

Australian Standard[®]

Health records

Part 1: Paper-based health records

STANDARDS
Australia



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Part 1: Paper-based health records

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PREFACE

This Standard was originally prepared by the Standards Australia Subcommittee HE-005-02, Medical Records, under the responsibility of Committee HE-005, Health Care Administration, to supersede AS 2828—1985, *Hospital medical records*. This current edition was prepared by Subcommittee IT-014-02, Health Concept Representation, in conjunction with input from NSW Health State Forms Subcommittee.

This Standard is a revision of AS 2828—1999 and forms part of a set to be known as Health Records, as follows:

AS

2828 Health records

2828.1 Part 1: Paper-based healthcare records

2828.2 Part 2: Digitized (scanned) health record system requirements

These documents should be read as a set to gain a better appreciation of the context.

The health record is a key instrument for recording details concerning the care given to a patient within the healthcare organization and for storing other appropriate information relating to that patient.

‘Subject of care’ is the preferred international term for one or more persons scheduled to receive, receiving, or having received a health service. The term ‘patient’ has been used in this document instead of subject of care for simplicity, but should be understood to encompass all clients and consumers of healthcare services.

The requirements of this Standard are intended to provide an effective health record and encourage standardization. The Standard will be used by health facilities developing and maintaining healthcare records.

This Standard considers that the purpose and function of the health record should reflect the needs of the user, both individual and healthcare organization, and should ensure commonality of identification, physical characteristics and location of the components of the record between different healthcare services.

Consideration has also been given to the following important criteria for the record as a whole:

- (a) Durability.
- (b) Ready identification.
- (c) Reproducibility (e.g. in relation to photocopying and scanning).
- (d) Cost.
- (e) Storage and retrieval.

The principal differences between this Standard and the 1985 and 1999 editions are as follows:

- (i) The 1985 edition was concerned with hospitals only, and had a medical focus. The 1999 edition recognized the changes that had occurred in delivery of health care including increased ambulatory settings. This edition considers the complexity of health record use across an enterprise or state-wide healthcare system.
- (ii) The nomenclature has evolved from ‘medical record’ to ‘healthcare record’ and now to ‘health record’ in this current Standard and is intended to reflect the various changes in the healthcare system over the past two decades.

- (iii) The 1999 edition was primarily concerned with paper-based healthcare records only. This Standard now includes a Part 2 that provides requirements for systems associated with digitized (scanned) electronic versions of paper-based records.
- (iv) A number of previously normative appendices are now informative because the complexity and variation of health record systems across jurisdictions and rapidly evolving technology has rendered mandating some requirements challenging at the time of publication.

Funding for this publication has been provided by the Commonwealth Department of Health and Ageing. The Commonwealth makes no representation or warranty that the information in this publication is correct and accurate.

Standards Australia wishes to thank the Department of Health and Ageing for their continued financial support in helping us develop this Australian Standard.

The term 'informative' has been used in this Standard to define the application of the appendix to which it applies. An 'informative' appendix is only for information and guidance.

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STANDARDS AUSTRALIA

Australian Standard Health records

Part 1: Paper-based health records

1 SCOPE

This Standard specifies requirements for the physical aspects of health records regarding size, quality, layout, colour, order of filing and record cover, and method of fixing health record forms/dividers within a record cover. Some aspects of this Standard will apply to digitized (scanned) versions of paper-based health records.

This Standard does not address record content, e.g. clinical documentation, because of the diversity in this area.

2 OBJECTIVE

The objective of this Standard is to improve the quality of health care by facilitating communication between healthcare professionals. In addition, it seeks to meet the following criteria:

- (a) Allow ease of making entries in the record.
- (b) Allow adequate and accurate filing and storage of patient information.
- (c) Allow ease of access by authorized users.
- (d) Facilitate improved retrieval of patient information.
- (e) Allow easier filing and culling of earlier cumulative reports, i.e. diagnostics (thereby reducing record bulk) by sectional filing.
- (f) Allow standardized practices for both paper-based and electronic forms as well as hybrid records.

3 APPLICATION

The Standard applies to health care facilities, including hospitals and hospital-type services (e.g. day surgery centres), community health centres and other facilities (e.g. aged care residential services and office-based practices).

4 REFERENCED DOCUMENTS

The following documents are referred to in the Standard:

AS	
1301	Methods of test for pulp and paper
1301.41s	Part 41s: Water absorptiveness of paper and paperboard (Cobb test)
1301.45s	Part 45s: Determination of moisture content in paper, board and pulps
1612	Paper sizes
2828.2	Health records—Digitized (scanned) health record systems requirements
P5	Punching patterns for round holes used in files and loose leaf binders
AS/NZS	
1301	Methods of test for pulp and paper
1301.422s	Part 422s: Determination of the pH value of aqueous extracts of paper, board and pulp—Hot extraction method