations (such as in the case of birth and death registrations) the client will be unable to answer the question themselves. In this case it is acceptable for certain others (such as mother, father, close friend, relative, or household member) to be asked the question and to answer the question on the client’s behalf if they feel confident to provide accurate information.

2.3.6 In instances where the client is temporarily unable to answer the question, it is also acceptable for certain others who know the client well to respond on their behalf; however this response should be verified with the client wherever possible.

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9. HEALTH RECORDS AND INFORMATION

3. RECORDING RESPONSES

3.1 How to record responses

3.1.1 Information systems should record information on whether a client is Aboriginal and/or Torres Strait Islander using the standard national categories, which are:
1. Aboriginal but not Torres Strait Islander origin
2. Torres Strait Islander but not Aboriginal origin
3. Both Aboriginal and Torres Strait Islander origin
4. Neither Aboriginal nor Torres Strait Islander origin
9. Not stated/inadequately described

In addition databases in NSW should use the following additional category:
8. Declines to respond

3.1.2 Responses to the standard questions should be coded to the following national standards.

<table>
<thead>
<tr>
<th>Response</th>
<th>Coding Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Yes, Aboriginal’ is ticked, but ‘Yes, Torres Strait Islander’ is not ticked.</td>
<td>1</td>
</tr>
<tr>
<td>‘Yes, Torres Strait Islander’ is ticked, but ‘Yes, Aboriginal’ is not ticked.</td>
<td>2</td>
</tr>
<tr>
<td>‘Yes, Aboriginal’ is ticked, and ‘Yes, Torres Strait Islander’ is ticked.</td>
<td>3</td>
</tr>
<tr>
<td>‘Yes, both Aboriginal and Torres Strait Islander’ is ticked</td>
<td>3</td>
</tr>
<tr>
<td>‘No’ is ticked</td>
<td>4</td>
</tr>
<tr>
<td>‘No’ is ticked and either/both ‘Yes, Aboriginal’, and ‘Yes, Torres Strait Islander’ is ticked.</td>
<td>1, 2 or 3</td>
</tr>
<tr>
<td>Client is capable of responding but declines to respond following prompting/follow-up</td>
<td>8</td>
</tr>
<tr>
<td>Where it is impossible for the question to be asked during the contact period</td>
<td>9</td>
</tr>
<tr>
<td>Response to the question has been left blank or is incomplete</td>
<td>9</td>
</tr>
</tbody>
</table>

(Note these categories represent national standards, with the addition of the code 8, used by NSW to identify clients who have declined to respond. In the national categories, the NSW Code 8 would be coded as 9. See Section 3.3 for further information).

3.2 Mandatory completion

A response to the standard question on a person’s Aboriginality should be a mandatory requirement when registering or entering client details in electronic recording systems. Staff registering or entering details of a client should not be able to proceed with registration until a response has been completed.

3.3 Identifying records for follow up

3.3.1 Local data management systems should be able to identify those records that require follow up. In NSW the code 8 is used (as described in 3.1.2) to identify clients who have declined to answer, and therefore do not require follow up. Client’s coded as 9 (not stated/inadequately described) because of situations where it was impossible for the question to be asked during the contact episode, and other situations where the response was left blank or incomplete, require follow up with the client, to determine the correct code.

3.3.2 Additional categories used by NSW or in local systems for the purposes of workflow management and follow-up must be mapped to the correct national category (Categories 1, 2, 3, 4, and 9) before the data are provided to the national data custodian. In NSW, data coded as category 8 (declined to respond) must be recoded to category 9 before submission to national data custodians.

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9. HEALTH RECORDS AND INFORMATION

4. IMPLEMENTING THE PROCEDURES IN SPECIFIC SITUATIONS

4.1 In the event of a birth

4.1.1 For perinatal data collections, the standard questions on whether a client is Aboriginal and/or Torres Strait Islander should be asked directly of the mother, regardless of the information separately recorded in the hospital database.

4.1.2 In NSW, information on whether the mother and the newborn baby are Aboriginal and/or Torres Strait Islander must be recorded in the NSW Perinatal Data Collection (See NSW Policy Directive PD2015_025).

4.1.3 The mother should be asked to provide the information on whether her baby is Aboriginal and/or Torres Strait Islander in addition to her own Aboriginality.

4.1.4 It should not be assumed that the baby will share the mother’s origin. In particular, if the mother does not report her origin as Aboriginal and/or Torres Strait Islander, it should not be assumed that the newborn is therefore not Aboriginal or Torres Strait Islander.

4.2 If the client is a child under 15

4.2.1 Where the client is a child under 15 years of age, the parent or guardian is asked to declare whether the client is Aboriginal and/or Torres Strait Islander on their behalf.

4.2.2 If the parent or guardian is not available, certain others may be asked to provide this information (see 2.3.4).

4.2.3 If the accompanying adult is unable to provide this information, the child’s parent/guardian should be contacted as follow-up to establish whether the child is Aboriginal and/or Torres Strait Islander.

4.3 If the client is too ill to be questioned or is unable to respond

4.3.1 When the client is unable to respond to the standard question because they are too ill, unconscious, or too ill due to psychiatric condition or dementia, in the first instance the staff member should ask the client’s carer, relative, or any other person accompanying the client (see 2.3.4).

4.3.2 The response provided by this person should be verified with the client when they have recovered sufficiently to be able to answer the questions themselves.

4.3.3 If the person accompanying the client does not know whether the client is Aboriginal and/or Torres Strait Islander, the client should be asked the question directly when they are capable of responding.

4.3.4 In the event that the person accompanying the client does not know whether the client is Aboriginal and/or Torres Strait Islander and the client does not recover sufficiently to provide this information, the answer to the standard question on Aboriginality should be recorded as a non-response.
9. HEALTH RECORDS AND INFORMATION

4.4 If the client does not speak English, or cannot read or write

4.4.1 If the client does not speak English, but is accompanied by someone who can interpret for them, it is recommended that the person accompanying them is asked to translate the question and their response.

4.4.2 If there is no-one with the client who can speak English, it is recommended that an interpreter, or Aboriginal or Torres Strait Islander liaison officer (who can interpret the relevant Aboriginal or Torres Strait Islander language spoken by the client) be called to assist.

4.4.3 If a form is to be provided and the client cannot read or write, it is recommended that an appropriate staff member (e.g. an interpreter, social worker, Aboriginal or Torres Strait Islander Liaison Officer) go through the questions with the client.

4.4.4 All clients’ should be given the opportunity to respond to the standard Aboriginality question for themselves. While a client who speaks an Aboriginal language may be highly likely to be an Aboriginal person, their Aboriginality cannot be assumed; the client may be of both Aboriginal and Torres Strait Islander for example.

4.4.5 Non-English speaking clients from various cultural backgrounds should also be asked the question and given the opportunity to self-report in response to the standard question.

4.5 If the client is deceased

4.5.1 Funeral directors, undertakers, medical practitioners and coroners responsible for registering a death or assessing the cause of death must ask the next-of-kin about whether the deceased is Aboriginal and/or Torres Strait Islander. If no next-of-kin is available, then the question should be asked of the broader family. If this information is not able to be obtained from either of these sources, another person who knew the deceased well may be asked to provide this information.

4.5.2 If information on whether the deceased is Aboriginal and/or Torres Strait Islander is missing on the death registration form, the funeral director should follow up with the next-of-kin before the form is sent to the registry. Similarly, medical practitioners or the coroner responsible should attempt to complete this item before the deceased’s information is sent to the registry.

4.6 If staff are reluctant to ask the question

4.6.1 Staff should be encouraged to collect information from all clients in a professional and respectful manner, without anticipating or making assumptions about the client’s identity or about how the client is likely to react or respond to any given question. Staff should be encouraged to regard the standard question on a person’s Aboriginality as no more or less sensitive or problematic than other items of personal data routinely collected from clients.

