Authority number: PROS 11/06 VAR 1



PROS 11/06 VAR 1

Retention and Disposal Authority for Records of Patient Information Records

Status Date: 14/11/2019

Authority number: PROS 11/06 VAR 1
Public Records Act 1973 (Section 12)
Retention and Disposal Authority for Patient Information Records
Public Record Office Standard (PROS) 11/06

Variation 1:

In accordance with section 12 of the Public Records Act 1973 (as amended), I hereby vary the Standard applying to Patient Information records, issued as Public Record Office Standard (PROS) 11/06 on 09/09/2011, as follows:

Extension of the application of this Authority until varied or revoked.

The addition of the following text to the scope of the RDA and across the body as a footer:

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

PROS 19/08 will apply unless existing retention periods in this RDA are greater than or equal to those specified in PROS 19/08.

Class Number	Description of Change
2.0	Cross-reference to child sexual abuse reporting class 4.3.1 and to PROS 19/08
2.1	Cross-reference to class 2.7.1 for records of patients treated where child sexual abuse is reported or disclosed
2.2	Cross-reference to class 2.7.1 for records of patients treated where child sexual abuse is reported or disclosed
2.3	Cross-reference to class 2.7.1 for records of patients treated where child sexual abuse is reported or
2.7	New activity for the treatment and care of patients where child sexual abuse is reported or disclosed
2.7.1	New class to cover records of patient treatment where child sexual abuse is reported or disclosed with 99 year retention period
4.0	Cross-reference to patient treatment records class 2.7.1 and to PROS 19/08

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4.3	Name changed to 'Reporting of Suspected Criminal Activity'
4.3.1	Amendment to the class to cover only records of the reporting to appropriate authorities of child sexual abuse incidents or disclosures, retention period increased to 99 years
4.3.2	New class covering the reporting to appropriate authorities of patients presenting with suspected injuries resulting from child abuse or neglect (previously covered by 4.3.1)
4.3.3	New class covering reports made to appropriate authorities for adult patients presenting with suspected injuries suspected to be caused by criminal activity, including sexual assault or physical assault (previously covered by 4.3.1)

This Variation shall have effect from its date of issue.

[signed]

Justine Heazlewood

Director and Keeper of Public Records

Date: 14 November 2019

Authority number: PROS 11/06 VAR 1

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Authority number: PROS 11/06 VAR 1

Retention and Disposal Authority for Records of Patient Information Records

Retention and Disposal Authority No	PROS 11/06 VAR 1
Scope	Authorises disposal of patient information records created by health service agencies.
	PROS 11/06 authorises the disposal of records created during and post 1950 in accordance with its provisions. PROS 11/06 does not authorise the disposal of records created before 1950. Public Record Office Victoria must be contacted for advice on disposal of pre 1950 records.
	This Retention and Disposal Authority must be used in conjunction with PROS 19/08 Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.
	PROS 19/08 will apply unless existing retention periods in this RDA are greater than or equal to those specified in PROS 19/08.
Status	Issued by Keeper
Issue Date	14 November 2019

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Introduction

Purpose of this Authority

The purpose of this Authority is to provide a mechanism for the disposal of public records in accordance with the *Public Records Act 1973*. The Authority:

- identifies records which are worth preserving permanently as part of Victoria's archival heritage
- prevents the premature destruction of records which need to be retained for a specified period to satisfy legal, financial and other requirements of public administration, and
- authorises the destruction of those records not required permanently.

Context of this Authority

Public Record Office Victoria Standards

This Authority should be used in conjunction with the Standards issued by the Keeper of Public Records under Section 12 of the *Public Records Act 1973*. Copies of all relevant PROV standards, specifications and regulatory advice can be downloaded from www.prov.vic.gov.au. These documents set out the procedures that must be followed by Victorian public offices.

Disposal of records identified in the Authority

Disposal of public records identified in this Authority must be undertaken in accordance with the requirements of Public Record Office Standard PROS 10/13 *Disposal*.

It is a criminal offence to unlawfully destroy a public record under s 19(1) of the *Public Records Act 1973*.

The destruction of a public record is not unlawful if done in accordance with a Standard established under s 12 of the *Public Records Act 1973*.

This Standard (also known as an Authority) authorises the disposal of public records as described within its provisions. However, disposal is **not** authorised under this Standard if it is reasonably likely that the public record will be required in evidence in a current or future legal proceeding.

