Guidelines on patient recordkeeping

by HPCSA Corporate Affairs | 10 Nov 2022

The HPCSA has updated the Guidelines on the keeping of patient records (Booklet 9). Practitioners are advised to adhere to the revised guidelines on record keeping that will also improve clinical outcomes, reduce waste, and ensure stakeholder engagement and satisfaction. The HPCSA presents the following ethical guidelines to guide and direct the practice of healthcare practitioners. These guidelines form an integral part of the standards of professional conduct against which a complaint of professional misconduct will be evaluated.

The spirit of professional guidelines

High quality clinical outcomes are only achieved if patients and healthcare practitioner trust each other explicitly. Practice in the healthcare profession is therefore a moral enterprise and demands that healthcare practitioners have a life-long commitment to sound, ethical professional practice and an unstinting dedication to the interests and wellbeing of society and their fellow human beings.

It is in this spirit, that the HPCSA formulates these ethical guidelines, to guide and direct the practice of healthcare practitioners. They apply to all persons registered with the HPCSA and are the standard against which professional conduct is evaluated.

Note: In these guidelines, “healthcare practitioner” and “healthcare professional” refers specifically to persons registered with the HPCSA.

Contents

The revised HPCSA guidelines on patient recordkeeping (Booklet 9) is divided into the following sections:

1. Definition of a patient health record
2. Purpose of patient health records
3. Content of patient health records
4. Rules related to patient health records

5. Alteration of patient health records
6. Privacy and security of patient health records
7. Retention of patient health records
8. Ownership of patient health records
9. Access to health information and to patient health records
10. Checklist for patient health record keeping
11. Signing of official documents
12. Certificates and reports
13. Issuing of prescriptions

Guidelines on the Keeping of Patient Health Records

Section 13 of the National Health Act (Act No 61 of 2003) states that "Subject to National Archives of South Africa Act, 1996 (Act No. 43 of 1996), and the Promotion of Access to Information Act, 2000 (Act No. 2 of 2000), the person in charge of a health establishment must ensure that a health record containing such information as may be prescribed is created and maintained at that health establishment for every user of health services".

At a professional conduct inquiry, the professional board concerned shall be guided by the ethical rules, its annexures, ethical rulings or these guidelines and policy statements which the board concerned, or council makes from time to time.

1. Definition of a patient health record

A patient health record is the longitudinal collection of an individual's personal and health information, recorded by a healthcare practitioner or at the directive of the healthcare practitioner, regardless of the form or medium used to make such a record.

2. Purpose of patient health records

2.1 The primary purpose of keeping patient health records is:

- To be a reminder of what has been found, decided on or has been done;
- To promote and ensure continuity of care;
- To provide evidence of the standard of care.

2.2 Patient health records can also be used: –

- To promote good clinical practice;

- To conduct clinical audits;
- To promote teaching and research;

- For administrative purposes;
- As evidence for occupational disease and injury compensation;
- As evidence during litigation.

3. Content of patient health records

3.1 The patient health record should where appropriate consist of:

3.1.1 All relevant clinical findings, including (but not limited to): –

- Who is making the notation in the patient health record (this is particularly important when multiple healthcare professionals are responsible for a patient health care record);
- The times of consultation and other clinical interactions;
- The full clinical history;
- The clinical examination;
- The differential diagnosis;
- The information and advice given to the patient;
- The clinical decisions made and when and who made such decisions;
- The decisions and actions agreed to and when these were agreed to;
- When required the written affirmation of such agreements (consent forms);
- The treatment administered (including detailed operation or invasive intervention notes when such a procedure has taken place):
- The drugs and doses of drugs given;
- The investigations ordered and their results and dates when ordered and when results have been received;
- Future appointments and referrals made;
- Any other documentation relevant to a patient's health.

3.1.2 The interactions that need to be recorded in a patient health record include (but are not limited to): –

- The face-to-face discussions between the patient and a health practitioner;

- Progress notes when a patient is seen for review regarding a specific episode of care (e.g. while a patient is in hospital or when a particular condition requires follow- up);

- Any virtual, telephonic or similar discussions and/or consultations with the patient and their relatives;
- Discussions with colleagues related to the patient;
- All correspondence related to the care of a patient.