4.6.2 All client’s, whether Aboriginal, Torres Strait Islander, or non-Aboriginal or Torres Strait Islander, have the right to self-report, rather than have their identity assumed and recorded on their behalf. To refrain from asking any client the standard question on a client’s Aboriginality is an act of discrimination which infringes upon the client’s right to respond to this question for themselves.

4.6.3 Staff should not modify the standard question in any way. The question should be asked correctly, consistently, and uniformly of all clients, using the wording precisely as stated in this policy and procedure.

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4.7 If the client wants to know why they are being asked the question

4.7.1 The following provides several responses that may assist staff in explaining to clients the reasons for asking the standard question on a client’s Aboriginality:

a. The question on whether a person is Aboriginal and/or Torres Strait Islander is one of several questions related to a client’s identity and demographic characteristics that are asked of all clients who attend a health service, enrol with Medicare, or are involved in the registration of a birth or death.

b. The collection of information on whether a person is Aboriginal and Torres Strait Islander is necessary for government and other services to plan and deliver appropriate services for all Australians, to assess the impact of services on particular groups in the community, and to improve health care and to monitor changes in health and wellbeing over time.

c. The response to this question allows service providers to ensure that Aboriginal and Torres Strait Islander clients have an opportunity to access relevant services such as Aboriginal liaison officers and Aboriginal health workers, health checks, Aboriginal and Torres Strait Islander specific immunisation considerations and PBS listings if they choose.

d. Service providers cannot make assumptions about whether a person is Aboriginal, Torres Strait Islander, or non-Aboriginal and Torres Strait Islander, therefore this information can only be determined by asking the client the standard question.

e. All personal information is protected by privacy law. The Privacy Manual for Health Information (March 2015) provides operational guidance for health service staff to the legislative obligations imposed by the Health Records and Information Privacy Act 2002, and outlines procedures to support compliance with the Act in any activity that involves personal health information.

4.7.2 Should a client request a more detailed explanation of where the data go or the ways they are used, staff may wish to refer the client to the Australian Institute of Health and Welfare website www.aihw.gov.au or the Australian Bureau of Statistics website www.abs.gov.au.

4.8 If the client objects to the question or declines to answer

4.8.1 Where a client objects to the question or declines to answer they should be informed of their right to decline to answer the standard question on whether a client is a Aboriginal and/or Torres Strait Islander person and be advised that their level of care and access to services will not be affected if they choose not to answer the question.

4.8.2 While staff have a duty to collect and record information on whether a client is Aboriginal and/or Torres Strait Islander from all clients as correctly as possible, they are not obliged to convince a disgruntled, upset or unwilling client to respond to the question.

4.8.3 While staff have a duty, if queried, to explain to clients why this question is being asked, they are not obliged to justify the use of the standard question.
9. HEALTH RECORDS AND INFORMATION

4.9 If the client chooses not to answer the question ‘correctly’

4.9.1 There may be occasions where a client is known to staff as an Aboriginal or Torres Strait Islander person yet the client chooses not to report as such in response to the standard question. Conversely there may be occasions where a known non-Aboriginal or Torres Strait Islander person chooses to report themselves as Aboriginal or Torres Strait Islander in response to this question.

Clients have a right to self-report whether they are Aboriginal and/or Torres Strait Islander and staff should therefore always record the response that the client provides; they should not question or comment on the client’s response.

4.9.2 The client’s recorded response should not be altered or annotated in any way to reflect the views of the staff member collecting the information.

4.10 If a client identifies as Aboriginal and/or Torres Strait Islander

4.10.1 Any client who self-reports as Aboriginal and/or Torres Strait Islander should be offered the services of Aboriginal liaison officers or Aboriginal health workers where available; however, the client’s choice to engage or not engage with such services should be respected.

4.10.2 Information about a person’s Aboriginality should be included on the client’s discharge summary.

4.11 If the client wishes to change personal information on their record

4.11.1 All clients should have the opportunity to confirm or update any previously recorded personal information on a regular basis, including confirmation or alteration of a record that they are Aboriginal and/or Torres Strait Islander.

4.11.2 The NSW Health Client Registration Policy (PD2007_094) describes when to update client registration details. Client/patient details, including information on Aboriginal and Torres Strait Islander origin, should be checked and confirmed or updated, as appropriate each time a client presents for a new phase of treatment.

4.11.3 Any changes to the previously recorded information on whether a client is Aboriginal and/or Torres Strait Islander should be received without comment and clients should not be required to provide a reason for changing their record.

5. STAFF TRAINING

5.1 Training in the correct and consistent collection of information on whether clients are Aboriginal and/or Torres Strait Islander must be delivered to all staff.

5.2 This training may be delivered as part of a training that focuses on overall data collection and data quality.

5.3 While it is recommended that all staff receive training in cultural safety for Aboriginal and/or Torres Strait Islander clients, such training should not be considered a pre-requisite for the collection of information on whether a client is an Aboriginal and/or Torres Strait Islander person using the standard question.
9. HEALTH RECORDS AND INFORMATION

5.4 All staff must complete training requirements as outlined in the Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health (PD2011_069).

5.5 All persons responsible for collecting, recording and validating information on whether clients are Aboriginal and/or Torres Strait Islander should be able to demonstrate the following competencies:
   a. An ability to ask the standard questions *Are you of Aboriginal or Torres Strait islander origin?* correctly, and to correctly record responses on paper forms and/or computer systems.
   b. An ability to clearly explain to clients the reason for collecting this information.
   c. An understanding of why it is important to collect and record information on whether all clients are Aboriginal and/or Torres Strait Islander.
   d. An understanding of why it is important to collect this information correctly and consistently, using the standard question.
   e. An understanding of the voluntary nature of self-reporting a client’s Aboriginality, and of a client’s right to decline to answer this question or to change the information recorded.
   f. Knowledge of available information and services for Aboriginal and Torres Strait Islander clients, and ability to convey this to clients as required.
   g. Knowledge of and ability to conduct follow-up procedures for obtaining missing information, including whether a client is Aboriginal and/or Torres Strait Islander.

6. DATA QUALITY ASSURANCE AND VALIDATION AT LOCAL SERVICE LEVEL

For data quality assurance and validation at the local service level, local service providers must:

6.1 Review all forms and data recording systems to ensure the standard question on whether a client is Aboriginal and/or Torres Strait Islander is included and that coding categories are consistent with this policy and procedure.

6.2 Provide appropriate training, supervision and support to staff in primary data collection and data management roles, to ensure data items such as the item recording a client’s Aboriginality are collected correctly and consistently

6.3 Ensure data collection processes and systems are streamlined and user friendly for staff in data collection roles.

6.4 Review client intake procedures to ensure client privacy is maintained, particularly in areas where clients are interviewed to obtain personal information.

6.5 Ensure staff across various levels and disciplines within the service are prompted to check for and follow up on missing client registration details, including information on a client’s Aboriginality, in their contact with clients.

6.6 Establish business rules for distinguishing between ‘not stated/inadequately described’ records that are a result of a client’s inability to answer (and are therefore to be followed up) and ‘not stated/inadequately described’ records in which the client declined to answer (which do not require further follow up).
9. HEALTH RECORDS AND INFORMATION

6.7 Establish policies and procedures for correctly following up and correctly coding records with incomplete information on whether a client is Aboriginal and/or Torres Strait Islander.

6.8 Establish business rules for checking information on a client’s Aboriginality against other data items, particularly country of birth, language spoken, and Medicare eligibility.

6.9 Monitor trends in the number and proportion of Aboriginal and/or Torres Strait Islander clients by comparing with the previous year’s data, to determine whether there have been any obvious errors in coding.

6.10 Conduct data quality surveys involving direct surveys or interviews with clients, to determine the consistency and accuracy of the collection of information on whether clients are Aboriginal and/or Torres Strait Islander and to develop estimates of under-reporting.

