LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

MEDICAL RECORDS MANAGEMENT POLICY

CONTENTS

1. PREAMBLE

1.1 The advent of democracy in 1994 has resulted with several pieces of legislation aimed at reinforcing democratic principles as laid down in the South African Constitution (Act no. 108, 1996). Acts such as the Public Finance Management Act (Act no. 1, 1999), the Promotion of Access to Information Act (Act no 2, 2000) and the Promotion of Administrative Justice Act (Act no 3, 2000) were promulgated to promote noble constitutional values such as efficiency, transparency, and accountability.

1.2 It is worth noting that sound records management, as a central tenet of democratic governance features prominently in all the above-mentioned Acts. Good medical record-keeping is the cornerstone of any efficient, transparent, accountable administration. The value of a medical record in public administration cannot be emphasized. Every administrative process or transaction conducted by a government official involves or is informed by a record. A single transaction has the potential to generate multiple documents either through creation or receipt.

1.3 Conscious of the value of sound medical record-keeping in public health administration, the Parliament of the Republic of South Africa passed the National Archives and Records Service Act (Act no.43, 1996 as amended) to regulate records management functions in governmental bodies. In terms of Section 13 (1) of this Act, the National Archivist shall be charged with the proper management and care of public records in the custody of governmental bodies.

1.4 It is worth noting that the Constitution of the Republic of South Africa divides the responsibility for the management of records of public bodies between the National and the Provincial Archives Services. In terms of Schedule 5 of the Constitution, archives other than national archives are designated as a functional area of exclusive provincial legislative competence. Prior to 1996 public records of all three levels of government (national, provincial and local) were governed by national legislation. As a Constitutional imperative, provinces are therefore expected to promulgate their own archives and records services legislation and to create an archival and records management infrastructure. To this end, the Limpopo Provincial Administration (or the Northern Province Administration as it was then known) passed the Northern Province Archives Act (Act No.5, 2001) to regulate records management functions in the province. The provincial archives legislation is however, consistent and concomitant with the national archives legislation.

1.5 Public health records in the Province should therefore be managed in terms of the broad policy guidelines contained in both the National Archives and Records Service Act and the Northern Province Archives Act. However, the National Archives and Records Service (NARS) advices each public body to develop and implement its own records management policy to link its own unique processes and procedures to the requirements of the National Archives and Records Service Act.

1.6 This policy therefore, aims to address inconsistencies and uncertainties with regard to management of medical records within the Department. It is aimed at encouraging uniformity in the execution of medical records functions amongst institutions within the Department.

1.7 The policy also provides the framework for the Department to effectively fulfill its obligations and statutory requirements under the archival legislation in the new dispensation.

2. PURPOSE

Provide a clear framework on the proper management, maintenance and disposal of medical records within the Department.

3. OBJECTIVES

The objectives of this policy are to:

3.1. Strengthen security and safety on medical records;
3.2. Control the access to medical records;
3.3. Control the movement of medical records;
3.4. Promote accurate medical records classifications and proper storage;
3.5. Encourage the creation of medical records as evidence of business transactions;
3.6. Regulate the disposal of medical records; and
3.7. Promote regular inspections and monitoring of medical records.

4. BACKGROUND

In terms of National Health Act No. 61, 2003 sections13-17, makes provisions for the following:

- An obligation to keep records,
- confidentiality of records
- access to health records,
- access to health records by health care provider, and
- protection of the heath records

The policy should be red with any other law that promote and regulate medical record keeping.

5. PRINCIPLES

This policy is informed by the following underlying principles:

5.1 Medical record documents, patient's medical treatment, past and current health status, treatment for future healthcare;
5.2 Easy retrieval of information;
5.3 Medical records are essential as evidence of patient care;
5.4 Medical records can help to protect legal rights and entitlements of both internal and external clients;
5.5 Good record keeping is at the center of good patient care; and
5.6 Sound records management also has the potential to improve the flow of information and knowledge sharing among health care practitioners / Providers.

6. SCOPE OF APPLICATION

6.1 This policy, except otherwise indicated, is applicable to all institutions within the Department of Health in Limpopo Province.
6.2 The policy applies to all medical records created, regardless of form or medium and should be managed in accordance with this policy and the National Archives Act (Act No 43 of 1996).
6.3 Electronic medical records which are relevant to the information gathering are part of the scope of this policy, and should therefore be printed and filed in the appropriate individual patient file. All procedures and systems should be consistent with this policy.
6.4 Other records such as medical records registers should also be managed in line with this policy.

