Queensland Health

# Managing the clinical records of children available for adoption

Department of Health Standard

**QH-IMP-280-4:2014**

## 1. Statement

This standard describes the requirements for the management of clinical records of children for whom adoption is being considered, and children who are adopted. This standard outlines the requirements for establishing, accessing, sharing and release of information relating to clinical records of children for whom adoption is being considered and children who are adopted.

## 2. Scope

This standard applies to all employees, contractors and consultants within the Department of Health divisions and business units.

It applies to clinical records managed by the Hospital and Health Services (HHSs) and/or individual health facilities regardless of the medium:

- Physical records (physical form such as paper, photographs, film)
- Electronic records (a record created or captured through electronic means such as a computer, scanner or born digital materials). All information in digital formats should be maintained with necessary metadata to support the retrieval and access to the information
- Hybrid records (a combination of physical and electronic records).

This standard does not include corporate records (administrative and non-clinical functions).

This standard can be adopted by HHSs and re-branded as an HHS specific standard or used as a basis for a local HHS specific standard.

## 3. Requirements

### 3.1. Establishing a clinical record for a child for adoption

3.1.1. A clinical record shall be established for all children, including those for whom adoption is being considered, using the child's:

- Family name/Surname
- Given name(s)
- Date of birth
- Sex

3.1.2. The clinical record of a child for whom adoption is being considered shall not be unnamed, de-identified or in the name of a child's foster carer.

3.1.3. The clinical record of a child shall be established using the birth mother's family name/surname as the baby's family name/surname, unless instructed otherwise by the birth parents, regardless of whether the birth parents are considering adoption for their child. The baby's given name(s) should be recorded as identified by the birth registration certificate. If the baby's given name(s) has not been registered, use Baby of xxx (xxx is the mother's given name).[1]

3.1.4. The word 'adoption' must not be used as the family name/surname, given name(s), or alias for a newborn baby[2].

3.1.5. The clinical record of a child for whom adoption is being considered shall remain in the child's birth name until the Childrens Court makes an interim or final adoption order in relation to the child.[3]

3.1.6. Health professionals shall document in the clinical record as much information as possible about the medical background of the birth parents who are considering adoption for their child.

3.1.7. Staff shall send a copy of the relevant health facility's clinical record of a child for whom adoption is being considered to Adoption and Permanent Care Services, Department of Child Safety, Seniors and Disability Services, upon the child's discharge from hospital.

## 3.2. Registration of the birth for a child for whom adoption is being considered

3.2.1. Staff shall facilitate registration of the birth for all children for whom adoption is being considered in the child's birth name, in the same manner that other children are registered who are not being adopted.

3.2.2. The birth of a child for adoption shall be registered in the Patient Administration System (PAS) using the birth mother's family name/surname as the baby's family name/surname, unless instructed otherwise by the birth parents. The baby's given name(s) should be recorded as identified by the birth registration certificate. If the baby's given name(s) has not been registered, use Baby of xxx (xxx is the mother's given name).[4]

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[1] Department of Health 2023, Person and Provider Identification Data Set-Definitions, viewed October 2023, https://qheps.health.qld.gov.au/__data/assets/pdf_file/0025/2160970/Person-and-Provider-Identification-DSD.pdf

[2] Queensland Health Information Knowledgebase 2022, viewed November 2023, Elements Detail (health.qld.gov.au)

[3] *Adoption Act 2009* (Qld), viewed October 2023 https://legislation.qld.gov.au/view/html/inforce/current/act-2009-029

[4] Department of Health 2023, Person and Provider Identification Data Set-Definitions, viewed October 2023, https://qheps.health.qld.gov.au/__data/assets/pdf_file/0025/2160970/Person-and-Provider-Identification-DSD.pdf

## 3.3. Clinical records of children in foster care transitioning to adoption

3.3.1. Staff shall maintain a child's clinical record in the child's birth name, even when the child is placed in foster care while adoption is being considered/progressed.