7. DATA QUALITY ASSURANCE AND VALIDATION AT NSW MINISTRY OF HEALTH

For data quality assurance and validation state-wide, NSW Ministry of Health must:

7.1 Ensure data providers are aware of the policy and procedure

7.2 Ensure the correct business rules are applied to cope with different identifications when there are two sources of data (e.g. cause of death forms and death registrations). For example, if one data source identifies the client as Aboriginal or Torres Strait Islander, the record relating to this client should be coded accordingly.

7.3 Regularly monitor information on whether clients are Aboriginal and/or Torres Strait Islander and provide continuing feedback on data quality to local services. In particular, monitor levels of ‘not stated’ reported from local service providers to determine whether further education or assistance is required.

7.4 Regularly check that codes used for recording a client’s Aboriginality in local systems are consistent with the policy and procedures, in particular check that invalid or inappropriate codes are not being used.

7.5 Compare data for Aboriginal and Torres Strait Islander persons with variables such as country of birth, language spoken, and Medicare eligibility, and follow up with local service providers to ensure any issues are investigated.

7.6 Regularly check that local service providers have not set default values for the standard question seeking information on whether a client is Aboriginal and/or Torres Strait Islander. This would be evidenced by no reporting of records with a ‘not stated’ response to the standard question.

7.7 For each local service, compare the number and proportion of records with information indicating clients are Aboriginal and/or Torres Strait Islander with the previous year’s data to determine whether there have been any probable errors in coding.

7.8 Establish a system of review and audit of data collection processes and data quality for local service providers, including review and audit of Aboriginal and Torres Strait Islander data.

7.9 Inform the national data custodian of any events or issues that may have affected the quality of data recording whether clients are Aboriginal and/or Torres Strait Islander for a given period.
7.10 Establish a procedure for the prompt investigation and response to data validation requests from the national data custodian.

8. MONITORING

Monitoring of the implementation and impact of this policy directive will be undertaken by NSW Ministry of Health and Local Health Districts:

8.1 In partnership with the Australian Institute of Health and Welfare, NSW Ministry of Health conducts a biannual survey which estimates the level of correct reporting of Aboriginal and Torres Strait Islander people in NSW public hospital data.

8.2 Local Health Districts will be required to determine appropriate indicators to monitor the adherence to this policy.

9. REFERENCES

- Privacy Manual for Health Information (March 2015).

FRONT SHEET/PRINCIPAL DIAGNOSIS

To be read in conjunction with the Health Care Records Documentation and Management Policy (PD2012_069).

The front sheet of the health record must contain the principal diagnosis, other diagnoses and any operation(s) performed. Other conditions of significant concern should also be recorded.

The condition to be selected as Principal Diagnosis is the diagnosis established, after study, to be chiefly responsible for occasioning the patient’s episode of care in hospital (or attendance at the health care facility). For acute surgical hospitals this will generally be the condition or reason for the surgical procedure(s) performed. The principal diagnosis is the major collection item for hospital morbidity statistics and is an important factor in research, evaluation, planning and allocation of resources.

The front sheet must be signed and designated by the medical officer in charge of the patient’s care. This responsibility may be delegated to another medical officer, however, the medical officer in charge of the patient’s care remains responsible for ensuring that the delegated duty is performed.

The front sheet of the medical record should be completed within 14 days of the patient being discharged.
HEALTH CARE RECORDS – DOCUMENTATION AND MANAGEMENT (PD2012_069)


PURPOSE
The purpose of this policy is to:
• Define the requirements for the documentation and management of health care records across public health organisations (PHOs) in the NSW public health system.
• Ensure that high standards for documentation and management of health care records are maintained consistent with common law, legislative, ethical and current best practice requirements.

MANDATORY REQUIREMENTS
Documentation in health care records must provide an accurate description of each patient/client’s episodes of care or contact with health care personnel. The policy requires that a health care record is available for every patient/client to assist with assessment and treatment, continuity of care, clinical handover, patient safety and clinical quality improvement, education, research, evaluation, medico-legal, funding and statutory requirements.

Health care record management practices must comply with this policy.

IMPLEMENTATION
Chief Executives are responsible for:
• Establishing mechanisms to ensure compliance with the requirements of this policy.
• Ensuring health care personnel are advised that compliance with this policy is part of their patient/client care responsibilities.
• Ensuring line managers are advised that they are accountable for implementation of this policy.
• Ensuring implementation of a framework for auditing of health care records and reporting of results.
• Ensuring health care records are audited and results reported within the PHO.

Facility/service managers are responsible for:
• Ensuring the requirements of this policy are disseminated and implemented in their hospital/department/service.
• Ensuring health care personnel within their facility/service have timely access to paper based and electronic health care records.
• Monitoring compliance with this policy, including health care record audit programs, and acting on the audit results.

Health care personnel are responsible for:
• Maintaining their knowledge, documentation and management of health care records consistent with the requirements of this policy.
• Ensuring they are aware of current information about the patient/client under their care including where appropriate reviewing entries in the health record.
1. OVERVIEW

1.1 Introduction

This standard sets out the requirements for documentation and management for all models of health care records within the NSW public health system. Health care records promote patient safety, continuity of care across time and care settings, and support the transfer of information when the care of a patient/client is transferred eg. at clinical handover, during escalation of care for a deteriorating patient and transfer of a patient/client between settings.

1.2 Key definitions

<table>
<thead>
<tr>
<th>Attending medical practitioner</th>
<th>Visiting Medical Officer or Staff Specialist responsible for the clinical care of the patient for that episode of care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved clinician</td>
<td>A clinician, other than a medical practitioner, approved to order tests eg Nurse Practitioner.</td>
</tr>
<tr>
<td>Health care personnel</td>
<td>A person authorised to provide assessment, diagnosis, treatment/care, observation, health evaluation or professional advice or those personnel who have access to the patient/client health care records on behalf of the NSW public health system to facilitate patient/client care. Health care personnel include clinicians (and students) and clinical support staff. Clinicians include registered health practitioners and other including Assistants in Nursing, social workers, dieticians, occupational therapists and Aboriginal Health Workers. Clinical support staff include Health Information Managers, Clinical Governance and Patient Safety staff, ward clerks, health care interpreters and accredited chaplains.</td>
</tr>
<tr>
<td>Health care record</td>
<td>The main purpose of a health care record is to provide a means of communication to facilitate the safe care and treatment of a patient/client. A health care record is the primary repository of information including medical and therapeutic treatment and intervention for the health and wellbeing of the patient/client during an episode of care and informs care in future episodes. The health care record is a documented account of a patient/client’s history of illness; health care plan/s; health investigation and evaluation; diagnosis; care; treatment; progress and health outcome for each health service intervention or interaction. The health care record may also be used for communication with external health care providers, and statutory and regulatory bodies, in addition to facilitating patient safety improvements; investigation of complaints; planning, audit activities; research (subject to ethics committee approval, as required); education; financial reimbursement and public health. The record may become an important piece of evidence in protecting the legal interests of the patient/client, health care personnel, other personnel or PHO. The health care record may be paper, electronic form or in both. Where a health care record exists in both paper and electronic form this is referred to as a hybrid record. Where PHOs maintain a hybrid record health care personnel must at all times have access to information that is included in each part. This policy applies to health care records that are the property if, and maintained by, PHOs, including health care records of private patients seen in the PHO. The policy does not apply to records that may be maintained by patients/clients and records that may be maintained by clinicians in respect of private patients seen in private rooms.</td>
</tr>
</tbody>
</table>

83 Health practitioners registered under the following National Boards - Chiropractic, Dental, Medical, Nursing and Midwifery, Optometry, Osteopathy, Pharmacy, Physiotherapy, Podiatry and Psychology - are required to comply with the health care records section of their relevant code of conduct/guidelines/competency standards. On 1 July 2012 the following healthcare personnel will be represented by a national registration board - Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners, and occupational therapists http://www.ahpra.gov.au/.
9. HEALTH RECORDS AND INFORMATION

<table>
<thead>
<tr>
<th>Must</th>
<th>Indicates a mandatory action required by a NSW Health policy directive, law or industrial instrument.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical practitioner</td>
<td>A person registered under the Health Practitioner Regulation National Law (NSW) in the medical profession.</td>
</tr>
</tbody>
</table>
| Public health organisation (PHO) | a) Local health district.  
b) Statutory health corporation that provides patient/client services.  
c) Affiliated health organisation in respect of its recognised establishment or recognised service that provides patient/client services, or  
d) Ambulance Service of NSW. |
| Should | Indicates an action that ought to be followed unless there are justifiable reasons for taking a different course of action. |

1.3 Privacy and confidentiality

All information in a patient/client’s health care record is confidential and subject to prevailing privacy laws and policies. Health care records contain health information which is protected under legislation. The requirements of the legislation, including the Privacy Principles, are explained in plain English in the NSW Health Privacy Manual. Health care personnel should only access a health care record and use or disclose information contained in the record when it is directly related to their duties and is essential for the fulfilment of those duties, or as provided for under relevant legislation.