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For the purposes of this Retention and Disposal Authority, a 'legal proceeding' has the same meaning as the *Evidence (Miscellaneous Provisions) Act 1958*, and includes any civil, criminal or mixed proceeding and any inquiry in which evidence is or may be given before any court or person acting judicially, including a Royal Commission or Board of Inquiry under the *Inquiries Act 2014*.

If the public office identifies that public records must be retained under other applicable legislation for a period that exceeds the retention period specified under the Standards, then the longer retention period must apply.

Access by or on behalf of a patient

'Access by or on behalf of the patient' refers to access for the purposes of providing patient treatment and care. It does not refer to access for legal or other purposes which do not relate directly to a patient's treatment or care. For further advice regarding the disposal of records subject to or likely to be subject to legal proceedings refer to 'Disposal of records identified in the Authority' in the Context section of this RDA.

Normal Administrative Practice

The destruction of some public records is permitted without final authorisation under normal administrative practice (NAP). NAP covers the destruction of ephemeral material of a facilitative nature created, acquired or collected by public officers during the course of their duties.

The following material may be destroyed under NAP:

- working papers consisting of rough notes and calculations used solely to assist in the preparation of other records such as correspondence, reports and statistical tabulations
- drafts not intended for retention as part of the office's records, the content of which has been reproduced and incorporated in the public office's record keeping system
- extra copies of documents and published material preserved solely for reference.

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Transfer of records to Public Record Office Victoria

Contact Public Record Office Victoria for further information on procedures for transferring permanent records to archival custody.

Use of Other Authorities

In applying the disposal sentences set out in this Authority, reference should be made to other current Authorities where applicable. Where there is a conflict between two Authorities (for instance this Authority and the General Retention and Disposal Authority for Records of Common Administrative Functions), consult the Public Record Office Victoria for advice.

Explanation of Authority Headings

Class Number

The class number or entry reference number provides citation and ease of reference.

Description

The description of each record class is specified in this entry. A record class is a group of records that relate to the same activity, function or subject and require the same disposal action.

Status

This entry provides the archival status of each class - either permanent or temporary.

Custody

This entry specifies whether the records are to be retained by the public office or transferred to the Public Record Office Victoria. Permanent electronic records are to be transferred in VERS Encapsulated Object (VEO) format according to PROS 99/007 - Management of Electronic Records (Version 2). The storage of public records identified in this Authority must also be in accordance with the requirements of Public Record Office Standard PROS 11/01 *Storage*.

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Concurrence of Public Office

This Authority has the concurrence of:

Signed: [signed]

Name: Fran Thorn

Position: Fran Thorn

Date: 02/09/2011

Establishment of Standard

Pursuant to Section 12 of the *Public Records Act 1973*, I hereby establish these provisions as a Standard (also known as a Retention and Disposal Authority) applying to Health Agencies, all. This standard as varied or amended from time to time, shall have effect from the date of issue unless revoked.

[signed]

Justine Heazlewood, Keeper of Public Records

Date of Issue: 09/09/2011

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No	Function/Activity	Description	Status	Disposal Action
1	PATIENT ASSESSMENT, REGISTRATION AND ADMISSSION	The assessment of persons for treatment by a health service, the registration of patients, and admission into a health service for inpatient or outpatient treatment.		
1.1	Patient Assessment	The assessment of prospective patients for treatment and/or admission. Includes the assessment of injured or ill people presenting at emergency or casualty desks without referral for treatment.		
1.1.1		Records of assessment that results in treatment or care. Includes referrals and records of triage activities. [For appointment records, use 1.1.4]	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
1.1.2		Records of assessment that does not result in treatment or care. Includes referrals and records of triage activities.	Temporary	Destroy 12 years after last action.
1.1.3		Referrals which do not result in an assessment, treatment nor care. [For appointment records, use 1.1.4]	Temporary	Destroy 2 years after last action.
1.1.4		Appointment records.	Temporary	Destroy 2 years after last action.
1.2	Patient Registration	The activity of uniquely identifying patients, including the allocation of a unique identifier for each patient		