3.3.2. When a child presents to a health facility, the contact details of Adoption and Permanent Care Services, Department of Child Safety, Seniors and Disability Services should be recorded in the PAS. This will ensure all correspondence will go directly to the appropriate delegate. Details for carers, including family members and foster carers are not to be entered. Medicare and general practitioner details can be updated if known at time of presentation.

3.3.3. Staff shall ensure that birth parents are not provided with any information that identifies the foster carer. Any clinical record information released to the birth parents prior to adoption being finalised shall be checked to ensure it does not identify the foster carer.

3.3.4. All written communication with foster carers shall be filed in the correspondence section of the child's clinical record.

## 3.4. Adopted child clinical record

3.4.1. A separate, new clinical record is to be created when the Childrens Court makes an interim or final adoption order in relation to the child when the child represents to the health facility.

3.4.2. Health facility staff shall create a new clinical record under the adopted name of an adopted child when they attend the same and/or any other health facility for treatment and/or care. A new Unit Record Number (URN) and clinical record shall be created.[5]

3.4.3. If the adopted child retains their birth name after a final adoption order is made[6], health facility staff shall create a new clinical record under the child's name when they attend the same and/or any other health facility for treatment and/or care. A new Unit Record Number and clinical record shall be created.

3.4.4. Health facility staff shall ensure the clinical record created after a final adoption order is finalised is not linked to any information that is held in the clinical record of the child before the final adoption order is

[5] Department of Health 2014, Assignment of unique unit record number, viewed October 2023, https://www.health.qld.gov.au/__data/assets/pdf_file/0030/397254/qh-imp-280-3.pdf

[6] Adoption and Other Legislation Amendment Bill 2016, viewed October 2023, https://www.legislation.qld.gov.au/view/whole/html/bill.third/bill-2016-097

finalised i.e. not linked to any information that is held in the record prior to adoption.

3.4.5. Where a child retains their birth name, once adopted, the record created prior to adoption will become inactive and will not be linked to the new clinical record.

3.4.6. Health facility's shall dispose of clinical records in accordance with the Health Sector (Clinical Records) Retention and Disposal Schedule and Retention and disposal of clinical records Standard QH-IMP-280-1:2014.

## 3.5. Release of information

3.5.1. After a child has been adopted, all requests for access to the clinical records created before the child's adoption shall be directed to Adoption and Permanent Care Services, Locked Bag 3405, Brisbane, Qld, 4001.

3.5.2. Where the birth parents decide not to proceed with their child's adoption, access to and information release of the child's information shall be managed in accordance with any other request for information under legislative requirements.

3.5.3. All requests for access to the clinical records created after a child's adoption (i.e. in the adopted name of an adopted child) shall be managed in accordance with any other request for information under legislative requirements (see section 3.4 – adopted child clinical record).

3.5.4. For the purposes of child safety and wellbeing concerns, prescribed entities may be required to share relevant information on request from other prescribed entities subject to limited exceptions.[7]

3.5.5. All requests for access to the clinical record of a child placed in foster care while adoption is being considered shall be managed in accordance with any other request for information under legislative requirements.

3.5.6. Birth parents are not to be provided with any information that identifies the child's carer or adoptive parents. Any clinical record information released to the child's birth parents prior to adoption being finalised shall be reviewed to ensure it does not identify the carer. The carer or adoptive parents are not to be provided information that would identify the birth parents.

[7] Royal Commission into Institutional Responses to Child Sexual Abuse 2017, Final Report: Volume 8, Recordkeeping and information sharing, Page 13, viewed October 2023, https://www.childabuseroyalcommission.gov.au/sites/default/files/final_report_-_volume_8_recordkeeping_and_information_sharing.pdf

### 3.6. Access to clinical records

3.6.1. Health facility staff shall only access clinical records if the access is required, permitted, or authorised.[8]

3.6.2. All other access to the clinical record shall be managed in accordance with any other request for information under legislative requirements (see section 3.5 – Release of information).