1.4 Auditing

Health care records across all settings and clinical areas must be audited for compliance with this policy. PHOs must establish a framework and schedule for auditing of records and approve and designate audit tools and processes.

Clinical audits of documentation in health care records should involve a team based approach with the clinical team consisting of medical practitioners, nurses, midwives, allied health practitioners and other health care personnel, as appropriate.

Health care record audit results should be:

a) Provided to relevant clinical areas and health care personnel.  
b) Included in PHO performance reports.  
c) Referred to PHO quality committees to facilitate quality improvement.

1.5 Education

PHOs must establish a framework for the development and delivery of suitable education on documentation and management of health care records. All health care personnel who document or manage health care records must be provided with appropriate orientation and ongoing education on the documentation and management of health care records.

The content and delivery of education programs should be informed by health care record audits. The results of such audits should be used to target problem areas relating to particular health care personnel groups or facets of documentation and management.

Specific education must be conducted for the introduction of any new complex health care record forms and for changes in documentation models.


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2. DOCUMENTATION

2.1 Identification on every page/screen

The following items must appear on every page of the health care record, or on each screen of an electronic record (with the exception of pop up screens where the identifying details remain visible behind):

a) Unique identifier (eg. Unique Patient Identifier, Medical Record Number).
b) Patient/client’s family name and given name/s.
c) Date of birth (or gestational age/age if date of birth is estimated).
d) Sex. The exception is ObstetriX records where sex of the mother is not recorded.

2.2 Standards for documentation

Documentation in health care records must comply with the following:

a) Be clear and accurate.
b) Legible and in English.
c) Use approved abbreviations and symbols.
d) Written in dark ink that is readily reproducible, legible, and difficult to erase and write over for paper based records.
e) Time of entry (using a 24-hour clock - hhmm).
f) Date of entry (using ddmmyy or ddmmyyyy).
g) Signed by the author, and include their printed name and designation. In a computerised system, this will require the use of an appropriate identification system eg. electronic signature.
h) Entries by students involved in the care and treatment of a patient/client must be co-signed by the student’s supervising clinician.
i) Entries by different professional groups are integrated ie. there are not separate sections for each professional group.
j) Be accurate statements of clinical interactions between the patient/client and their significant others, and the health service relating to assessment; diagnosis; care planning; management/treatment/services provided and response/outcomes; professional advice sought and provided; observation/s taken and results.
k) Be sufficiently clear, structured and detailed to enable other members of the health care team to assume care of the patient/client or to provide ongoing service at any time.
l) Written in an objective way and not include demeaning or derogatory remarks.
m) Distinguish between what was observed or performed, what was reported by others as happening and/or professional opinion.
n) Made at the time of an event or as soon as possible afterwards. The time of writing must be distinguished from the time of an incident, event or observation being reported.

87 Each registered health practitioner is required to comply with the health care records section of the code of conduct/guidelines/competency standards under their relevant National Board
9. HEALTH RECORDS AND INFORMATION

o) Sequential - where lines are left between entries they must be ruled across to indicate they are not left for later entries and to reflect the sequential and contemporaneous nature of all entries.

p) Be relevant to that patient/client.

q) Only include personal information about other people when relevant and necessary for the care and treatment of the patient/client.

r) Addendum - if an entry omits details any additional details must be documented next to the heading ‘Addendum’, including the date and time of the omitted event and the date and time of the addendum.

For hardcopy records, addendums must be appropriately integrated within the record and not documented on additional papers and/or attached to existing forms.

s) Written in error - all errors are must be appropriately corrected.

No alteration and correction of records is to render information in the records illegible.

An original incorrect entry must remain readable i.e. do not overwrite incorrect entries, do not use correction fluid. An accepted method of correction is to draw a line through the incorrect entry or ‘strikethrough’ text in electronic records; document “written in error”, followed by the author’s printed name, signature, designation and date/time of correction.

For electronic records the history of audited changes must be retained and the replacement note linked to the note flagged as “written in error”. This provides the viewer with both the erroneous record and the corrected record.

2.3 Documentation by medical practitioners

Documentation by medical practitioners must include the following:

a) Medical history, evidence of physical examination.

b) Diagnosis/es (as a minimum a provisional diagnosis), investigations, treatment, procedures/interventions and progress for each treatment episode.

A principal diagnosis must be reported for every episode of admitted patient care.

c) Medical management plan.

d) Where an invasive procedure is performed and/or an anaesthetic is administered, a record of the procedure including completion of all required procedural checklists. Where a general anaesthetic is administered, a record of examination by a medical practitioner prior to the procedure is also required.

e) Comprehensive completion of all patient/client care forms.

f) A copy of certificates, such as Sick and Workers Compensation Certificates, provided to patients/clients must be retained in the patient/client’s health care record.

2.3.1 Attending Medical Practitioner

The Attending Medical Practitioner (AMP) is responsible for the clinical care of the patient/client for that episode of care and is responsible for ensuring that adequate standards of medical documentation are maintained for each patient/client under their care.

When documentation is delegated to a medical practitioner e.g. Intern, Resident, Registrar, the AMP remains responsible for ensuring documentation is completed to an appropriate standard that would satisfy their professional obligations.

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The AMP should review the preceding medical entries and make a written entry in the health care record (print name, signature, designation and date/time) to confirm they have been read at the same time as they are reviewing the medical management plan for the patient/client to ensure it remains current and clinically appropriate, consistent with the AMP’s duty of care to the patient/client.

### 2.4 Documentation by nurses and midwives

Documentation by nurses and midwives must include the following:

a) Care/treatment plan, including risk assessments with associated interventions.

b) Comprehensive completion of all patient client care forms.

c) Any significant change in the patient/client’s status with the onset of new signs and symptoms recorded.

d) If a change in the patient/client’s status has been reported to the responsible medical practitioner documentation of the name of the medical practitioner and the date and time that the change was reported to him her.

e) Documentation of medication orders received verbally, by telephone/electronic communication including the prescriber’s name, designation and date/time.

### 2.5 Frequency of documentation

The frequency of documentation entries should conform to the following as minimum requirements.

#### 2.5.1 Acute Care Patient/clients

a) Registered Nurse/Midwife, Enrolled/Endorsed Nurse should make an entry in the patient/ client’s health care record a minimum of once a shift. An entry by an Assistant in Nursing should not be the only entry for a shift.

Entries should reflect in a timely way the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient/client’s condition and/or treatment should be documented as these occur.

b) Medical practitioners should make an entry in the health care record at the time of events, or as soon as possible afterwards, including when reviewing the patient/client.

c) Other health care personnel should make entries to reflect their level of assessment and intervention consistent with the medical management plan.

#### 2.5.2 Long Stay or Residential Patients/Clients

Depending on the health care setting and the length of stay (or expected length of stay) of the patient/ client, health care personnel should make an entry at least weekly in the health care record particularly when warranted by the patient’s medical condition or frailty.

Additional entries should be made to reflect changes in the patient/client status, condition and/or treatment or care plan as these occur.