Authority number: PROS 11/06 VAR 1

No	Function/Activity	Description	Status	Disposal Action		
PATIENT A	PATIENT ASSESSMENT, REGISTRATION AND ADMISSSION - Patient Registration					
		to ensure matching of individual patients to medical and financial records and to trace patient movement.				
		[Excludes the state-wide registration of mental health patients. See <i>Retention and Disposal Authority for Records of Mental Health, Alcohol and Drugs Service Functions</i> PROS 09/09]				
1.2.1		Records which uniquely identify each patient, including the allocation of a unique identifier (e.g. Unit Record (UR) number) for each patient.	Temporary	Destroy 75 years after last action.		
		Includes name, address and date of birth. May include health insurance details, next of kin, guardian (if applicable), referring practitioner, concession eligibility, and summary note of the authority for admission and treatment (if applicable).				
		[Excludes consents or any legal instruments authorising admission, use 1.3.1]				
1.3	Patient Admission	The admission of patients to a hospital or health facility, including the allocation of accommodation and services.				
1.3.1		Records documenting the admission of individual patients and the authority under which they were admitted. Includes formal orders, warrants and consents authorising admission.	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have		
		Includes the initial allocation of accommodation and services to patients and assigning a primary medical practitioner responsible for the patient.		reached 30 years of age.		

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No	Function/Activity	Description	Status	Disposal Action
PATIENT /	ASSESSMENT, REGISTRATIO	ON AND ADMISSSION - Patient Admission		
		[Excludes orders and warrants under the <i>Mental Health Act</i> , see 1.3.2]		
1.3.2		Records authorising the admission and movement of patients under the <i>Mental Health Act</i> . Includes authorisation to transport and transfer orders. Includes formal orders and warrants. [For records of patient treatment during transfer, see 2.0.0 Patient Treatment and Care.]	Temporary	Destroy 25 years after date of last attendance or access by or on behalf of the patient provided they have reached 43 years of age.
1.3.3		Records of patients' Medicare details, health insurance or other payment arrangements for treatment.	Temporary	Destroy 7 years after last action.
1.3.4		Submission of Acute Care Certificates as per the Private Health Insurance (Benefit Requirements) for patients who would ordinarily be residing in aged care accommodation, but require admission for treatment of a condition that would usually be provided under out-patient conditions e.g. chemotherapy, radiation therapy.	Temporary	Destroy 7 years after last action.
2	PATIENT TREATMENT AND CARE	Provision of medical examination, diagnosis, treatment, care services and advice to acute, subacute and mental health patients.		
		Refers to admitted, non-admitted and emergency department patients.		
		Includes treatment and services from allied health professionals which includes but is not limited to:		

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No	Function/Activity	Description	Status	Disposal Action
PATIENT TR	EATMENT AND CARE			
		Occupational therapy		
		Speech therapy		
		Pathology		
		Pharmacology		
		• Podiatry		
		Social work		
		 Physiotherapy 		
		 Psychology 		
		Includes records of patients treated where child abuse is reported or disclosed.		
		[For records of reporting of child sexual abuse incidents or disclosures, including mandatory reporting, see 4.3.1]		
		[For records of the agency's prevention, identification and response to child sexual abuse incidents and allegations, use PROS 19/08 RDA for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations.]		
		[For the treatment of pre 1996 mental health patients (voluntary and involuntary) provided by State institutions, use PROS 09/09 RDA for <i>Records of Mental Health, Alcohol and Drugs Services</i> .]		

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No	Function/Activity	Description	Status	Disposal Action
PATIENT	TREATMENT AND CARE - Er	nergency Department Patient Treatment and Care		
2.1	Emergency Department Patient Treatment and Care	The treatment and care of patients by an emergency department of a public hospital or health facility who are discharged from the emergency department and are not admitted for further treatment and care as either an inpatient or outpatient.		
		[For assessments that do not result in treatment, use 1.1.2.]		
		[For emergency department patients subsequently admitted as an inpatient, use 2.2.0.]		
		[For emergency department patients subsequently treated as an outpatient, use 2.3.0.]		
		[For records of patients treated where child sexual abuse is reported or disclosed use 2.7.1.]		
2.1.1		Records of emergency department patients, who are not admitted for further treatment and care as either an inpatient or outpatient, where treatment in emergency department included blood transfusion or the receipt of blood product.	Temporary	Destroy 20 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.1.2		Records of emergency department patients who are not admitted for further treatment and care as either an inpatient or outpatient, where treatment did not include blood transfusion or the receipt of blood product.	Temporary	Destroy 12 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.