3.2 The compulsory elements of a patient health record are: –

- The personal (identifying) particulars of a patient;
- The full biopsychosocial history of a patient, including allergies and idiosyncrasies;
- The time, date and place of consultation;
- The assessment of the patient;
- The proposed management of the patient;
- The medication and dosage prescribed;
- Details of referrals to specialists and other healthcare professionals;
- The patient's response to treatment, including adverse effects;
- Investigations ordered and their results;
- Details of the times that a patient was booked off work or similar activities and the relevant reasons;
- Written proof of informed consent when this is relevant.

4. Rules related to patient health records

In terms of ethical rule 27A, a practitioner shall at all times act in the best interests of his or her patients, respect patient confidentiality, privacy, choices and dignity, maintain the highest standards of personal conduct and integrity; provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others, keep his or her professional knowledge and skills up to date, maintain proper and effective communication with his or her patients and other professionals, except in an emergency, obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment himself or herself, from his or her next of kin, and keep accurate patient records.

The patient health record shall always have regard for the following principles: –

4.1. Patient health records must be contemporaneous:

- This means that they must be made at the time of each patient interaction or as soon as possible thereafter;
- Late entries and addenda must be noted as such and reasons for such belated entries must be given.

4.2 Patient health records must have integrity:

- They must be accurate, complete and comprehensive;
- The must be clear and legible;
- They must be unambiguous (especially relating to the use of abbreviations);
- They may not be not tampered with (see section 8);
- They may not contain derogatory or similar language;
- They must be regularly checked;
- They must be in order and all pages in a written document must identify the patient to which those notes refer.

4.3 Patient health records must be attributable:

- Any person making an entry in a patient health record must be identifiable;
- When multiple healthcare professionals are responsible for a patient health record (particularly in the case of hospital records), each entry must be dated and timed. When such an entry is made in writing (or when an electronic record will not identify the practitioner), the record must be signed in full (or by electronic means in the case of an electronic health record). The name of the healthcare professional must be recorded alongside the signature in block letters including the practitioner's contact details.

4.4 Patient health records must be accessible:

- The patient health record must be readily available whenever a patient is seen in a healthcare setting or facility;
- Information in the patient health record must be stored in a manner that allows easy access to all important information. Critical information related to allergies, significant idiosyncrasies and special needs should be prominently recorded to reduce the risk that these will be overlooked.

4.5 Patient health records must be securely stored:

4.3 Patient health records must be securely stored.

- In terms of section 17 (1) of the National Health Act No. 61 of 2003, the person in charge of a health establishment in possession of a user's health record, must set up control measures to prevent unauthorised access to those records and to the storage facility, or system by which records are kept.

5. Alteration of patient health records

5.1 Late and additional entries must be dated and signed in full, when made in an electronic format, they must be fully attributable to the person making such a change (see 4.3).

5.2 The reason for an amendment or error must be specified on the record.

6. Privacy and security of patient health records

6.1 In terms of section 17 (1) of the National Health Act No. 61 of 2003, the person in charge of a health establishment in possession of a user's health records, must set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept.
6.2 The above applies to the storage of all patient health records irrespective of the format of the record, whether electronic or hard copy.
6.3 Ensuring secure and timely access to a patient's health record is essential in delivering safe and effective healthcare services.
6.4 All patient health records must be protected against improper access and disclosure. (i.e., storage facilities must have secure restricted and authorised access control, electronic data must be managed, stored and backed up using internationally accepted standards, e.g., ISO 27799:201, for information security management in health).
6.5 Ensure protection of patient confidentiality during electronic data transmission and when documents are being transferred between facilities and/or healthcare professionals.

7. Retention of patient health records

7.1 Patient health records should ideally be stored indefinitely particularly if this can be done using an electronic format. If this is not practical, a patient health record should be stored for at least a minimum of six (6) years as from the date that a patient health record has become dormant (dormancy commences at the time when a patient was last treated by a healthcare practitioner).