#### 2.5.3 Non-Admitted Patient/Clients

An entry must be made in the health care record for each patient/client attendance (including video conference sessions) and for failures to attend.

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Entries should reflect the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient/client’s condition and/or treatment should be documented.

Attendance of individual patient/clients at sessions of a formal multiple session group program should be noted. Such attendances may be documented in an attendance register or scheduling system rather than the patient/client’s health care record. Where a patient/client receives specific individual care or treatment in addition to the group session interaction, this care or treatment should be documented in their health care record.

2.6 Alerts and allergies

Clinicians must flag issues that require particular attention or pose a threat to the patient/client, staff or others including:

a) Allergies/sensitivities or adverse reactions, and the known consequence.

b) Infection prevention and control risks.

c) Behaviour issues that may pose a risk to themselves or others.

d) Child protection/well being matters including

   i. alerts and flags for High Risk Birth Alerts or prenatal reports
   ii. children at risk of significant harm
   iii. where NSW Police or the Department of Family and Community Services have issued a general alert to a PHO.

e) Where patients/clients have similar names and other demographic details.

PHOs must implement systems for the identification of such alerts and allergies. If a label is used on the outside folder of a paper based health care record this does not negate the need for documentation in the health care record of the alert/allergy, and known consequence.

Any such issue should be ‘flagged’ or recorded conspicuously on appropriate forms, screens or locations within the health care record. Where alerts relate to behaviour issues or child protection matters the alert should be discreet to ensure the privacy and safety of the patient/client, staff or others.

These flags, especially where codes or abbreviations are used, must be apparent to and easily understood by health care personnel; must not be ambiguous; and should be standardised within the PHO.

A flag should be reviewed at each admission. When alerts and allergies are no longer current this must be reflected in the health care record and inactivated where possible.

2.7 Labels

Non-permanent adhesive labels should be avoided. Where considered essential the label must be relevant to the patient/client and placed so that all parts of the health care record are able to be read and patient/client privacy maintained. State approved labels must be used.
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2.8 Tests - requests and results

The health care record must document pathology, radiology and other tests ordered, the indication and the result.

When tests are ordered the name of the ordering medical practitioner/approved clinician and their contact number must be clearly printed (if written) or entered (if computerised) on the request form.

Pathology, radiology and other test results must be followed up and reviewed with notation as to action required. The results must be endorsed by the receiving medical practitioner/approved clinician, with endorsement involving the name, signature, designation of the medical practitioner/approved clinician, and date/time.

PHOs must develop local procedures, including steps to be taken, when:
   a) Relevant details on the request form are incomplete or illegible.
   b) The ordering medical practitioner/approved clinician is not on duty or contactable.

**Critical/unexpected/abnormal results** should be documented in the patient/client’s health care record by the responsible medical practitioner/approved clinician as soon as practicable and any resultant change in care/treatment plans documented.

2.9 Patient/client clinical incidents

All actual clinical incidents must be documented in the patient/client’s health care record.90

Staff must document in the health care record.
   a) Incident Information Management System (IIMS) identification number.
   b) Clinically relevant information about the incident.
   c) Interactions related to open disclosure processes.91

2.10 Complaints

Complaint records are not to be kept with the patient’s health care record.92

2.11 Emergency Department records

Emergency Department records must include the following:
   a) Date and time triaged including triage score.
   b) Presenting problem and triage assessment.
   c) Date and time seen by a medical practitioner, other clinicians such as a Clinical Initiatives Nurse, Nurse Practitioner, nursing, midwifery and allied health staff.
   d) Medical, nursing, midwifery and allied health assessment.
   e) Pathology, radiology and other tests ordered. Pathology, radiology and other test results must be followed up and reviewed with notation as to action required.
   f) Description of critical/unexpected/abnormal pathology, radiology and other test results. If the patient/client has left the Emergency Department and not been admitted, document the steps taken to contact the patient/client or their carer if the test results indicate that urgent treatment/care is required.

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g) Details of treatment.
h) Follow up treatment where applicable.
i) Transfer of care date and time, destination (e.g. home, other level of health care) method and whether accompanied.

2.12 Anaesthetic reports

Anaesthetic reports must include the following:

a) Pre-operative assessment, including patient anaesthetic history.
b) Risk-rating eg. American Society of Anaesthesiologists (ASA) score.
c) Date and time anaesthetic commenced and completed.
d) Anaesthesia information and management ie. medications, gases, type of anaesthetic.
e) NSW safety checklists including patient assessment and equipment checklists consistent with Australian and New Zealand College of Anaesthetists requirements.
f) Operative note/monitor results.
g) Post-operative notes/orders.

2.13 Operation/procedure reports

Operation/procedure reports must include the following:

a) Date of operation/procedure.
b) Pre-operative and post-operative diagnosis.
c) Indication for operation/procedure.
d) Procedure safety checklist.
e) Surgical operation/procedure performed.
f) Personnel involved in performing the operation/procedure.
g) Outline of the method of surgery/procedure.
h) Product/device inserted and batch number.
i) Changes to, or deviations from, the planned operation/procedure, including any adverse events that occurred.
j) Tissue removed.
k) Pathology ordered on specimens.
m) Post-operative orders.

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2.14 Telephone/electronic consultation with patient/clients

When clinical information is provided to a patient/client, or their carer/guardian/advocate, the consultation must be documented in the health care record. The identification of the caller must be documented.

Where the caller is not the patient/client, or their carer/guardian/advocate obtain consent from the patient/client, or their carer/guardian/advocate prior to the consultation. Document the:
- a) Caller’s name,
- b) Relationship to the patient/client, and
- c) That the patient/client, or their carer/guardian/advocate has consented to the caller seeking clinical information about the patient/client in the patient/client’s health care record.

2.15 Telephone/electronic consultation between clinicians

Where a clinician involved in the care and treatment of a patient/client formally consults another clinician, via telephone/electronic means, about the patient/client and the consulted clinician provides advice, direction or action, that advice, direction or action must be documented in the health care record by the clinician seeking the advice. The name and designation of the consulted clinician, and the date/time of the consultation must also be documented as soon as practical following consultation with the other clinician and in a manner as to ensure continuity of care for patients.

2.16 Leave taken by patients/clients

Any leave taken by the patient/client should be documented in their health care record with the date/time the patient/client left and returned. The patient/client should be assessed before proceeding on leave and the outcome of that assessment documented in the health care record, together with the documented approval of the AMP noting the assessment.

2.17 Leaving against medical advice

A patient/client who decides to leave the health service/program against medical advice must be asked to sign a form to that effect with the form filed in the patient/client’s health care record. If the patient/client refuses to sign the form this must be documented in the health care record, including any advice provided.

Examples of advice that could be provided to the patient/client include:
- a) The medical consequences of the patient’s decision, including the potential consequences of no treatment.
- b) The provision or offering of an outpatient management plan and follow-up that is acceptable and relevant to the patient.
- c) Under what circumstances the patient should return, including an assurance that they can elect to receive treatment again without any prejudice.
9. HEALTH RECORDS AND INFORMATION

3 MANAGEMENT

3.1 Responsibility and accountability

The Chief Executive of the PHO must comply with the State Records Act and its regulation in respect of health care records.93

Responsibility for the maintenance of appropriate health care records must be included in the terms and conditions of appointment (including position descriptions) for all health care personnel as defined in this policy.

Documentation must be included as a standing item in annual performance reviews of clinicians. Failure to maintain adequate health care records will be managed in accordance with current NSW Health policies and guidelines for managing potential misconduct.

3.2 Individual health care record

An individual health care record with a unique identifier (eg unique patient identifier, medical record number) must be created for each patient/client who receives health care. Every live or still born baby must be allocated a unique identifier that is different to the mother.

Where multiple patient identifiers exist for the same patient/client within a PHO there must be processes established for their reconciliation and linkage, with the ability to audit those processes.

