Health Professions Council of Zambia

GUIDELINES FOR GOOD PRACTICE IN THE HEALTH CARE PROFESSION

Generation and Management of

PATIENT RECORDS

"Promoting Quality Healthcare and Safeguarding the Public is our Prime Concern"

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GUIDELINES ON THE KEEPING OF PATIENT RECORDS

These guidelines are applicable to health practitioners and institutions in both public and private practice .

1.0 DEFINITION OF A HEALTH RECORD

A health record may be defined as any relevant record made by a health practitioner at the time of or subsequent to a consultation and/or examination or the application of health management.

A health record contains the information about the health of an identifiable individual recorded by a health care professional, either personally or at his or her direction.3

2.0 WHAT CONSTITUTES A HEALTH RECORD?

2.1 The following documents can be regarded as the essential components of a health record, depending on the nature of the individual case:

2.1.1 Hand-written or typed notes taken by the attending health practitioner.

2.1.2 Notes taken by previous practitioners regarding a patient receiving health care, including typed patient discharge summary or summaries.

2.1.3 Referral letters to and from other health practitioners.

2.1.4 Laboratory reports and other laboratory evidence such as histology sections, Cytology slides and printouts from automated analyzers, X-ray films and reports, ECG, traces and other acceptable technology(electronic records).

2.1.5 Audiovisual records such as photographs, videos and tape-recordings.

2.1.6 Clinical research forms and clinical trial data.

2.1.7 Other forms completed during the health interaction such as insurance forms, disability assessments and documentation of injury on duty.

2.1.8 Medical Certificate of the cause of death, Death Certificates and Autopsy Reports.

2.1.9 Stored patient specimens

2.2 The above records may be archived on microfilm, microfiche or magnetic data files.

3.0 WHY DOCUMENTS OR MEDICAL MATERIALS SHOULD BE RETAINED

3.1 Documents and materials should be retained in order to:

3.1.1 Further the diagnosis or ongoing health related management of the patient;

3.1.2 Conduct clinical audits;

3.1.3 Promote teaching and research;

3.1.4 Be used for administrative or other purposes;

3.1.5 Be kept as direct evidence in litigation or for occupational disease or injury compensation purposes;

3.1.6 Be used as research data;

3.1.7 Be kept for historical purposes;

3.1.8 Promote good clinical and laboratory practices;

3.1.9 Make case reviews possible;

3.1.10 Serve as the basis for accreditation.

4.0 COMPULSORY KEEPING OF RECORDS

4.1 Health practitioners should ensure that at least the following information for each patient is entered and maintained:

4.1.1 Personal particulars of the patient which should include; name, age, gender, physical address, phone no. email, patient ID code, next of kin, physical address.

4.1.2 The bio-psychosocial history of the patient, including allergies

4.1.3 The time, date and place of every consultation.

4.1.4 The assessment of the patient's condition

4.1.5 The proposed clinical management of the patient including ,medication and dosage prescribed 4.1.7 Details of referrals to either specialists or other health facility, if any.

4.1.6 The patient's reaction to treatment or medication, including adverse effects.

4.1.7 Test results.

4.1.8 Imaging investigation results.

4.1.9 Information on the times that the patient was booked off from work and the relevant reasons.

4.1.10 Written proof of informed consent, where applicable

4.1.11 Name, profession, qualifications and signature of the attending practitioner .

4.2 Records should be written in legible non-erasable ink. Any form of erasure on patient records is prohibited.

5.0 SIGNING OF OFFICIAL DOCUMENTS

"Any practitioner who, in the execution of his or her professional duties, signs official documents relating to patient care, such as prescriptions, certificates patient records, hospital or other reports, shall do so by signing such document next to his or her initials and surname in block letters."