7.2 Exceptions to 7.1

7.2.1 For patients who were under the age of 18 years, when they were cared for (including obstetric care), the patient health records should be kept at least until the patient's 21st birthday, as legally, minors have up to three years after reaching the age of 18 years to make a claim against a health practitioner or health care establishment.
7.2.2 For mentally incapacitated patients, the patient health records should be kept for the duration of the patient's lifetime.
7.2.3 In terms of the Occupational Health and Safety Act (Act No. 85 of 1993) patient health records falling under this act must be kept for 20 years after treatment.
7.2.4 Several other factors require that patient health records are kept for longer periods. For instance, certain health conditions that take a long period to manifest, (e.g. asbestosis). Patient health records of patients who may have been exposed to the risk of developing such conditions, should be kept for a sufficient period to allow such patients equitable access to the care they may require at a later stage. The recommendation is that this period should not be less than 25 years.

7.2.5 When statutory obligations prescribe the period for which patient health records should be kept, a practitioner must comply with these obligations.

7.3 The patient health records kept in a state hospital or clinic shall only be destroyed if such destruction is authorised by the Deputy Director-General concerned.
7.4 In principle, a balance must be reached between the costs of long-term retention of records and the risk to a practitioners' defence in a matter of litigation or complaint. The value of the record for academic and research purposes, and the risks of late complications occurring, are additional considerations.

8. Ownership of patient health records

8.1 A patient health record is owned by the health practitioner or the entity generating such a patient health record.
8.2 A patient is entitled to have access and obtain the information contained in such a record (see section 9).
8.3 In the case of state institutions, where records e.g., radiographs are the property of the institution, original records and images should be retained by the institution. Copies must, however, be made available to the patient (or referring health practitioner) on request for which a reasonable fee may be charged in terms of the Promotion of Access to Information Act (Act No. 2 of 2000).
8.4 In cases where patients are required to pay for records and images (e.g., private patients or patients in private hospitals) such patients must be allowed to retain such records

- unless the health practitioners deem it necessary to retain such records for purpose of monitoring treatment for a given period. Should the patient however require the records and / or images to

further or protect an interest (e.g., such as consulting with another practitioner) he or she must be allowed to obtain the originals for these purposes.

8.5 As the ownership of patient health records in a multi-disciplinary practice depends on the legal structure of the practice, the governing body of such multi-disciplinary practice should ensure that these guidelines and the provisions of the Promotion of the Access to Information Act (Act No. 2 of 2000) relating to health records are adhered to. The Act requires public institutions to appoint information officers to administer access to information, and similar provisions apply to private bodies.

8.6 Should a health practitioner in private practice (both in a single practice and in a partnership) pass away, his or her estate, which includes the patient health records, will be administered by the executor of the estate:

8.6.1 Should a practice be taken over by another health practitioner, the executor shall carry over the patient health records to the new health care professional. The new health practitioner is obliged to take reasonable steps to inform all patients regarding the change in ownership and that the patient could remain with the new health care practitioner or could request that their patient health records be transferred to another health care practitioner of their choice.

8.6.2 Should the practice not be taken over by another health practitioner the executor should inform all patients in writing accordingly and transfer those patient health records to other health care practitioners as requested by individual patients.

8.6.3 The remaining patient health records should be kept in safe keeping by the executor for a period of at least twelve (12) months with full authority to further deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

8.6.4 It should be noted that certain partnership agreements may make specific provision for the management of a deceased partner's share in the partnership after the death of a partner and such management would include dealing with patient health records.

8.7 If health practitioners in private practice decide to close their practice for whatever reason (e.g. retirement, change in profession, voluntary erasure, etc.) they shall within three months of closure inform all their patients in writing that:

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

8.7.2 Requests may be made that patient health records are transferred to other health care practitioners of a patient's choice;

8.7.3 After the date of closure, the patient health records must be kept in safe keeping for a period of at least twelve (12) months by an identified health practitioner or health institution with full authority to deal with the files as they may deem appropriate, provided the provisions of the rules on professional confidentiality and keeping of patient health records are observed.

9. Access to health information and to patient health records

9.1 Section 10 of the National Health Act (Act 61 of 2003) states that a health practitioner must provide a patient with a discharge report at the time of discharge from a health establishment. This report must always be in writing when discharging an inpatient. A verbal report can be provided in case of an outpatient, although it is not routinely recommended as a record have to be maintained on patient file.

9.2 In terms of the law the following principles apply in regard to access to information in patient health records:

9.2.1 A health practitioner shall provide any person of age 12 years and older with a copy or abstract or direct access to his or her own records regarding medical treatment on request (Children's Act (Act No. 38 of 2005)).