# 4. Aboriginal and Torres Strait Islander considerations

- Adoption is not part of Aboriginal tradition or Island custom. Adoption of an Aboriginal or Torres Strait Islander child should be considered as a way of meeting the child's need for long-term stable care only if there is no better available option.[9] The Queensland Aboriginal and Torres Strait Islander Child Placement Principle recognises the importance of connections to family, community, culture and country in the child and family welfare legislation, policy and practice.
- A legally recognised cultural parent of a Torres Strait Islander child through a Cultural Recognition Order enables the permanent transfer of parentage from the birth parent to the cultural parent. A Cultural Recognition Order allows cultural parents to make legal decisions about their child's health.[10]
- The Aboriginal and Torres Strait Islander status of the child must be confirmed, as the status may differ from the mother for the registration of the birth of the child.

# 5. Legislation

- *Adoption Act 2009* (Qld)
- Adoption and Other Legislation Amendment Bill 2016 (Qld)
- *Births, Deaths and Marriages Registration Act 2003* (Qld)
- *Coroners Act 2003* (Qld)
- *Electronic Transactions (Queensland) Act 2001*
- *Hospital and Health Boards Act 2011* (Qld)
- *Human Rights Act 2019* (Qld)
- *Information Privacy Act 2009* (Qld)

[8] *Information Privacy Act 2009* (Qld), viewed October 2023, https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-014

[9] *Adoption Act 2009* (Qld), viewed October 2023, https://legislation.qld.gov.au/view/html/inforce/current/act-2009-029

[10] *Meriba Omasker Kaziw Kazipa (Torres Strait Islander Traditional Child Rearing Practice) Act 2020* (Qld), viewed October 2023, https://www.legislation.qld.gov.au/view/html/asmade/act-2020-033

- *Judicial Review Act 1991* (Qld)
- *Mater Public Health Services Act 2008* (Qld)
- *Mental Health Act 2016* (Qld)
- *Meriba Omasker Kaziw Kazipa (Torres Strait Islander Traditional Child Rearing Practice) Act 2020* (Qld)
- *Public Health Act 2005* (Qld)
- *Public Records Act 2002* (Qld)
- *Public Sector Act 2022* (Qld)
- *Right to Information Act 2009* (Qld)
- *Working with Children (Risk Management and Screening) Act 2000* (Qld)

# 6. Supporting documents

**Australian Standards**

- Australian Standard 2828.1:2019, Health Records, Part 1: Paper health records
- Australian Standard 2828.2:2019, Health Records, Part 2: Digitized health records

**Department of Child Safety, Seniors and Disability Services**

- Aboriginal and Torres Strait Islander Child Placement Principle

**Federal Government**

- Royal commission into Institutional Responses to Child Sexual Abuse

**Queensland Government Enterprise Architecture (QGEA)**

- Information access and use policy (IS33)
- Information security assurance and classification guideline
- Information Security Classification Framework (QGISCF)
- Information security policy (IS18:2018)
- Records governance policy
- Records governance policy implementation guideline

**Queensland Health**

- Assignment of unique Unit Record Number standard (QH-IMP-3:2014)
- Clinical documentation guideline
- Clinical records management policy (QH-IMP-280:2014)
- Code of Conduct for the Queensland Public Service
- Documentation of date and time entry in the paper-based clinical record standard (QH-IMP-279-2:2013)
- Managing the clinical records of children available for adoption guideline (QH-GDL-280-1:2015)
- Management and access to documents and records Legal Branch fact sheet
- Retention and disposal of clinical records standard (QH-IMP-280-1:2014)
- Terminology Guide: for the use of First Nations and Aboriginal and Torres Strait Islander peoples references

**Queensland State Archives**

- Health Sector (Clinical Records) Retention and Disposal Schedule

**United Nations**

- United Nations Convention on the Rights of the Child (UNCRC), of 20 November 1989
- United Nations Declaration on Social and Legal Principles relating to the Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally (General Assembly Resolution 41/85: General Family and Child Welfare - Article 8, 6 February 1987)