6.0 CERTIFICATES AND REPORTS

"(1) A practitioner shall only grant a certificate of illness if such certificate contains the following information, namely -

(a) the name, address and qualification of the practitioner;
(b) the name of the patient;
(c) the employment number of the patient (if applicable);
(d) the date and time of the examination;
(e) whether the certificate is being issued as a result of personal observations by the practitioner during an examination, or as the result of information received from the patient and which is based on acceptable medical grounds;
(f) a description of the illness, disorder or malady in layman's terminology with the informed consent of the patient: Provided that if the patient is not prepared to give such consent, the health practitioner shall merely specify that, in his or her opinion based on an examination of the patient, the patient is unfit to work;
(g) whether the patient is totally indisposed for duty or whether the patient is able to perform less strenuous duties in the work situation;
(h) the exact period of recommended sick leave;
(i) the date of issuing the certificate of illness; and
(j) a clear indication of the identity of the practitioner who issued the certificate which shall be personally and originally signed by him or her next to his or her initials and surname in printed or block letters.

7.0 ISSUING OF PRESCRIPTIONS

"A practitioner -

(a) shall be permitted to issue standardized prescriptions for medicines in accordance with the relevant law that guides the issuance of prescriptions. Such prescriptions may only be issued under his or her personal and original signature;

8.0 ALTERATIONS OF HEALTH RECORDS

8.1 No information or entry may be removed from a health record.

8.2 An error or incorrect entry discovered in the record may be corrected by placing a line through it with ink and correcting it. The date of change must be entered and the correction must be signed in full. The original record must remain intact and fully legible.

8.3 Additional entries added at a later date must be dated and signed in full.

8.4 The reason for an amendment or error should also be specified on the record.

9.0 DURATION FOR THE RETENTION OF HEALTH RECORDS

9.1 Health records should be stored in a safe place and if they are in electronic format, safe guarded by passwords. Practitioners should satisfy themselves that they understand these guidelines with regard to the retention of patient records on computer compact discs.

9.2 Health records should be stored at a health facility for a period of not less than six (6) years as from the date they became dormant. The patient file may be dormant for several reasons such as death, patient not visiting the facility,or transfer to another facility.

9.3 In the case of minors and those patients who are mentally incompetent, health practitioners should keep the records for a longer period:

9.3.1 For mentally incompetent patients the records should be kept for the duration of the patient's lifetime.

9.6 In addition to the time periods mentioned above there are a number of other factors that may require health records to be kept for longer periods, but no clear-cut rules exist in this regard. For instance, certain health conditions take a long period to manifest themselves, (e.g. asbestosis), and records of patients who may have been exposed to such conditions, should be kept for a sufficient period of time. The HPCZ recommends that this should not be less than 25 years.

9.7 A balance must be reached between the costs of (indefinite) retention of records (in terms of space, equipment, etc.) and the occasional case where the practitioners' defence of a case of negligence is handicapped by the absence of records. The value of the record for academic or research purposes, and the risks resulting from the handling or complications of the case, are additional considerations.

9.8 Where there are statutory obligations that prescribe the period for which patient records should be kept, a practitioner must comply with these obligations.

10.0 OWNERSHIP OF RECORDS

10.1 Health records are a property of the health facilityHowever, copies must , be made available to the patient (or referring practitioner) on request for which a reasonable fee may be charged to cover the cost of making the copies. Where copies are required for other purposes, other than consulting another health practitioner , they should be certified.

10.3 Should a health practitioner in private practice (both in a single practice and in a partnership) pass away or cease to practice, his or her health facility, which includes the records, will be administered by the administrator of the estate in consultation with the Health Professions Council of Zambia:

10.3.1 Should a practice be taken over by another health practitioner, the new owner shall carry over the records to the new health facility. The new health practitioner is obliged to take reasonable steps to inform all patients regarding the change in ownership and that the patients could remain with the new health practitioner or could request that his or her records be transferred to another health practitioner of his or her choice.