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No	Function/Activity	Description	Status	Disposal Action
PATIENT	TREATMENT AND CARE - Er	nergency Department Patient Treatment and Care		
2.1.3		Records of emergency department patients who die while or after receiving treatment in an emergency department.	Temporary	Destroy 12 years after date of last attendance, or access on behalf of the patient.
2.2	Admitted Patient Treatment and Care	The treatment and care of admitted patients. Admitted patients are defined as those patients who meet the criteria contained in the Victorian Hospital Admissions Policy. Includes patients admitted for overnight stays and day patients.		
		[For records of patients treated where child sexual abuse is reported or disclosed use 2.7.1.]		
2.2.1		Records documenting admitted patient treatment and care under <i>Mental Health Act</i> [gazetted mental health service].	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
2.2.2		Records documenting admitted patient treatment and care where treatment included a blood transfusion or treatment with blood products.	Temporary	Destroy 20 years after date of last attendance, or access by or on behalf of the patient provided
		[Excludes patient treatment under <i>Mental Health Act</i> , use 2.2.1]		they have reached 30 years of age.
2.2.3		Records documenting admitted patient treatment and care where treatment did not include blood transfusions or treatment with blood products.	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf

Status

Temporary

Disposal Action

access by or on behalf of

the patient provided the

child has reached 30

Destroy 50 years after

date of last attendance,

or access by or on behalf

years of age.

of the patient.

Description

[Excludes patient treatment under Mental Health Act,

Records documenting patient treatment and care

counselling and/or treatment for gender identity

Refers to the treatment and care of non-admitted

Non-admitted patients are those for whom the hospital/service does not assume primary responsibility for the treatment and care of the patient's medical condition/s, but instead delivers treatment and care upon referral by the patient's

outpatients and sub-acute ambulatory care service

where patients have been admitted to hospital for

use 2.2.11

disorder.

patients.

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Non-Admitted

and Care

Patient Treatment

Function/Activity

No

2.2.6

2.3

	[Excludes patient treatment under <i>Mental Health Act</i> , use 2.2.1]	of the patient provided they have reached 30 years of age.
2.2.4	Records documenting admitted patient treatment and care of those patients who die. Includes deaths whilst receiving treatment and those that occur after discharge. [Excludes obstetric patients, use 2.2.5]	Destroy 12 years after the date of death of the patient or last access on behalf of the patient.
2.2.5	Records documenting treatment and care of an obstetric patient and child.	Destroy 15 years after date of last attendance or

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No	Function/Activity	Description	Status	Disposal Action		
PATIENT TR	PATIENT TREATMENT AND CARE - Non-Admitted Patient Treatment and Care					
		primary medical practitioner.				
		[For records of treatment and care of outpatients and sub-acute ambulatory care service patients who were previously or subsequently admitted during the course of treatment for their medical condition, use 2.2.0 Admitted Patients.]				
		[For records of patients treated where child sexual abuse is reported or disclosed use 2.7.1.]				
2.3.1		Records documenting treatment and care under the <i>Mental Health Act</i> [gazetted mental health services] for non-admitted outpatient, ambulatory, and community based patients.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.		
2.3.2		Records documenting treatment and care of non-admitted patients of out-patient and sub-acute ambulatory care services where treatment included a blood transfusion or treatment with blood products.	Temporary	Destroy 20 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.		
2.3.3		Records documenting treatment and care of non-admitted patients of out-patient and sub-acute ambulatory care services where treatment did not include a blood transfusion or treatment with blood products.	Temporary	Destroy 12 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.		

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No	Function/Activity	Description	Status	Disposal Action
PATIENT	TREATMENT AND CARE - N	Ion-Admitted Patient Treatment and Care		
2.3.4		Records documenting treatment and care of those non-admitted patients who die. Includes deaths whilst receiving treatment and those that occur after treatment ceases.	Temporary	Destroy 12 years after the date of death of the patient or last access on behalf of the patient.
2.3.5		Records documenting treatment and care of non-admitted patients receiving dental services. Includes impressions and casts of patient dental structure. [For patients who are admitted for treatment as an inpatient, use 2.2.0 Admitted Patients.]	Temporary	Destroy 12 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.4	Assisted Reproductive Technology (ART)	The treatment and care of patients of Assisted Reproductive Technology (ART) procedures including In Vitro Fertilisation (IVF), gamete intrafallopian transfer (GIFT) and artificial insemination. Includes case management of each individual person or family unit, consent to ART procedures, donation and use of gametes (semen or ova) or embryos, and the withdrawal of consent for such procedures/use.		
2.4.1		Records of Assisted Reproductive Technology patients where a child is born or pregnancy achieved using donated gametes or embryos.	Permanent	Retain as State archives
2.4.2		Records of Assisted Reproductive Technology patients where a child is born from non-donated gametes or embryos.	Temporary	Destroy 75 years after date of last attendance, or access by or on behalf of the patient.