7. DEFINITIONS

7.1 **"Department"** means the Limpopo Department of Health.

7.2 **"Institutions"** means a hospital, a health Centre, a clinic and other service points within Department of Health.

7.3 **"Records Management"** means the management of information resources in the manner that makes information easily accessible, securely stored and disposed of when no longer required for administrative purposes.

7.4 **"Records"** means recorded information regardless of form or medium

7.5 **"Medical Records"** collection of information concerning a patient and his or her health care status.

7.6 **"Disposal"** means the action of either destroying/deleting a record or transferring it into archival custody

7.7 **"File"** means an organised arrangement of records on the same subject accumulated in a chronological order within the same cover/folder/container

7.8 **"Archives"** means records in the custody of an archives repository

7.9 **"Disposal Authority"** means a written authority issued by the National / Provincial Archivist specifying which records should be transferred into archival custody or specifying which records should be destroyed/deleted or otherwise disposed of

7.10 **"Other Records"** means records that do not form part of a patient file e.g. registers

7.11 **"Schedule of other records"** means a control mechanism for records other than correspondence files (other records), which contains a description of all other records

7.12 **"Electronic records"** means information which is generated electronically and stored by means of computer technology

7.13 **"Classification systems"** means a plan for the systematic identification and arrangement of business activities and/or records into categories according to logically structured conventions, methods and procedural rules represented in the classification system

7.14 **"Employee"** means any person employed by the Department either on temporary basis or permanent basis or offering services to the Department voluntarily.

7.15 **"Province"** means the Limpopo Province

7.16 **"National Archives"** means the National Archives and Records Service of South Africa

7.17 **"Provincial Archives"** means the Limpopo Provincial Archives

7.18 **"Archives Repository"** means either the Limpopo Provincial Archives repository or the National Archives repository.

7.19 **"Retention period"** means the period or the number of years a file is retained by the Department before it is either destroyed or transferred to an archives repository.

7.20 "Termination" process of moving in-active medical records from active filing storage to semi-active filing storage.

7.21 "Semi-active records" records which are not frequently used.

8 LEGAL FRAMEWORK

This policy is informed by the following prescripts

8.1.	The Constitution of the Republic Of South Africa (Act no. 108 of 1996 as amended).
8.2.	The National Health Act (Act no. 61 of 2003)
8.3.	The Northern Province Health Services Act (Act No 1998)
8.4.	The National Archives and records service of South Africa Act (Act no. 43 of 1996 as amended)
8.5.	The Northern Province Archives act (Act No. 5 of 2001)
8.6.	The Promotion of Access to Information Act (Act no. 2 of 2000)
8.7.	The Promotion of Administrative Justice Act (Act no.3 of 2000)
8.8.	The Public Service Act (Act No.103 of 1994)
8.9.	The Public Service regulation 2001
8.10.	The Basic Conditions of Employment Act (Act no. 75 of 1997)
8.11.	Skills development Act (Act no.31 of 2003)
8.12.	The Employment Equity Act (Act no.55 of 1998)
8.13.	The Health Act (Act no.55 of 1997)
8.14.	The Public Finance Management Act (Act no.1 of 1999 as amended)
8.15.	Protection of Information Act (Act no. 84 of 1984)
8.16.	Limpopo Information Security policy
8.17.	Electronic Communication and transactions act (Act no. 25 of 2005)
8.18.	Minimum information security standards
8.19.	Labour Relations Act (Act no. 66 of 1995)

9 RELATIONSHIP WITH OTHER POLICIES

9.1 The Department of Health Records Management Policy informs the Medical Records Policy. This policy is managed by the Records Manager.

9.2 Other policies that are closely related to the Records Management Policy are

- The Information Security Policy which is managed by the Security Manager;
- Information and Communication Technology Policy which is managed by the IT Manager.

10 ROLES AND RESPONSIBILITIES

10.1 PROVINCIAL OFFICE

10.1.1 The Head of Department (**HOD**) is ultimately accountable for the medical records keeping and management practices of Department of Health in line with the National Archives Act (No 43 of 1996).

10.1.2 The Senior General Manager (**SGM**) is committed to enhance accountability, transparency and improvement of service delivery by ensuring that sound medical records management practices are implemented and maintained.