10.5 If health practitioners in private practice decide to close their practice for whatever reason they shall within three months before the date of closure inform all their patients in writing that:

10.5.1 The practice is being closed as from a specific date;

10.5.2 Requests may be made that records are transferred to other health practitioners or facility of their choice;

10.5.3 After the date concerned, the records will be kept in safe custody for a period of at least twelve (12) months by an identified health practitioner or health facility with full authority to deal with the files as he or she may deem appropriate, provided the provisions of the rules in the Code of Ethics on professional confidentiality are observed.

11.0 ACCESS TO RECORDS

11.1 The following principles shall apply with regard to access to information in health records:

11.1.1 A health practitioner shall provide any patient with a

copy or abstract or direct access to his or her own records regarding medical treatment on request .

11.1.2 Where the patient is under the legal age of 18 years to access the records, the parent or legal guardian may make the application for access to the records., Where the patient is deceased , the legal next of kin may be allowed to access the records with a written request.

11.1.3 No health practitioner shall make information available to any third party without the written authorization of the patient or a court order or where non-disclosure of the information would represent a serious threat to public health and safety.

11.2 A health practitioner may make available the records to a third party without the written authorization of the patient or his or her legal representative under the following circumstances:

11.2.1 Where a court orders the records to be handed to the third party;

11.2.2 Where the third party is a health practitioner who is being sued by a patient and needs access to the records to mount a defence.

11.2.3 Where the third party is a health practitioner who has had disciplinary proceedings instituted against him or her by the HPCZ and requires access to the records to defend himself or herself.

11.2.4 Where the health care practitioner is under a statutory obligation to disclose certain medical facts, (e.g. reporting a case of suspected child abuse).

11.2.5 Where the non-disclosure of the medical information about the patient would represent a serious threat to the public health and safety.

12.0 RETENTION OF PATIENT RECORDS ON CD-ROM

12.1 Storage of clinical records on computer compact disc (CD-ROM) is permissible, provided that protective measures are in place:

12.1.1 Only CD-ROM technology that is designed to record a CD once only, so that old information cannot be overwritten, but new information can be added is used;

12.1.2 All clinical records stored on computer compact disc and copies thereof are to be encrypted and protected by a password in order to prevent unauthorized persons to have access to such information;

12.1.3 A copy of the CD-ROM to be used in the practitioner's rooms will be in a read-only format;

12.1.4 A back-up copy of the CD-ROM must be kept and stored in a secured physically different site in order that the two discs can be compared in the case of any suspicion of tampering;

12.1.5 Effective safeguards against unauthorized use or retransmission of confidential patient information must be assured before such information was entered on the computer disc. The right of patients to privacy, security and confidentiality must be protected at all times.

13.0 CHECKLIST FOR HEALTH RECORD-KEEPING

Good notes imply good practice and the following checklist may serve to guide health practitioners in the appropriate keeping of patient records:

13.1 Records should be complete, but concise.

13.2 Records should be consistent.

13.3 Self-serving or disapproving comments should be avoided in patient records. Unsolicited comments should be avoided (i.e. the facts should be described, and conclusions only essential for patient care made).

13.4 A standardized format should be used (e.g. notes should contain in order the history, physical findings, investigations, diagnosis, treatment and outcome.).

13.5 If the record needs alteration in the interests of patient care, a line in ink should be put through the original entry so that it remains legible; the alterations should be signed in full and dated; and, when possible, a new note should refer to the correction without altering the initial entry.

13.6 Copies of records should only be released after receiving proper authorization.

13.7 Billing records should be kept separate from patient care records.

13.8 Attached documents such as diagrams, laboratory results, photographs, charts, etc. should always be labeled. Sheets of paper should not be identified simply by being bound or stapled together – each individual sheet should be labeled.

14.0 Conclusion

The objective of the Council in formulating these guidelines to enhance processes, systems and procedures for generation and management of patient health information at facility level while taking into consideration ethical issues of confidentiality and consent from patients. The document is further aimed at clarifying and offering guidance regarding the long standing contentious issue – 'Who owns the patients record?'.

These guidelines should, therefore, improve the record keeping in public and private health facilities for the benefit of both the practititioner and the patient.

References

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