AS 2828.1:2019

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Health records

Part 1: Paper health records

AS 2828.1:2019

This Australian Standard® was prepared by HE-025, Health Records. It was approved on behalf of the Council of Standards Australia on 5 July 2019.

This Standard was published on 24 July 2019.

The following are represented on Committee HE-025:

Australasian College of Health Informatics
Australian Information Industry Association
Australian Private Hospitals Association
Catholic Health Australia
Consumers Federation of Australia
Department of Health and Human Services (VIC)
Health Informatics Society of Australia
Health Information Management Association of Australia
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This Standard was issued in draft form for comment as DR AS 2828.1:2018.

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ISBN 978 1 76072 535 8

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Originated as AS 2828—1985.
Second edition 1999.
Revised and redesignated as AS 2828.1—2012.
This edition AS 2828.1:2019.

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Preface

This Standard was prepared by the Standards Australia Committee HE-025, Health Records, to supersede AS 2828.1—2012.

The objective of this Standard is to specify the physical aspects of paper health records and minimal requirements for the design of health record forms to ensure that paper health records are fit for purpose, easy to use, consistent within and across Healthcare Providers, and address legal, safety and quality requirements. The Standard is intended for persons and Healthcare Providers that create, maintain and curate paper health records.

The major changes in this edition are as follows:

(a) Terminology has been updated and made more consistent.

(b) There is greater emphasis on consistency of health record forms, proper identification, and the use of barcodes to facilitate data capture from paper health records.

(c) Requirements have been revised to recognize greater diversity in the sources and types of material being held in paper health records.

(d) Appendices that were previously normative are now informative, recognizing variations between jurisdictions and the pace of technological change.

This Standard is one of a series of Standards, as follows:

AS 2828.1 , *Health records, Part 1: Paper health records* (this Standard).

AS 2828.2 , *Health records, Part 2: Digitized health records*.

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

The health record is the primary communication tool for capturing historical, present and future health information pertaining to the management and treatment of individuals.

The health record is a key instrument for recording details concerning the care given to an individual by the healthcare provider and for storing other appropriate information relating to that individual.

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

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

In the drafting of this standard, consideration has also been given to the following important criteria for the record:

(i) Durability.

(ii) Ready identification.

(iii) Reproducibility.

(iv) Cost.

(v) Storage, retrieval and destruction.

(vi) Privacy, confidentiality and security.

(vii) Accessibility.

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(viii)Usability.

The terms “normative” and “informative” are used in Standards to define the application of the appendices or annexes to which they apply. A “normative” appendix or annex is an integral part of a Standard, whereas an “informative” appendix or annex is only for information and guidance.

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Introduction

This Standard represents an update of requirements first published in AS 2828—1985, *Hospital medical records* and supports the key role of paper health records in recording details of the care given to subjects of care (individual/patients) by a healthcare provider and for storing other relevant information relating to a subject of care. Part 2 in the series addresses the specific requirements for digitized health records. Requirements for health records stored as electronic health records have yet to be addressed.

Good quality health records enhance the quality and continuity of health care by —

(a) facilitating communication, especially between healthcare providers;

(b) providing evidence of care provision; and

(c) providing an efficient source of knowledge acquisition and exchange.

This Standard seeks to capture the benefits of standardizing the identification, physical characteristics and organization of paper health records while recognizing the needs of a wide range of healthcare providers operating within different jurisdictions.

This Standard particularly recognizes that paper-health records need to be durable, unambiguously and clearly identified, easy to access and use, reproducible, cost-effective to create, store and manage, and that they need to be maintained in an environment that preserves privacy, confidentiality and security of individuals' health information.

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Health records

Part 1: Paper health records

1 Scope

This Standard specifies requirements for the physical aspects of paper health records, including size, quality, reproducibility, layout, colour, division, methods of fixing, and cover. This Standard also provides advice on design of forms for incorporation into health records.

This Standard does not address specific record content in terms of the quality of clinical documentation requirements. For clinical documentation requirements refer to National Safety and Quality Health Service (NSQHS) Standards produced by the Australian Commission for Safety and Quality in Health Care.

2 Normative references

The following documents are referred to in the text in such a way that some or all of their content constitutes requirements of this document:

NOTE Documents referenced for informative purposes are listed in the Bibliography.

AS 1612, *Paper sizes*

AS 2828.2, *Health records, Part 2: Digitized health records*

AS 4846, *Person and provider identification in healthcare*

AS P5, *Punching patterns for round holes used in files and loose leaf binders*

AS/NZS 1301.422s, *Methods of test for pulp and paper, Part 422s: Determination of the pH value of aqueous extracts of paper, board and pulp—Hot extraction method*

AS/NZS 1301.457s, *Methods of test for pulp and paper, Part 457s: Determination of moisture content in paper, board and pulps*

Pantone Matching System (PMS)

NOTE The Pantone Colour Matching System is a standardized colour reproduction system. By standardizing the colours, different manufacturers in different locations can all refer to the Pantone System to make sure colours match without direct contact with one another.

3 Terms and definitions

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

3.1
admission form
health record form containing demographic information specific to an admitted individual's episode of care, including data such as admission date and time, fund details and medical officer

Note 1 to entry: Synonyms — Front sheet, face sheet, MR 1, administration form/sheet.

Note 2 to entry: This is usually printed directly from the Patient Administration System (PAS).

Note 3 to entry: This may contain clinical information such as the reason for admission.

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