A reference notation should be placed on the health care record to identify any relevant other documents that relate to the patient’s health care. Index or patient administration systems must reference the existence of satellite/decentralised health care records that address a specific issue and that are kept separate from the principal health care record. Due to the nature of the information contained in sexual assault records these must be maintained separately from the principal health care record and be kept secure at all times; as should child protection/wellbeing and genetics records.

Staff screening and vaccination records are considered as personnel rather than health care records and must be maintained separately.

3.3 Access

Health care records should be available at the point of care or service delivery. Health care records must not be removed from the campus unless prior arrangements have been made with the PHO eg. required for a home visit, required under subpoena.

Health care records are only accessible to:94
b) Health care personnel currently providing care/treatment to the patient/client.
c) Staff involved in patient safety, the investigation of complaints, audit activities or research (subject to ethics committee approval, as required).
c) Staff involved in urgent public health investigations for protecting public/population health, consistent with relevant legislation.95

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d) Patient/client to whom the record relates, or their authorised agent, based on a case by case basis in accordance with health service release of information policies and privacy laws.

e) Other personnel/organisations/individuals in accordance with a court subpoena, statutory authority, valid search warrant, coronial summons, or other lawful order authorised by legislation, common law or NSW Health policy.

All requests for information, that is contained in a patient/client’s health care record, from a third/external party should be handled by appropriately qualified and experienced health care personnel, such as Health Information Managers, due to the sensitive nature of health care records; the special terminology used within them; and regulatory requirements around access to, and disclosure of, information.

3.4 Ownership

The health care record is the property of the PHO providing care, and not individual health care personnel or the patient/client.

Where shared care models or arrangements exist for clinicians to treat private patient/clients within PHO facilities/settings, responsibility for the management of those health care records must be included in the terms of the arrangement between the PHO and the clinician.

3.5 Retention and durability

Health care records must be maintained in a retrievable and readable state for their minimum required retention period.96

Entries should not fade, be erased or deleted over time. The use of thermal papers, which fade over time, should be restricted to those clinical documents where no other suitable paper or electronic medium is available e.g. electrocardiographs, cardiotocographs.

Electronic records must be accessible over time, regardless of software or hardware changes, capable of being reproduced on paper where appropriate, and have regular adequate backups.

3.6 Storage and security

The Health Records and Information Privacy Act 2002 establishes statutory requirements for the storage and security of health care records, which are also included in the NSW Health Privacy Manual. A summary of these requirements is provided below. However, the Privacy Manual should be consulted for further detail in this area.

Personal health information, including healthcare records, must have appropriate security safeguards in place to prevent unauthorised use, disclosure, loss or other misuse. For example, all records containing personal health information should be kept in lockable storage or secure access areas when not in use.

Control over the movement of paper based health care records is important. A tracking system is required to facilitate prompt retrieval to support patient/client care and treatment and to preserve privacy.

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A secure physical and electronic environment should be maintained for all data held on computer systems by the use of authorised passwords, screen savers and audit trails. If left unattended, no personal health information should be left on the screen. Screen savers and passwords should be used where possible to reduce the chance of casual observation. Consideration may be given to providing staff with different levels of access to electronic records where appropriate (i.e. full, partial or no access).

Details of the roles and responsibilities of staff, including system administrators and IT technical and support staff, concerning the protection of health care records held on electronic information systems are given in the NSW Health Electronic Information Security Policy


3.7 Disposal

Health care records, both paper based and electronic, must be disposed of in a manner that will preserve the privacy and confidentiality of any information they contain.

Disposal of data records should be done in such a way as to render them unreadable and leave them in a form from which they cannot be reconstructed in whole or in part.

Paper records containing personal health information should be disposed of by shredding, pulping or burning. Where large volumes of paper are involved, specialised services for the safe disposal of confidential material should be employed.

The disposal of health care records must be documented in the PHO’s Patient Administration System and undertaken in accordance with the relevant State General Disposal Authority.

## 4 IMPLEMENTATION SELF ASSESSMENT CHECKLIST

An Implementation Self Assessment Checklist is provided to support implementation of this policy.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Self Assessment:</th>
<th>Nil</th>
<th>In development</th>
<th>Partial implementation</th>
<th>Mature</th>
</tr>
</thead>
</table>

### A. STRATEGIC FUNDAMENTALS

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Self Assessment:</th>
<th>Nil</th>
<th>In development</th>
<th>Partial implementation</th>
<th>Mature</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO has documented processes to manage health care records</td>
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<tr>
<td>PHO uses an approved abbreviation list</td>
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<tr>
<td>There are resources and support to implement the Health Care Records policy and regular monitoring of progress by a responsible officer</td>
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<tr>
<td>Key performance indicators are developed to monitor and measure implementation of the Health Care Records policy in the PHO</td>
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</tr>
</tbody>
</table>

Examples of performance measures:

1. Patient identification is on every page of the health care record or on each screen of the electronic record.
2. Handwritten entries are legible to a reader other than the author.

### B. INTEGRATION INTO NORMAL BUSINESS SYSTEMS

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Self Assessment:</th>
<th>Nil</th>
<th>In development</th>
<th>Partial implementation</th>
<th>Mature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility and accountability for documentation and management of health care records is clearly stated in position descriptions and incorporated into performance review for all relevant health care personnel</td>
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<tr>
<td>The design, approval and implementation of health care records forms (including electronic systems) is consistent with state policies and procedures.</td>
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</tbody>
</table>
9. HEALTH RECORDS AND INFORMATION

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</thead>
<tbody>
<tr>
<td></td>
<td>Nil</td>
</tr>
</tbody>
</table>

C. ORGANISATIONAL IMPLEMENTATION

- A schedule is in place for auditing of health care records across clinical settings. This should include both record completeness and clinical audits.
- All clinical areas are audited for compliance with the Health Care Record policy according to the schedule noted above.
- Results and analysis of health care record audits are provided to clinicians and managers, and are used to inform remedial quality improvement activities.
- Results and analysis of health care record audits are used to inform education on clinical documentation.
- There is a process for recognition of excellence in the documentation and management of health care records.
- Health care records key performance indicators are monitored at ward/unit, hospital/service and PHO level and benchmarked with appropriate peers.

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NOTIFICATION OF ACUTE RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE
– THE NSW PUBLIC HEALTH ACT 2010 (IB2015_057)

PURPOSE

This Information Bulletin provides guidance on the addition of Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) to the list of medical conditions in Schedule 1 of the *NSW Public Health Act*, and to the list of notifiable diseases in Schedule 2 of the Act.

Under the provisions of the *Public Health Act 2010* and the *Public Health Regulation 2012*, doctors, hospital chief executive officers (or general managers), pathology laboratories, directors of child care centres and school principals are required to notify certain medical conditions listed on the NSW Ministry of Health website.

KEY INFORMATION

On 2 October 2015 the *NSW Public Health Act 2010* was amended to add ARF and RHD in a person under the age of 35 to:

a) The list of medical conditions in Schedule 1 to that Act:
   i. That must be notified by medical practitioners to the Secretary of the NSW Ministry of Health, and

b) The list of notifiable diseases in Schedule 2 to that Act:
   i. That must be notified by health practitioners providing care in hospitals to the chief executive officer of the hospital concerned, and
   ii. That must be notified by the chief executive officer of a hospital to the Secretary of the NSW Ministry of Health.

NOTIFICATION MECHANISMS

Information on the notification of infectious diseases under the *Public Health Act 2010* is detailed in the Information Bulletin IB2013_010.

Infectious disease notifications should be directed to the local Public Health Unit, and should be initiated as soon as possible within 24 hours of diagnosis.

In order to protect patient confidentiality, notifications must not be made by facsimile machine except in exceptional circumstances and when confidentiality is ensured.

Disease notification guidelines and notification forms for notifiers are available at: www.health.nsw.gov.au/Infectious/Pages/notification.aspx
NON-ADMITTED PATIENT DATA COLLECTION: CLASSIFICATION AND CODE STANDARDS FOR REPORTING SERVICES PROVIDED FROM 1 JULY 2016 IN A WEBNAP EXTRACT FORMAT (IB2016_039)

PURPOSE

The purpose of this Information Bulletin is to inform NSW Health service providers and source system administrators of changes to the classification and code set standard for reporting non-admitted patient service provided from 1 July 2016.

