Australian Standard™

Paper-based health care records

This Australian Standard was prepared by Committee HE/5, Health Care Administration. It was approved on behalf of the Council of Standards Australia on 17 September 1999 and published on 15 November 1999.

The following interests are represented on Committee HE/5:

Association for Australian Rural Nurses

Australian College of Rural and Remote Medicine

Australian Medical Association

Australian Nursing Federation

Australian Private Hospitals Association

Commonwealth Department of Health and Aged Care

Department of Community and Health Services, Tasmania

Department of Defence

Department of Human Services, Vic.

Health Department, W.A.

Health Information Management Association of Australia

Health Professions Council of Australia

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PREFACE

This Standard was prepared by the Standards Australia Subcommittee HE/5/2, Medical Records, under the responsiblity of Committee HE/5, Health Care Administration, to supersede AS 2828—1985, *Hospital medical records*.

The health care record has been considered as a key instrument for recording details concerning the care given to a patient within the health care facility and for storing other appropriate information relating to that patient.

All aspects of the Standard may not apply to the records in Primary/Community Health Care agencies and private health care services, including office-based practices. However, the Standard provides important principles and useful guidelines which may be applied with appropriate modification in these categories.

It was not thought appropriate, because of the diversity in this area, to make any recommendations about record content, and this is a matter for individual institutions to consider.

The term ‘patient’ has been used for simplicity, but should be taken to encompass clients and consumers of health care services.

The requirements of this Standard will provide a most effective standardized health care record. The Standard will be used by health care facilities developing new health care records, or would be implemented over a period of time in existing systems as these are reviewed and/or stocks need replenishment. In the preparation of this Standard, it was recognized that practical considerations would not necessarily allow its immediate implementation in existing systems. The Standard is, however, intended as a set of conditions to aim for.

In developing this Standard, the Committee took into account the whole purpose and function of the record which should reflect the needs of the user, both individual and health care facility, and to ensure commonality of identification, physical characteristics and location of the components of the record between different health care facilities.

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

(a) To allow ease of making written entries in the record.

(b) To allow adequate storage of patient information.

(c) To allow ease of access by authorized users.

(d) To facilitate improved retrieval of patient information.

(e) To assist ease of filing.

(f) To allow improved accuracy of filing by clerical staff.

(g) To allow easier filing and culling of earlier cumulative diagnostic reports (thereby reducing record bulk) by sectional filing.

The use of dividers and the delineation of certain sections of the record will meet the criteria outlined above.

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

(i) Durability.

(ii) Ready identification.

(iii) Reproducibility, (e.g. in relation to photocopying, microfilming).

(iv) Imaging.

(v) Cost.

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

(A) The 1985 edition was concerned with hospitals only, and had a medical focus. This edition recognizes the changes which have occurred in philosophies of, and practices in, health care.

(B) The nomenclature has been changed, e.g. ‘medical record’ to ‘health care record’, giving the Standard a broader outlook. Other changes in nomenclature, such as ‘non-admitted patient’ are intended to reflect the various changes in the health care system over the past decade.

The terms ‘normative’ and ‘informative’ have been used in this Standard to define the application of the appendix to which they apply. A ‘normative’ appendix is an integral part of a Standard, whereas an ‘informative’ appendix is only for information and guidance.

CONTENT

STANDARDS AUSTRALIA

Australian Standard

Paper-based health care records

1 SCOPE This Standard specifies requirements for the physical aspects of health care records such as size, quality, layout, colour, order of filing and record cover, and method of fixing the health care record forms/dividers within the record cover.

2 APPLICATION The Standard is relevant 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). While the Standard may not apply to non-hospital-type services, it provides important principles and useful guidelines which may be applied.

3 REFERENCED DOCUMENTS The following documents are referred to in this Standard:

AS	
1301	Methods of test for pulp and paper
1301.411s	Method 411s: Water absorptiveness of paper and paperboard (Cobb test)
1301.457s	Method 457s: Determination of moisture content in paper, board and pulps
1612	Paper sizes
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	Method 422s: Determination of the pH value of aqueous extracts of paper, board and pulp—Hot extraction method

Pantone Matching System (PMS), Fourteenth Printing, 1999.

4 DEFINITIONS For the purpose of this Standard, the definitions below apply.

4.1 Chronological order—in date order, from first date to last date, front to back, i.e. in book fashion.

4.2 Patient—encompasses all clients of health care services.

4.3 Shall, should, may—the word ‘shall’ indicates that a statement is mandatory, and the word ‘should’ indicates a recommendation. The word ‘may’ indicates the existence of an option.

5 HEALTH CARE RECORD FORMS

5.1 Constructional requirements and physical characteristics.

5.1.1 *Size* For ease of handling and retrieval, general availability and cost savings associated with uniformity, health care record forms shall be A4 (ISO A series) in size in accordance with AS 1612.

Where a larger form is required, it shall be A4 depth (297 mm) and folded to A4 size (297 mm × 210 mm) with allowance for a binding margin on the left-hand side (see Appendix A). Labels, computer-generated records, backing sheets for electro-cardiographs and diagnostic reports shall be compatible with A4 size. Attachments shall be compatible with the backing form and be narrower in width than A4 size (see also, Clause 5.10).

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