10.1.3 The Senior General Manager (**SGM**) supports the implementation of this policy and requires each staff member to support the values contained in this policy.

10.1.4 The **HOD** shall designate the Government Information Technology Officer (**GITO**) to be the records manager of the Department of Health. **GITO** shall mandate the **Senior Manager: Records Management** to perform such duties as they are necessary to enhance the medical records keeping and management practices of the Department of Health to enable compliance with legislative and regulatory requirements.

10.1.5 **Records Managers** in the institutions are responsible for sound medical record-keeping within their areas of responsibility. However, a uniform integrated medical records creation, storage and archiving system will be used across the Department.

10.1.6 **Executive and all Departmental Managers** should ensure that this policy and its associated standards are implemented within their business units.

10.1.7 The **Medical Records Sub-division** is responsible for the management of medical records programs in the Department, including the development of records classification systems, advising employees about records related issues, training of medical records personnel, inspection of records, and day-to-day management of medical records.

10.1.8 **Employees**, as public servants should be aware of record-keeping requirements that affect the performance of their duties. Relevant officials have an obligation to:

- Create medical records
- Register records in medical record-keeping systems
- Transfer records to appropriate medical record-keeping systems
- Ensure that records are not destroyed without authorization.

10.2 DISTRICT OFFICE

10.2.1 The District Executive Manager (**DEM**) is committed to enhance accountability, transparency and improvement of service delivery by ensuring that sound medical records management practices are implemented and maintained.

10.2.2 The District Executive Manager (**DEM**) supports the implementation of this policy and requires each staff member to support the values contained in this policy.

10.2.3 **Executive and all District Managers** should ensure that this policy and its associated standards are implemented within their business units.

10.2.4 **Employees**, as public servants should be aware of record-keeping requirements that affect the performance of their duties. Relevant officials have an obligation to:

- Create medical records
- Register records in medical record-keeping systems
- Transfer records to appropriate medical record-keeping systems
- Ensure that records are not destroyed without authorization

10.3 INSTITUTIONS

10.3.1 **Records Managers** in the institutions are responsible for sound medical record-keeping within their areas of responsibility. However, a uniform integrated medical records creation, storage and archiving system will be used across the Department.

10.3.2 **Employees**, as public servants should be aware of record-keeping requirements that affect the performance of their duties. Relevant officials have an obligation to:

- Create medical records
- Register records in medical record-keeping systems
- Transfer records to appropriate medical record-keeping systems
- Ensure that records are not destroyed without authorization

11. POLICY PRONOUNCEMENTS

11.1. IDENTIFICATION OF RECORDS SYSTEM

11.1.1. The system that is used to create and store medical records is Provincial Health Information System (PHIS)

11.1.2. The system is used to administer patient's health care services such as registration, booking, admission, discharging, dispensing of medicine and billing.

11.1.3. The system contains personal details, medical history and financial information of the patients.

11.2. CREATION OF MEDICAL RECORDS

11.2.1. All relevant administrators/health professionals are obliged to create medical records that adequately document medical health status and treatment of the patient.

11.2.2. A new patient file should only be created or opened on the first day of consultation.

11.2.3. Only patient administrative staff must open patient files.

11.2.4. Patient administrative staff should update personal details of the patient regularly to ensure that they are complete, accurate and reliable.

11.2.5. All medical records created in pursuance of public health care service of the Department shall remain the property of the Department throughout their life-cycle (thus until they are either officially destroyed or transferred to an archives repository).

11.3. CLASSIFICATION SYSTEM

11.3.1. All medical records shall be classified and managed according to approved electronic system.

11.3.2. All medical records should be kept in accordance with alpha-numerical order as classified/produced by the electronic system.

11.3.3. Standard file folder must be used for all non- special cases.

11.3.4. All medical records should have a colour-coded speed taps.

11.3.5. All medical records should be colour-coded according to financial classification of the patients using a sticker.

11.3.6. Medical records folder will be colour-coded according to nature of the cases in the records which are inter alia: MVA, Maternity, WCA and police cases.

11.4. STORAGE OF MEDICAL RECORDS

11.4.1. Medical records should be stored in a purpose built storage rooms fitted with burglars, air conditioner, fire extinguishers and proper illumination system.

11.4.2. Static and steel-open filing cabinets should be installed.

11.4.3. Special case files should be stored in separate storage rooms.

11.4.4. All medical records should be stored in standard plastic containers.

11.5. ACCESS AND SECURITY OF MEDICAL RECORDS

11.5.1. Medical records shall at all times be protected against unauthorized access and tampering to protect their authenticity and reliability as evidence of the business of Department of Health.