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No	Function/Activity	Description	Status	Disposal Action
PATIENT	TREATMENT AND CARE - As	sisted Reproductive Technology (ART)		
2.4.3		Records of Assisted Reproductive Technology patients where a child is not born.	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient.
2.4.4		Records of donors of gametes or embryos for reproductive procedures.	Permanent	Retain as State archives
2.5	Treatment Consents and Authorisation	The provision of consent or authorisations for patient treatment and care including participation in research and clinical trials.		
2.5.1		Records of consent by patients or their authorised representative for treatment, refusal of treatment (do not resuscitate), and organ donations. Includes consents to participate in clinical trials and research.	Temporary	Dispose in accordance with Patient Treatment and Care, 2.1.0 – 2.4.0.
		[Excludes gazetted mental health services, use 2.5.2]		
2.5.2		Records authorising or consenting to patient treatment (warrants and orders) for gazetted mental health services including:	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided
		 the use of seclusion, electroconvulsive therapy, pharmacological therapy, and mechanical restraints 		of the patient provided they have reached 43 years of age.
		involuntary treatment		
		 compulsory treatment 		
ı		the attendance and examination of persons.		

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No	Function/Activity	Description	Status	Disposal Action
PATIENT	TREATMENT AND CARE - TI	reatment Consents and Authorisation		
2.5.3		Applications to the Psychosurgery Review Board to perform psychosurgery. Includes determinations (successful and unsuccessful).	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.5.4		Reporting of recovery and response to psychosurgery performed under approval of the Psychosurgery Review Board.	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
2.6	Secondary Consultations	The provision of specialist medical advice, in the form of a secondary consultation, requested by a medical practitioner or health service on the treatment of a patient. Includes, for example, secondary consultations provided by specialist eating disorder units or drug and alcohol rehabilitation units. For advice received from secondary consults dispose in accordance with the patient record.		
2.6.1		Records documenting advice provided to another medical practitioner or health service in the form of a secondary consultation. Records include the patient's conditions upon which advice was developed, and summary of advice provided.	Temporary	Destroy 7 years after advice provided.
2.7	Child Sexual Abuse	The treatment and care of patients where child		

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No	Function/Activity	Description	Status	Disposal Action
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PATIENT TREATMENT AND CARE - Child Sexual Abuse Incidents and Disclosures

	Incidents and Disclosures	sexual abuse is reported or disclosed. Includes the care of children who present with suspected cases of sexual abuse. Includes all patients including admitted, non-admitted and emergency department patients.		
2.7.1		Records of patients treated where child sexual abuse is reported or disclosed. Includes the care of children who present with suspected cases of sexual abuse. Includes all patients including admitted, non-admitted and emergency department patients.	Temporary	Destroy 99 years after action completed.
		[For records of reporting of child sexual abuse incidents or disclosures, including mandatory reporting, see 4.3.1]		
3	DIAGNOSTIC AND TESTING SERVICES	The analysing and determining the nature or cause of a patient's poor physical or mental health, through diagnostic and testing services, in order to determine the course of treatment.		
		[For records of diagnostic reports which form part of a patient history, see 2.0.0.]		
		[For records of new born congenital metabolic disorder screening, see Retention & Disposal Authority for Records of Statewide Health Services.]		
3.1	Pathology Diagnostic Services	The procedures and tests performed by a pathology service on specimens taken from the body of a patient.		
		Includes requests and instructions for carrying out		

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No	Function/Activity	Description	Status	Disposal Action
DIAGNOS	TIC AND TESTING SERVICE	CES - Pathology Diagnostic Services		
		diagnostic examinations.		
		Includes:		
		 Anatomical Pathology (Histopathology) 		
		• Cytology		
		 Haematology 		
		Clinical Chemistry/Chemical Pathology		
		Blood Banks		
		• Immunology		
		Microbiology		
		Genetics.		
3.1.1		Requests for pathology procedures.	Temporary	Destroy 1 year after request is fulfilled.
3.1.2		Examined material, diagnostic recordings and laboratory results created in the process of diagnosing a patient.	Temporary	Destroy in accordance with standards and guidelines issued by the National Pathology Accreditation Advisory Council.
3.1.3		Records documenting the evaluation and interpretation of results of pathological examinations performed for patient diagnosis.	Temporary	Destroy in accordance with 2.0.0 Patient Treatment and Care.
3.2	Non-Pathological Diagnostic	Refers to non-pathological procedures and tests, including imaging, for the purpose of patient		

