

PRIMARY HEALTH CARE



PATIENTS SAFETY

RECORDS MANAGEMENT

PRESENTATION BY

MR. MAHLAKO



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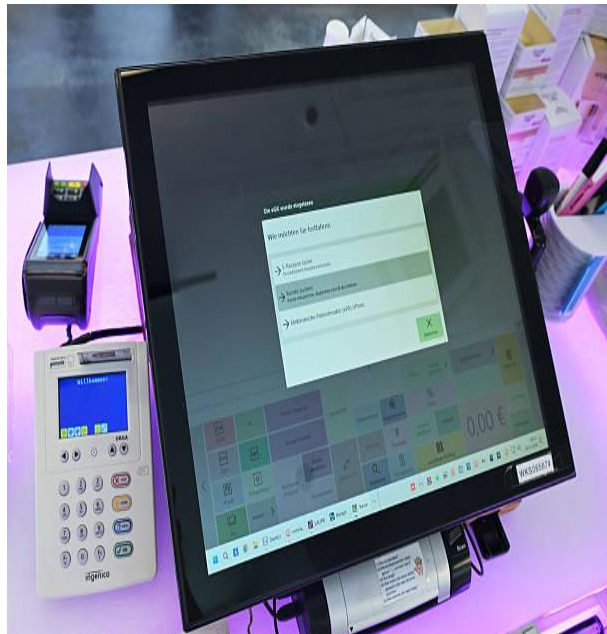
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PATIENT'S RECORDS



NATIONAL GUIDELINES FOR FILING, ARCHIVING OF PATIENT RECORDS HEALTH CARE FACILITIES NE & DISPOSAL, 2017



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PURPOSE



THE GUIDELINE MATTERS

- 01** — Guidance on procedures to follow on ensuring patients' records are stored safely and filed in a systematic manner
- 02** — Archiving and disposal of patient records to ensure sufficient space for new records
- 03** — Guideline is based on Section 13 of the National Archives and Records Service of South Africa Act (Act 43 of 1996)
- 04** — Province and district are allowed to develop their own guidelines based on the national guidelines, which can be district specific



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ESSENTIAL COMPONENTS OF A PATIENT RECORD (PART 1)



A patient record starts with the care encounter



- Any written notes taken by a healthcare practitioner
- Patient discharge summary or summaries
- Referral letters to and from other healthcare practitioners
- Laboratory reports
- Laboratory evidence such as histology sections, cytology slides, automated-analysis printouts, x-ray reports and electrocardiography traces



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ESSENTIAL COMPONENTS OF A PATIENT RECORD (PART 2)



The record extends beyond written notes

- **AUDIOVISUAL RECORDS**

Photographs, videos and tape-recordings

- **RESEARCH RECORDS**

Clinical research forms and clinical-trial data

- **INTERACTION FORMS**

Insurance, legal, consent, prescription, charts and administrative forms

- **END-OF-LIFE RECORDS**

Death certificate and/or autopsy reports



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STATUTORY AND LEGISLATIVE FRAMEWORK-PART 1



Accountability and records control share one foundation

CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA,
1996 · ACT 108 OF 1996

SECTION 195

Effective, economical and efficient use of
resources

Timely, accessible and accurate information

The public service must be accountable



NATIONAL ARCHIVES AND RECORDS SERVICE OF SOUTH
AFRICA ACT, 1996 · ACT 43 OF 1996

SECTION 13

Determine which record-keeping
systems governmental bodies should
use

Authorize disposal of public
records or transfer into archival
custody

Set conditions for microfilming or
electronic reproduction

Set conditions for managing
electronic records systems



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STATUTORY AND LEGISLATIVE FRAMEWORK-PART 2



Privacy and access must be balanced

PRIVACY

Protection of Personal Information Act, 2013
(Act 4 of 2013)

Section 2 gives effect to the constitutional right to privacy by safeguarding personal information.

It balances privacy against other rights—particularly access to information—and protects the free flow of information within South Africa and across borders.



BALANCE THE RIGHTS

ACCESS

Promotion of Access to Information Act, 2000
(Act 2 of 2000)

PAIA flows from section 32 of the Constitution.

It protects the right of access to information held by the State—and information held by another person when required to exercise or protect rights.

Chief Director presentation · POPIA / PAIA



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PROVINCIAL ARCHIVES AND RECORDS ACTS



EIGHT PROVINCIAL FRAMEWORKS LOCALISE THE NATIONAL RULES



PROVINCE	YEAR	LEGISLATION
Eastern Cape	2003	Act 7 of 2003
Free State	1999	Act 4 of 1999
Gauteng	2013	Act 5 of 2013
KwaZulu-Natal	2011	Act 8 of 2011
Limpopo	2001	Act 5 of 2001
Mpumalanga	1998	Act 14 of 1998
Northern Cape	2013	Act 7 of 2013
Western Cape	2005	Act 3 of 2005