KEY INFORMATION

Due Dates for Reporting

Non-admitted patient activity data must be submitted and of acceptable quality by the 10th calendar day of the month after the month the service was delivered.

Patient or summary level non-admitted patient activity reporting

Patient level non-admitted patient activity is to be reported for in scope activity.

Where the requirement to report patient level activity data cannot be met summary level data must be reported.

The following services are only required to report non-admitted patient activity at the summary level.

1. Group immunisation services (Service Type 023 Immunisation – On Mass (no patient level data)

2. Group diagnostic screening services

3. Needle exchange services and supervised injecting room services (including service units classified to Service Unit Establishment Type 11.04 Needle Exchange Allied Health / CNS Unit).

4. Crisis line counselling telephone services.

This data is to be reported by WebNAP, or by mLoad when that capability is provided.

Summary level must not be reported for any service unit reporting activity at the patient level.

There is no longer a requirement to advise the Executive Director, Health System Information and Performance Reporting Branch of the Local Health Districts (LHDs) and Specialist Health Networks (SHNs) intention to decommission summary level reporting for those service units reporting at the patient level.

Reporting of Services with Multiple Providers

When reporting non-admitted patient services in a WebNAP extract via mLoad each individual service provider should be reported, even if two or more providers have the same provider type code.

Occasion of Service Record Identifier

Each occasion of service must be reported with a unique record identifier in the ‘Service Event Record ID’ field. When resubmitting an occasion of service record the same record identifier must be reported so that the original record is identified and updated.

Where a record identifier is not unique within a single submission to EDWARD, mLoad will prevent the entire file from loading.

Data element classifications subject to change

The requirements for reporting non-admitted patient activity to the Non-Admitted Patient Data
Collection will change for the following data elements:

1. Provider Type
2. Setting Type
3. Financial group.

The changes are of the following type:

1. Some new categories will become effective from 1 July 2016
2. Some existing categories will expire on 30 June 2016
3. Some continuing categories have descriptive label changes.

**Implementation**

The classification changes must be implemented for the reporting of non-admitted patient services provided on or after 1 July 2016 where they are reported via a WebNAP extract format.

These changes will require LHDs / SHNs to:

- Modify local source system classifications
- Map the local source system categories to the appropriate WebNAP alias code values
- Modify WebNAP Service Options for the service units reporting summary level data and impacted by the changed classifications

This involves:

- End dating existing service options containing expired reference codes effective 30 June 2016
- Establishment of new service options containing the new reference codes effective from 1 July 2016.

LHD / SHNs must advise and instruct their source system vendors of the changed requirements and any subsequent need to modify systems. Where a source system is shared between multiple LHDs / SHNs; are compliant with a State Based Build; and / or are subject to application support services provided by eHealth NSW, it is the responsibility of each LHD / SHN to ensure the technical implementation of the modified reporting requirements are raised through the appropriate application support mechanisms. This includes:

- The LHD / SHN Application Advisory Group (AAG) representative ensuring that the change requirements are on the AAG meeting agenda, discussed at the AAG meetings and are approved within a time frame that will enable the implementation due date to be met.
- Directing and authorising eHealth NSW to make the application build change by raising the request for change on the State-wide Service Desk and tracking the change through to its delivery.

**Clarification Advice**

The NSW Ministry of Health will provide clarification advice regarding the changed reporting requirements outlined in the attachments. Requests for advice should be directed to the Health System Information and Performance Reporting Branch, NSW Ministry of Health.

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9. HEALTH RECORDS AND INFORMATION

Escalation Contact:

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LINK TO ATTACHMENTS:


ATTACHMENT 1

Non-admitted Patient Activity Reporting – Changes to Classification and Code Standards for Reporting Services Provided from 1 July 2016 via a WebNAP Extract Format.

This attachment outlines changes to Non-admitted Patient Data Collection (NAPDC) data elements domains, in scope of the existing WebNAP extract, for services provided on or after 1 July 2016.

The final classifications for each data element reported in a code format, incorporating the changes applicable from 1 July 2016, are provided Attachment 2.

The NAPDC WebNAP Data Dictionary in HIRD provides detailed information pertaining to the concepts and classification, including the new and changed category definitions. Links to this data dictionary are provided on the following NSW Ministry of Health Intranet page:


ATTACHMENT 2

Non-admitted Patient Activity Reporting – Classification and Code Standards for Reporting Services Provided from 1 July 2016 via a WebNAP Extract Format.

This document provides the NSW Health State classification and code standards applicable to services provided from 1 July 2016 for data elements in scope of the Non-admitted Patient Data Collection Core Minimum Data Set and reported via the legacy WebNAP patient level extract.

The NSW Health State classification and code standards applicable to services reported in the EDWARD extract format are provided at the following NSW Ministry of Health intranet page:


60(18/8/16)

NON-ADMITTED PATIENT DATA COLLECTION TRANSITION FROM WEBNAP TO EDWARD REPORTING (GL2015_012)

PURPOSE

The purpose of this Guideline is to advise NSW Health non-admitted patient service providers and non-admitted patient activity source system support staff of the changes in requirements involved in the transition from reporting via WebNAP to reporting via the EDWARD.

An understanding of these differences, and the three phases of implementation, is required to reconfigure source system builds and patient level activity extracts, and redesign non-admitted patient activity reporting business processes.

262(18/8/16)
9. HEALTH RECORDS AND INFORMATION

KEY PRINCIPLES

In line with NSW Health’s strategic direction and the significantly increased volumes of non-admitted patient services being reported at the patient level by NSW Health services the Non-Admitted Patient Data Collection will transition to be reported via EDWARD rather than the interim system WebNAP.

The migration of the data collection to EDWARD will have significant benefits for Local Health Districts (LHDs) / Specialist Health Networks (SHNs) and other NSW Health agencies. LHDs / SHNs should expect higher data availability, more efficient data loading and resubmission processes, significantly improved data error reporting functionality and appropriately secured access to activity data.

When reported via EDWARD the non-admitted patient, admitted patient and emergency department activity data will be automatically allocated the appropriate National Weighed Activity Unit (NWAU) and integrated into a single data mart that supports full patient journey analysis utilising the Enterprise Patient Registry unique identifier.

USE OF THE GUIDELINE

In order to minimise the transition burden, requirements have been prioritised across three phases:

- **Phase 1**: Report current scope via EDWARD and decommission WebNAP
- **Phase 2**: Convert source system extracts and classifications to the EDWARD format
- **Phase 3**: Integrate additional reporting requirements for specific clinical streams

The EDWARD Business Implementation (EBI) Program collaborating with the NSW Ministry of Health’s Health Systems Information and Performance Reporting (HSIPR) Branch will establish a small project team to support transition, testing and address queries as they arise during the migration period.

**Phase 1**

Implementation of phase 1 requires LHDs/SHNs to load WebNAP patient level and summary level extracts into EDWARD and to cease reporting to WebNAP.

To support the transition to EDWARD reporting during Phases 1 and 2, a file upload, conversion and transfer tool, the EDWARD mLoad Tool, will be available for LHDs/SHNs to upload patient level and summary level data extracts from source systems in either the WebNAP extract format, or the EDWARD extract format.

The tool will apply the necessary file format conversions to WebNAP extracts compliant with the 2015/16 WebNAP reporting requirements and file format. It will also produce a container header file (based on user inputs) for both WebNAP and EDWARD flat file formats, and transfer files to the EDWARD drop zone where they will be automatically loaded into EDWARD.

During this phase LHDs / SHNs:

1. Must build EDWARD extracts for non-admitted patient source systems that are not yet reporting at the patient level
2. Must commence the reconfiguration of WebNAP extracts such that the source system can report activity directly in the EDWARD extract format
3. May cease reporting summary level data for services reporting at the patient level once reporting through the EDWARD mLoad Tool
4. May commence (or fully implement any) transition steps outlined in later phases.