Authority number: PROS 11/06 VAR 1

	No	Function/Activity	Description	Status	Disposal Action
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DIAGNOSTIC AND TESTING SERVICES - Non-Pathological Diagnostic Procedures and Tests

	Procedures and Tests	diagnosis. Includes the reporting of results.		
3.2.1		Requests for procedures including X-rays, Computed Tomography (CT) scans, ultrasounds and cardiotocograms.	Temporary	Destroy 1 year after request is fulfilled.
3.2.2		Records documenting results from a diagnostic procedure. Examples include: Radiology (X-Rays) Images Recordings of electroencephalograms, electrocardiograms, electromyograms, cardiotocograms etc Ultra-Sound Images Computed Tomography (CT) scans Magnetic Resonance Images (MRI) Photographs Measurements, gradings, readings and other data. Completed worksheets, questionnaires or surveys.	Temporary	Destroy 5 years after creation.
3.2.3		Records documenting the evaluation and interpretation of imaging records created for patient diagnosis.	Temporary	Destroy in accordance with 2.0.0 Patient Treatment and Care.
4	STATUTORY REPORTING AND	The reporting of medical and non-medical conditions		

Authority number: PROS 11/06 VAR 1

No	Function/Activity	Description	Status	Disposal Action
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STATUTORY REPORTING AND MONITORING OF PATIENTS - Birth and Death Recording and Notification

	MONITORING OF	as required by legislation.		
	PATIENTS	Includes:		
		 reporting to the Registry of Births, Death and Marriages, 		
		the mandatory reporting of treatment under the <i>Mental Health Act</i> ,		
		 reporting for public health policy and planning purposes and 		
		 reporting of injury/illness suspected to be caused by criminal activity. 		
		[For treatment authorisations see 2.0.0 Patient Treatment and Care.]		
		[For records of patients treated where child abuse is reported or disclosed use 2.7.1.]		
		[For records of the agency's prevention, identification and response to child sexual abuse incidents and allegations, use PROS 19/08 RDA for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations.]		
4.1	Birth and Death Recording and Notification	The recording of births and deaths that have occurred in a public hospital or health service. Includes the notification of births and deaths to the Registry of Births, Deaths and Marriages.		
4.1.1		Notification of births that have occurred in a public hospital or health service to the Registry of Births,	Temporary	Destroy 1 year after date of notification.

Authority number: PROS 11/06 VAR 1

	No	Function/Activity	Description	Status	Disposal Action
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STATUTORY REPORTING AND MONITORING OF PATIENTS - Birth and Death Recording and Notification

		Deaths and Marriages.		
4.1.2		Register of Births within the hospital.	Permanent	Retain as State archives
4.1.3		Notification of deaths that have occurred in a public hospital or health service to the Registry of Births, Deaths and Marriages.	Temporary	Destroy 1 year after date of notification.
4.1.4		Register of Deaths within the hospital.	Permanent	Retain as State archives
4.2	Reporting of Notifiable Diseases, Birth, Morbidity and Mortality Rates	Reporting of notifiable diseases, birth, morbidity and mortality rates for public health policy and planning purposes.		
4.2.1		Reporting to Department responsible for public health of notifiable (infectious) disease cases and birth, mortality and morbidity rates.	Temporary	Destroy 6 months after date of notification.
4.3	Reporting of Suspected Criminal Activity	Reporting of suspected cases of child abuse and neglect; sexual and physical assault and injury suspected to be caused by criminal activity.		
4.3.1		Records documenting the reporting of child sexual abuse incidents or disclosures or any suspected cases of sexual abuse of children. Includes mandatory reports made to appropriate authorities.	Temporary	Destroy 99 years after action completed.
4.3.2		Records documenting the reporting of patients presenting with suspected injuries resulting from child abuse or neglect. Includes mandatory reports	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf

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	No	Function/Activity	Description	Status	Disposal Action
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STATUTORY REPORTING AND MONITORING OF PATIENTS - Reporting of Suspected Criminal Activity

		made to appropriate authorities. [does not include child sexual abuse - see 4.3.1]		of the patient provided they have reached 30 years of age.
4.3.3		Records documenting reports made to appropriate authorities for adult patients presenting with suspected injuries suspected to be caused by criminal activity, including sexual assault or physical assault.	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient.
4.4	Reporting of Treatment Regulated under the Mental Health Act	Reporting to the Chief Psychiatrist of treatment provided to mental health patients as required under the <i>Mental Health Act</i> to enable the Chief Psychiatrist to be informed and act accordingly. [For treatment of mental health patients, see 2.0.0]		
4.4.1		Notifications of the use of patient seclusion, electroconvulsive therapy (ECT) or mechanical restraints in the treatment of mental health patients.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
4.4.2		Monthly returns of the use of electroconvulsive therapy (ECT), mechanical restraint and seclusion used in the treatment of mental health patients.	Temporary	Destroy 2 years after notification to Chief Psychiatrist.
4.5	Protection of the Rights of Mental Health Patients	The protection of the rights of mental health patients in accordance with the <i>Mental Health Act</i> .		

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4.5.3

No	Function/Activity	Description	Status	Disposal Action
STATUTORY	REPORTING AND MONITO	ORING OF PATIENTS - Protection of the Rights of Mental	l Health Patients	
4.5.1		Statement of rights provided to patients and/or their appointed representative.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
4.5.2		Records documenting the annual examination of general physical and mental health made of all involuntary mental health patients and reported to the Chief Psychiatrist to ensure: • that all involuntary patients have access to medical advice and treatment of non-mental health conditions (at no cost to the patient), and • that undiagnosed non-mental health conditions and/or physical side effects of mental health treatment regimes are not having a further deleterious effect on the	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.

Temporary

This Retention and Disposal Authority **must be used in conjunction with PROS 19/08** Retention and Disposal Authority for Records of Organisational Response to Child Sexual Abuse Incidents and Allegations for records of child sexual abuse prevention, identification, investigation and resolution.

visit.

mental health of the patient.

Records of visits made by a Community Visitor to a

[For reports made by Community Visitors regarding their visits, see the *Retention & Disposal Authority for the Records of the Office of the Public Advocate.*]

public hospital or health facility offering mental

health services noting date, time and duration of

Destroy 7 years after

date visit concluded.

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No	Function/Activity	Description	Status	Disposal Action	
STATUTORY REPORTING AND MONITORING OF PATIENTS - Protection of the Rights of Mental Health Patients					

4.5.4		Records documenting individual requests made by a patient to see a Community Visitor.	Temporary	Destroy 7 years after last action.
4.6	Applications for Special Leave, Forensic Leave and Leave of Absence	The assessment of applications for special leave to security patients. Includes the submission of applications for forensic leave by forensic patients to the Forensic Leave Panel. Also includes the submission of applications for leave of absence by security patients to the Department of Justice. [For Appeals to Mental Health Review Board, see 4.7.0]		
4.6.1		Records of applications for special leave made for security patients to the Chief Psychiatrist. Includes determinations.	Temporary	Destroy 15 years after determination made.
4.6.2		Applications for forensic leave made by forensic patients to the Forensic Leave Panel. Includes determinations and orders made by the Panel.	Temporary	Destroy 15 years after determination made.
4.6.3		Applications for leave of absence made by security patients to the Department of Justice. Includes determinations made by the Department.	Temporary	Destroy 15 years after determination made.
4.7	Mental Health Review Board Applications	Submission of applications to the Mental Health Review Board to: • review involuntary treatment orders, • review orders made for involuntary and security patients and their treatment plans,		

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No	Function/Activity	Description	Status	Disposal Action
STATUTO	DRY REPORTING AND MONITO	ORING OF PATIENTS - Mental Health Review Board Appl	ications	·
		 appeal the refusal to grant special leave to security patients, 		
		 appeal the transfer of involuntary and security patients, and 		
		 review orders for the transfer of involuntary patients to interstate mental health facilities. 		
		[For Records of the Mental Health Review Board, see Retention and Disposal Authority for Records of Mental Health Review Board PROS 05/05]		
4.7.1		Applications to the Mental Health Review Board to review orders and to appeal determinations. Includes the Boards reasons for final determination.	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43 years of age.
4.8	Mental Health Patient Trust Accounts Management	The management of the Patient Trust Accounts in accordance with the requirements of the <i>Mental Health Act</i> .		
4.8.1		Account identification details for trust accounts established for each patient including details of the authorised deposit-taking institution, the patient trust account type, name, and numbers of the interest accounts and investment portfolios.	Temporary	Destroy 7 years after account closed.
4.8.2		Periodical transaction statements for each account.	Temporary	Destroy 7 years after the end of the financial year to which the statement