# 7. Definitions

| Term | Definition |
|---|---|
| Adoption order | A final adoption order or interim order. |
| Adoptive parent | A person who has adopted someone else under a final adoption order. |
| Approved foster carer | A person who holds a certificate of approval as an approved foster carer. |
| Birth name | The name a child is given by their parents at birth. |
| Birth parent | A person who was a parent of the adopted person at any time before the adoption, including-<br>(i) a biological parent of the adopted person; and<br>(ii) someone who was a parent of the adopted person under a previous adoption. |
| Carer | Means the entity in whose care the child has been placed under section 82(1) of the *Child Protection Act 1999* (Qld). |
| Child | A child is an individual under 18 years of age. |
| Child for whom adoption is being considered | A child whose parents are considering consenting to their adoption whose consent has been dispensed with by the Childrens Court or whose parent has consented to their adoption. |
| Clinical record (also referred to as a health record) | A collection of data and information gathered or generated to record clinical care and health status of an individual or group. Health records are made up of documents such as health record forms, clinical documents, legally authenticated documents and clinical referral letters received from clinical providers.<br>This term includes paper-based health records, clinical records, medical records, digitised health records, electronic health records, and healthcare records. |
| Cultural Parent | A person who, in accordance with Ailan Kastom child rearing practice, agrees to accept the permanent transfer of the parental rights and responsibility for a child from the child's birth parents to the person. |
| Electronic health record (EHR) | Health record with data structured and represented in a manner suited to computer calculations and presentation. Use of this term implies the ability to compute the content of the record. It is often described as presenting a lifetime record of health and care. It may |

| Term | Definition |
|---|---|
| | include digitised information, as well as born digital records and other database entries. |
| Final adoption order | A final adoption order under part 9 of the *Adoption Act 2009* (Qld). |
| Health Professional | A person who is authorised by a recognized body to be qualified to perform certain health duties. |
| Hybrid Record | Health record comprising paper, digitized and electronic formats, created and accessed using both manual and electronic processes. A hybrid health record often arises as a transitional health record during migration from digitised format to a full EHR. |
| Interim order | An interim order under part 9 of the *Adoption Act 2009* (Qld). |
| Parent | The child's mother or father; and anyone else, other than the chief executive (child safety) or a corresponding officer of another jurisdiction, with the right to have the child's daily care, and the right and responsibility to make decisions about the child's daily care, under-<br>(i) a law of the State other than the *Adoption Act 2009* (Qld); or<br>(ii) a law of the Commonwealth or another State; or<br>(iii) a court order other than an order under the *Adoption Act 2009* (Qld). |
| Prescribed entity | Prescribed entities are the chief executives of government agencies responsible for adult corrective services, community services, disability services, education, housing services and Queensland Health, the Queensland Police Service police commissioner, the chief executive officer of Mater Health Services, the principals of accredited Non-State Schools, specialist service providers, or the chief executive of another entity that provides a service to children and families and is prescribed by regulation. |
| Recordkeeping | The act of making and maintaining of complete, accurate and reliable evidence of business transactions in the form of recorded information. |
| Records | Recorded information created or received by an entity in the transaction of business or the conduct of affairs that provides evidence of the business or affairs and includes:<br>a) anything on which there is writing<br>b) anything on which there are marks, figures, symbols or perforations having a meaning for persons, including persons qualified to interpret them<br>c) anything from which sounds, images or writings can be reproduced with or without the aid of anything else, or<br>d) a map, plan, drawing or photograph. |

# Version Control

| Version | Date | Comments |
|---|---|---|
| 3.1 | 01 Jul 2013 | Approved. |
| 3.2 | 12 Jun 2015 | Transferred to new template and reviewed by Clinical Information Management. |
| 4.0 | 30 Jan 2024 | Transferred information into new template, content reviewed and updated. Amendments made to Requirements section 3.1, 3.2, 3.3, 3.4 and 3.5. Section 4 - Aboriginal and Torres Strait Islander considerations is additional content. Section 5, 6 and 7 have been updated. Approved by the Information Management Strategic Governance Committee. |
| 4.0 | 5 Apr 2024 | Approved for publishing by Deputy Director-General, eHealth Queensland. |