9.2.2 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 (Promotion of Access to Information Act (Act No. 2 of 2000)).

9.2.3 Information about termination of a pregnancy may not be divulged to any party, except the patient herself, regardless of the age of the patient (Choice on Termination of Pregnancy Act (Act No. 92 of 1996)).

9.2.4 No health practitioner shall make information available to any third party without the written authorisation of the patient or a court order or where non-disclosure of the information would represent a serious threat to public health (National Health Act (Act No. 61 of 2003)).

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

9.3.1 Where a court orders the patient health records to be handed to the third party;

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

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

9.3.4 Where the health practitioner 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)).

9.3.5 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)).

9.4 In healthcare institutions, patient health records must be kept under the care and control of the responsible manager. Access to such patient health records shall be subject to compliance

with the requirements of the Access to Information Act and such conditions as may be approved by the relevant authority.

9.5 Protection of Personal Information Act (Act No. 4 of 2013) (POPIA) provides that special personal information, such as religious beliefs, race, health or sex life, and biometric information may be processed by a health/medical professional, healthcare institutions or facilities or social services, if such information is necessary for the proper treatment and care for the data subject or patient for the administration of the institution or professional practice concerned.

9.5.1 Personal information should be kept confidential; and the rest of the conditions in POPIA should be complied with.
9.5.2 The POPI Act should be read in conjunction with Ethical Booklet 4- Seeking patients' informed consent: The ethical considerations, Ethical Booklet 5- Confidentiality: Protecting and providing information, and other rules and regulations of the HPCSA.

10. Checklist for patient health record keeping

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

10.1 Records should be complete, but concise.

10.2 Records should be consistent.

10.3 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).

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

10.5 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.

10.6 Copies of records should only be released after receiving proper authorisation.

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

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

OTHER ETHICAL RULES RELATED TO PATIENT HEALTH RECORDS OR THE MANAGEMENT THEREOF

11. Signing of official documents

Rule 15 of the HPCSA's ethical rules states that:-

"Any student, intern or practitioner who, in the execution of his or her professional duties, signs official documents relating to patient care, such as prescriptions, certificates (excluding death 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."

12. Certificates and reports

According to Rule 16 of the ethical guidelines:

"(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 medical practitioner or dentist 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 environment, and define period of such duties, where applicable;
(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.

(2) If preprinted stationery is used, a practitioner shall delete words which are irrelevant.
(3) A practitioner shall issue a brief factual report to a patient where such a patient, requires information concerning himself or herself."

13. Issuing of prescriptions

On the issuing of prescriptions, Rule 17 states that:

"A practitioner –

(a) shall be permitted to issue typewritten, computer-generated, pre-typed, pre- printed, or standardised prescriptions for medicine scheduled in schedules I, II, III and IV of the Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965), subject thereto that such prescriptions may only be issued under his or her personal and original signature;

(b) shall issue handwritten prescriptions for medicine scheduled in schedules 5,6,7 and 8 above of the Act referred to in paragraph (a) under his or her personal and original signature (see also rule 15)."

More information

Practitioners requiring more information can contact the HPCSA can at (012) 338 9300 or send an email to professionalpractice@hpcsa.co.za.

The following ethical guideline booklets are separately available online:

- Booklet 1: General ethical guidelines for health care professions
- Booklet 2: Ethical and professional rules of the health professions council of South Africa as promulgated in government gazette R717/2006
- Booklet 3: National Patients' Rights Charter
- Booklet 4: Seeking patients' informed consent: The ethical considerations
- Booklet 5: Confidentiality: Protecting and providing information

- Booklet 6: Guidelines for the management of patients with HIV infection or AIDS
- Booklet 7: Guidelines withholding and withdrawing treatment
- Booklet 8: Guidelines on Reproductive Health management
- Booklet 9: Guidelines on Patient Records
- Booklet 10: Guidelines for the practice of Telehealth
- Booklet 11: Guidelines on over servicing, perverse incentives and related matters
- Booklet 12: Guidelines for the management of health care waste
- Booklet 13: General ethical guidelines for health researchers
- Booklet 14: Ethical Guidelines for Biotechnology Research in South Africa
- Booklet 15: Research, development and the use of the chemical, biological and nuclear weapons
- Booklet 16: Ethical Guidelines on Social Media Booklet 17: Ethical Guidelines on Palliative Care

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