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No	Function/Activity	Description	Status	Disposal Action
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STATUTORY REPORTING AND MONITORING OF PATIENTS - Mental Health Patient Trust Accounts Management

				applies.
4.8.3		Patient requests for withdrawal of funds.	Temporary	Destroy 7 years after the end of the financial year in which the request was made.
5	DISCHARGING PATIENTS AND POST CARE	Discharging a patient from a health service after completion of a treatment, or at the patient's request. [For notification of deaths, see 4.1.3]		
5.1	Authorising Discharge	 The authorisation of patient discharge. Includes: capturing information about the date the hospital or health facility ceases to have primary responsibility for the medical treatment and care of the patient, arranging for the transfer of custody where the patient is on a custodial, forensic or security order. 		
5.1.1		Records authorising patient discharge either by a medical practitioner or by the patient. Includes formal discharge summary, and in the event of a patient death, the provision of a death certificate to next of kin /executors.	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
5.1.2		Records authorising the discharge of patients in	Temporary	Destroy 25 years after date of last attendance,

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No	Function/Activity	Description	Status	Disposal Action
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DISCHARGING PATIENTS AND POST CARE - Post Care Arrangements and Instructions

5.2	Post Care Arrangements and Instructions	accordance with the <i>Mental Health Act</i> . Includes authorities to transfer and transport a patient a patient to another facility. Post Care Arrangements and Instructions		or access by or on behalf of the patient provided they have reached 43 years of age.
5.2.1		 Instructions and arrangements upon discharge for patients, including; arrangements for the collection of the patient, including any specialist transport required instructions for medication, injury management, diet / exercise regimes, use of equipment, additional appointments provision of referrals to provide to General Practitioner (GP) or specialist for ongoing treatment medical certificate if required. [Excludes patients treated in accordance with the Mental Health Act, use 5.2.2.] 	Temporary	Destroy 15 years after date of last attendance, or access by or on behalf of the patient provided they have reached 30 years of age.
5.2.2		Instructions and arrangements upon discharge for patients treated under the <i>Mental Health Act</i> upon including: • arrangements for the collection of the patient, including any specialist transport required	Temporary	Destroy 25 years after date of last attendance, or access by or on behalf of the patient provided they have reached 43

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No	Function/Activity	Description	Status	Disposal Action			
ACCESS TO PATIENT INFORMATION							
		 instructions for medication provision of referrals to provide to GP or specialist for ongoing treatment medical certificate if required. 		years of age.			
6	ACCESS TO PATIENT INFORMATION	The management of access to patient information through requests by patients (or authorised representative) and to comply with legal processes such as subpoenas and warrants. Includes assessment of applications, determinations, and the arrangements for access to occur.					
6.1	Assessment of Applications	The assessment of requests for access to patient information. [For Freedom of Information (FOI) applications, use the General Retention & Disposal Authority for Records of Common Administrative Functions.]					
6.1.1		Records documenting requests to access to patient information. Includes determinations and patient consents.	Temporary	Destroy 5 years after action completed.			
7	STERILISATION OF MEDICAL EQUIPMENT	The sterilisation, disinfecting and cleaning of reusable medical and surgical instruments and equipment for infection prevention and control.					
7.1	Sterilisation, Cleaning and Disinfection of Reusable Medical	The recording of the cleaning, disinfection and sterilisation of reusable medical equipment that are used for patient treatment and care.					

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No	Function/Activity	Description	Status	Disposal Action			
STERILISATION OF MEDICAL FOLLIPMENT. Starilisation, Clasning and Disinfaction of Pousable Medical Equipment							

STERILISATION OF MEDICAL EQUIPMENT - Sterilisation, Cleaning and Disinfection of Reusable Medical Equipment

	Equipment			
7.1.1		Sterilisation records that identify individual patients.	Temporary	Destroy 15 years after action complete.
7.1.2		Sterilisation records that do not identify individual patients.	Temporary	Destroy after when action complete.