**Phase 1** must be completed by **30 June 2016**, to enable the decommissioning of WebNAP.
Phase 2
Implementation of Phase 2 requires LHDs / SHNs to complete the reconfiguration of WebNAP source system extracts into the EDWARD extract format and source systems to be fully aligned with the EDWARD classification standards.
During this phase any changes effective from 1 July 2016 will also need to be incorporated into the EDWARD extracts.
During this phase LHDs/SHNs may implement Phase 3 implementation steps.
Phase 2 must be completed by 30 June 2017, to enable the decommissioning of the WebNAP patient level file conversion functionality, compliance with 2016/17 reporting requirements and to establish the foundations required for implementation of Phase 3.

Phase 3
Phase 3 involves reporting the additional data elements set aside in the EDWARD extract file format for the integration of other non-admitted patient data collections for specific clinical streams. It will involve decommissioning the legacy extracts and legacy data repositories (such as HIE and other disparate databases).
This phase may only impact selected source systems. For example, radiotherapy sources system would add data elements required for the integration of radiotherapy waiting times and non-admitted patient cancer notifications, while source systems used by Hepatitis, HIV/AIDS and sexually transmissible diseases services would add data elements pertaining to communicable diseases.
Phase 3 is expected to be completed by 30 June 2018, to enable the decommissioning of the HIE and other legacy data repositories and to establish a single comprehensive non-admitted patient data collection.

FURTHER INFORMATION
The NSW Ministry of Health will provide advice and clarifications regarding the requirements for reporting non-admitted patient activity via EDWARD. Requests for advice should be directed to the Health System Information & Performance Reporting Branch, NSW Ministry of Health.

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ATTACHMENT

LINK TO COMPLETE GUIDELINE AND ATTACHMENT :
RIGHT TO ACCESS MEDICAL RECORDS BY LEGAL REPRESENTATIVES – MENTAL HEALTH REVIEW TRIBUNAL HEARINGS (IB2018_019)

PURPOSE
The purpose of this information bulletin is to inform Local Health Districts/Specialty Networks of the right of a patient’s legal representative to inspect and access the patient’s medical records when the patient has a matter before the Mental Health Review Tribunal and the need to facilitate a legal representative’s access to such records.

KEY INFORMATION
Under the Mental Health Act 2007, where the Mental Health Review Tribunal (Tribunal) holds a hearing or review in respect of a mental health patient, the patient has a right to be represented by a legal representative. In certain hearings, such as a mental health inquiry, the patient must be represented by a legal representative (or other person approved by the Tribunal). In most cases, a patient’s legal representative will be a legal practitioner from LegalAid or a LegalAid panel firm.

In order to ensure that a patient’s legal representative can appropriately represent the patient, the Mental Health Act gives a patient’s legal representative the right to inspect or have access to any medical records in the possession of the mental health facility at the Local Health District/Specialty Network relating to a patient who has a hearing before the Tribunal.

A legal representative’s right to access a patient’s records is important in order to ensure that the legal representative can understand the basis on which the patient has been detained and can properly and fully make submissions to the Tribunal in relation to the patient’s detention.

A Local Health District/Specialty Network must facilitate a patient’s legal representative’s right to inspect or access information about a patient’s detention, including admission documents, progress notes and relevant reports.

In advance of a hearing before the Tribunal, the relevant unit in a Local Health District/Specialty Network (such as a mental health facility or medical record unit) must provide the patient’s legal representative with access to the medical records of patients who have a hearing before the Tribunal and who are represented by the legal representative. This should generally be done as follows:

- A list of all patients who will be seen by the Tribunal should be prepared by the relevant unit in the Local Health District/Specialty Network in advance of the Tribunal hearing.
- Two copies of the each patient’s “relevant medical records” should be printed in advance of the Tribunal hearing - one copy for the Tribunal and one for the patients’ legal representative.
- Where a legal practitioner from LegalAid, or a LegalAid panel firm, attends to represent patients, they should be asked to confirm they have been appointed by LegalAid to act as the patients’ legal representative. Once they have confirmed they are acting for the patient/s that will be seen by the Tribunal and the practitioner’s identification documents have been sighted, a copy of the relevant records should be provided to the legal representative. A form of Confirmation as Legal Representative is at Appendix 1.
- The relevant unit in a Local Health District/Specialty Network (such as a mental health facility or medical record unit) must keep a copy of the Confirmation as Legal Representative form. This could be kept in a separate file or register in the relevant unit and where reasonable a note should be included in each patient’s file noting that the patient’s legal representative has been given access to the records.
• In a small number of cases, a legal representative other than from LegalAid, or a LegalAid panel firm, will represent a patient. In such cases, written confirmation they act for the patient, and identification documents sighted, must be provided for inclusion in the patient’s medical record before a copy of the relevant records is provided to the legal representative. A copy of the written confirmation should be placed in the patient’s medical record.

• If a medical practitioner considers that there is information in the medical records that will be harmful for the patient’s legal representative to share with the patient, the medical practitioner should warn the legal representative that it would be harmful to share the information with the patient. A legal representative is obliged to have due regard to the warning and not obliged to disclose the information to the patient. If the medical practitioner remains concerned, the practitioner can seek an order prohibiting the disclosure of information to the patient from the Tribunal.

This procedure can be adapted locally when giving access to electronic records.

Relevant medical records will include, at a minimum:

• For a mental health inquiry, all admission and detention documents relating to the current detention of the patient. This will include Assessment Form/s completed at the time of admission. If a person is transferred from another facility there may be more than one such form.

• For a mental health inquiry, a copy of the Statement of Rights, signed and dated by the patient where possible or, if refused, annotated copies recording the same and notations documenting later service.

• Nomination of Designated Carer form/s (including any exclusions) and, if nomination is refused, documentation of any determination by an authorised medical officer or Director of Community Treatment in relation to their appointment of a Principal Care Provider; evidence of further attempts to have the person nominate a Designated Carer.

• Documentation of any recent reviews carried out by a Consultant and/or Registrar or other member of the treating team.

• Documentation by the Consultant/Registrar of their final review prior to the Tribunal hearing, including any plan that specifies the order to be sought at the hearing.

• Recent progress notes.

• Any recent medical practitioner’s report.

• Any recent social work or allied health report.

• Any other documents specifically requested by the Tribunal in relation to the matter.

If the patient’s medical record contains details about a risk of significant harm under the Children and Young Persons (Care and Protection) Act, details about the mandatory reporter or the report must not be disclosed to the patient’s legal representative.

In some circumstances, a patient’s legal representative may request access to additional information about the patient. Where the request relates to the patient’s mental health or detention, the information should be provided to the patient’s legal representative.

Once the legal practitioner is given a copy of the records, the copy of the records is the responsibility of the legal practitioner and can be removed from the hospital. A patient’s legal representative will have their own professional and privacy obligations to maintain the confidentiality of the patient’s medical records.
Appendix 1: Confirmation as Legal Representative – LegalAid (including LegalAid Panel Firms) - for matters before the Mental Health Review Tribunal

**Confirmation as Legal Representative**

I, ____________________________, of ____________________________, confirm that I have been appointed by LegalAid to legally represent the patients below who have a hearing before the Mental Health Review Tribunal and who are detained at ____________________________.

*Name of patients and their MRN to be included by the mental health facility*

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[Legal representative to delete any patient’s name who they are not representing]

If a patient does not confirm the instructions, I undertake to inform the mental health facility and return all records provided to me by the facility.

Signed this ____________________________ day of 20 20

Note: under the Mental Health Act 2007, if a medical practitioner warns the legal representative of that it may be harmful to communicate to the patient, or any other person, specified information contained in the medical records, the legal representative is to have full and proper regard to that warning and the legal representative is not obliged to disclose to the patient any information in the records.

300(30/05/18)