11.5.2. All medical records shall be managed in terms of the Information Security Policy.

11.5.3. No member of staff shall remove medical records from the premises of Department of Health without the explicit permission of the Records Manager in consultation with the Risk and/or Security Manager.

11.5.4. No member of staff shall provide medical records and/or information to any third party without the written consent of the patient and authorization of the Head of Department in terms of Promotion of Access to Information Act (Act No. 2 of 2000).

11.5.5. An effective file tracking system should be developed and implemented to manage the movement of medical records.

11.5.6. Medical records storage areas shall at all times be protected against unauthorized access. The following shall apply:

- Storage areas shall be locked when not in use.
- Access to server rooms and storage areas for electronic medical records shall be protected against unauthorized access through the ICT Manager.

11.5.7. Where the patient is under the age of 16 years, the parent or legal guardian may make the application for access to the records, but such access should only be given on receipt of written authorization by the patient (Access to Information Act (Act No 2. of 2000)

11.5.8. The Department 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:

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

- Where the Department is being sued by a patient and needs access to the records to mount a defence.

- Where the third party is a Departmental employee who has had disciplinary proceedings instituted against him or her and requires access to the records to defend himself or herself.

- Where the Departmental employee is under a statutory obligation to disclose certain medical facts, (e.g. reporting a case of suspected child abuse in terms of the Children's Act, (Act No. 38 of 2005)

- Where the non-disclosure of the medical information about the patient would represent a serious threat to public health (National Health Act (Act No. 61 of 2003).

11.6. MAINTENANCE OF MEDICAL RECORDS

All medical records, regardless of form or format must be maintained in their entirety, and no document or entry may be disposed without disposal authority from the Head of Department. The following should be considered for maintenance of medical records:

- The worn out files should be replaced regularly.
- All medical records should be content indexed.
- The worn out folder labels and plastic containers must be replaced regularly.
- All medical records control registers should be made available and maintained.
- There should be no eating, smoking and drinking in a medical records storage area to avoid hazardous perils.
- There should be effective and efficient illumination system in medical records storage areas.
- Great care should be taken to ensure that flammable cleaning materials are not used in medical records storage areas.
- Medical records storage areas should always be kept under lock and key.
- Care should be taken to avoid the use of wooden static shelves to avoid potential harmful perils (e.g. arson).
- Regular baiting and fumigation should be conducted in the medical records storage areas.

11.7. DISPOSAL OF MEDICAL RECORDS

11.7.1. No medical records of the Department shall be destroyed, erased or otherwise be disposed of without the prior written approval of the Head of the Department.

11.7.2. All disposal actions should be authorized by the Senior Manager, Records prior to their execution to ensure that medical records are not destroyed unintentionally.

11.7.3. Medical records that are needed for litigation, Promotion of Access to Information requests or Promotion of Administrative Justice actions may not be destroyed until such time that the Manager: Legal Services has indicated that the destruction hold can be lifted.

11.7.4. The National Archivist has issued Standing Disposal Authority Number AK2 and PAK4 for the disposal of medical records. The Records Manager manages the disposal schedule. The retention period for patient medical records shall be as follows:

11.7.5. Medical records shall be destroyed 5 years after last consultation or last access on behalf of the client for whatever reason except for special cases such as Motor Vehicle Accident (MVA), Maternity, Injury on duty (WCA), X-RAY, Psychiatry, Anti-Retroviral Treatment (ART), Deceased and police cases. The retention period for special medical records shall be as follows:

SPECIAL CASES	RETENTION FOR SEMI-ACTIVE	RETENTION PERIOD FOR DISPOSAL
1. Motor Vehicle Accident (MVA)	Medical records shall be terminated 3 years after last consultation or last access on behalf of the client for whatever reason.	Medical records shall be destroyed 7 years after last consultation or last access on behalf of the client for whatever reason.
2. Maternity	Medical records shall be terminated 2 years after death of the patient or last access on behalf of the client for whatever reason.	Medical records shall be destroyed 7 years after death of the patient or last access on behalf of the client for whatever reason.
3. Psychiatry	Medical records shall be terminated 2 years after death of the patient or last access on behalf of the client for whatever reason.	Medical records shall be destroyed 5 years after death of the patient or last access on behalf of the client for whatever reason.
4. ART	Medical records shall be terminated 2 years after death of the patient or last access on behalf of the client for whatever reason.	Medical records shall be destroyed 3 years after death of the patient or last access on behalf of the client for whatever reason.
5. X-RAY Films	X-RAY records shall be terminated 2 years after date of last production or last access on behalf of the client for whatever reason.	X-RAY records shall be disposed 5 years after date of last production or last access on behalf of the client for whatever reason.
6. Deceased other than special cases	Medical records shall be terminated immediately after death of the patient.	Medical records shall be destroyed 5 years after death of the patient or last access on behalf of the client for whatever reason.
7. Police cases	Medical records shall be terminated 2 years after death of the patient or last access on behalf of the client for whatever reason.	Medical records shall be destroyed 7 years after death of the patient or last access on behalf of the client for whatever reason.

11.8. TRAINING OF MEDICAL RECORDS PERSONNEL

11.8.1. The Records Manager shall successfully complete the National Archives and Records Service's Records Management Course, as well as any other related medical records management training that may equip him with skills to execute his duties.

11.8.2. The Records Manager shall identify such training courses that are relevant to the duties of medical records management personnel and shall ensure that the latter are appropriately trained.

11.8.3. The Records Manager shall ensure that all medical records management personnel are aware of the medical records management policies and shall further conduct and/or arrange training workshops for the latter to equip them with skills about medical records management.

11.9. LEGAL ADMISSIBILITY AND EVIDENTIAL WEIGHT

11.9.1. No records shall be removed from paper-based files (PHD 009) without the explicit permission of the Records Manager

11.9.2. Records that are and/or were placed on files shall not be altered in any way.

11.9.3. No alterations of any kind shall be made to records other than correspondence files without the explicit permission of the Records Manager.

11.9.4. Should evidence be obtained of tampering with records, the staff member involved shall be subject to disciplinary action.

11.9.5. The Department shall use systems which ensure that its electronic records are:

- authentic;
- not altered or tampered with;
- auditable; and
- Produced in systems which utilize security measures to ensure their integrity.

11.10. INSPECTIONS OF MEDICAL RECORDS

11.10.1. In order for the Provincial Archives/National Archives to conduct inspections as provided for by Section 13(2)c of the National Archives and Records Act, all Departmental units should, subsequent to consultations with the HOD, provide access for authorized NARS officials to records in their custody.

11.10.2. Heads of Records Management units in all institutions shall conduct records inspection in their institutions on a regular basis and shall advise the heads of their institutions about the conditions under which records are managed.

11.10.3. The Head of the Medical Records unit at the Provincial Office shall conduct records inspections in all institutions on a regular basis and shall advise the HOD through the office of the Senior Manager: Records Management about the conditions under which medical records are managed.

11.10.4. The Medical Records unit shall inspect and verify all records due for destruction to recommend authorization and appropriateness.

11.10.5. Reports of all medical records audits/inspections shall be managed in line with this policy.

12. POLICY IMPLEMENTATION

The policy should be disseminated and communicated to the staff. It is an obligation that, besides providing staff with copies of the policy document, the Senior Manager, Records Management should launch medical records management awareness campaigns/workshops to inform all staff about their responsibilities.

After implementation of awareness workshops, all members of staff must adhere to the entire policy requirements.

13. DEFAULT

Any employee who contravenes and/or transgresses with any of the provisions of this policy shall be guilty of misconduct and the necessary disciplinary measures shall be taken against him and/or her.

14. PROCEDURES

Standard procedures for managing medical records shall be developed under the authority of this policy.

15. INCEPTION DATE

The inception date of this policy shall be upon the signature of approving authority.

16. LAPSE/TERMINATION

This policy shall remain in force unless withdrawn or amended.

17. REVIEW PERIOD

This policy will be reviewed by a special review committee appointed by the HOD tri-annually or whenever a need arises.

18. ENQUIRIES

Enquiries regarding this policy should, in the first instance, be directed to:

The Senior Manager: Records Management
Private Bag x 9302
Polokwane
0700
Tel: 015 293 6039
Fax: 015 293 6211
E-mail: registry@dhsd.limpopo.gov.za

Supported/ ~~Not Supported~~

HOD: Health

29/08/2012
Date

Approved/ ~~Not Approved~~

Honorable MEC for Health and Social Development

2012/09/18
Date