Provincial Archives and Records Service / Archives Acts



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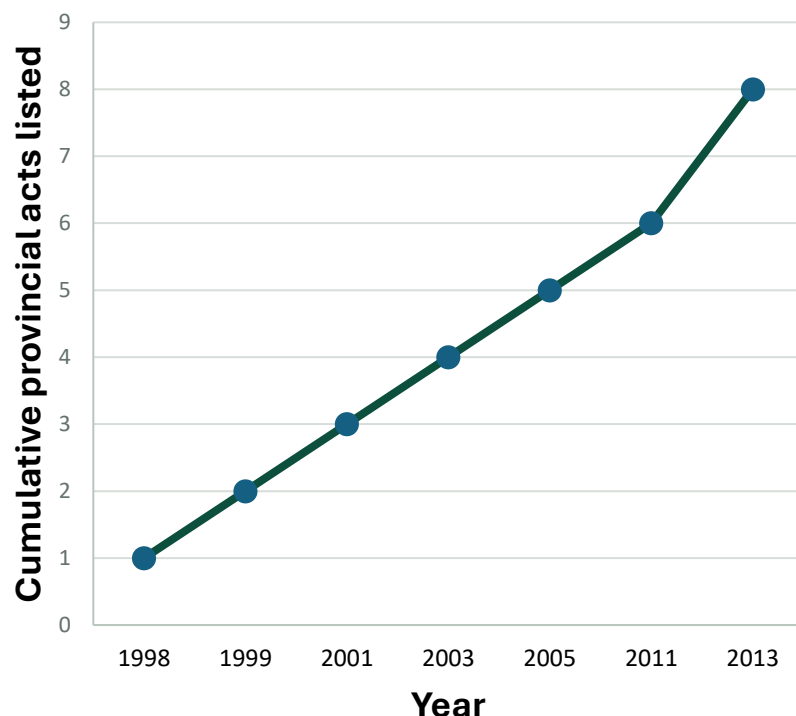
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Provincial legislation accumulated over 15 years

CUMULATIVE PROVINCIAL ACTS LISTED (1998–2013)



NATIONAL → LOCAL

Provinces and districts may develop their own guidelines based on national guidance.

Those guidelines can be district specific.

Chart note: cumulative count derived only from the eight enactment years listed in the source.



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NATIONAL GUIDANCE · LOCAL APPLICATION



RESPONSIBILITIES

Accountability must be explicit at every step

PROVINCIAL AND DEPARTMENTAL DUTIES

- | | | |
|-----------|-------------------|---|
| 01 | POLICY | Develop and publish a province-wide policy or guideline for physical care, security, archiving and disposal under departmental standing orders. |
| 02 | DIRECTIVES | Comply with all directives and instructions issued by the National Archivist. |
| 03 | EVIDENCE | Monitor that prescribed certificates of destruction are submitted to the Provincial Archivist. |
| 04 | ESCALATE | Report serious damage, loss or unauthorised destruction of records to the Provincial Archivist without delay. |
| 05 | OWNERSHIP | Appoint a departmental records manager to implement the province-wide records-management policy or guideline. |

The departmental records manager converts policy into consistent practice across facilities.

FILING OF PATIENT RECORDS



The storage room is the first line of protection

LOCATION AND PROTECTION

One designated patient record storage room, close to the registration desk.

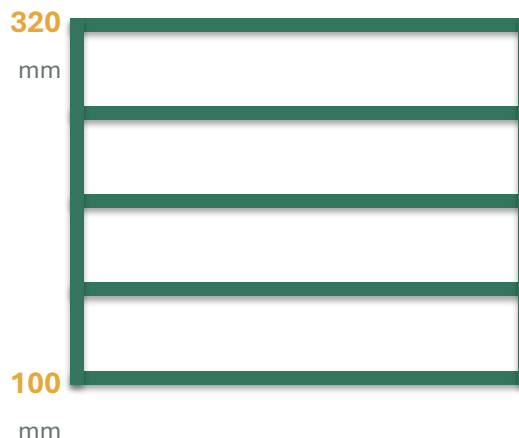
- Security gate
- Fireproof door and roof
- Fire extinguisher
- Away from waterpipes, leaks and flood risk
- Small windows—or dark blinds kept closed



SHELVING AND ENVIRONMENT

18–20°C

maintained by air-conditioning



Coated-metal shelves or cabinets
Top and bottom clearances preserve airflow

DAILY OPERATING STANDARD

- Aisles and shelves labelled to approved filing standards
- Counter and/or sorting table
- Proper lighting
- Clean and dust free
- Free of rodents and other pests



Sunlight, dust, moisture and pests all damage records.



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RECORD REGISTRATION AND ACCESS



One identity

STANDARDISED RECORD REGISTRATION
SYSTEM

Every facility uses the same
registration logic.

ID number
or date of birth

+

Numbers / letters
or a combination



UNIQUE REGISTRATION NUMBER

Generated manually or electronically—and shown
clearly on every patient record.

Controlled access

ACCESS TO THE **RECORDS** ROOM

LOCKED

Keep the room locked at all times.

AUTHORISED

Only authorised employees may
enter.

PASSWORD

Restrict electronic records with
password protection.

**WRITTEN
APPROVAL**

Non-Department of Health access
requires written approval from the
district or facility manager.

FILING AND TRACKING



A Closed loop keeps every record accounted for:

PHYSICAL RECORD RETURN CYCLE

1

RECEPTION

Administrative staff
issue and receive
records.

2

REGISTER

Use the standard
registration system.

3

RECONCILE

Check against the day's
patient registration list.

4

CLOSE THE LOOP

Confirm every record
returns to reception.

ELECTRONIC RECORD CONTROL

SAVE

BACK UP

FOLLOW SOP

Electronic records must be saved and backed up according to the standard operating procedure of the health-information software application.



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RECORDS NOT RETURNED TO RECEPTION



Escalation intensifies only when recovery fails

REPORT THE INCIDENT TO THE FACILITY MANAGER

IF THE RECORD IS STILL IN THE FACILITY

- 01** Call the patient and establish why the record was not returned.
- 02** Ask for the exact location where the record was left and retrieve it.

Resolve, document and return the record to reception.

IF THE RECORD LEFT THE FACILITY

- | | |
|-----------------------|--|
| 1 DAY | Ask the patient to return it within one day. |
| WBOT | If not returned, arrange retrieval by the responsible ward-based outreach team member. |
| POLICE | If unreachable or refusing, ask the police to retrieve it. |
| WRITTEN REPORT | If still withheld, report via the supervisor to the district manager in writing. |

NO-SHOWS AND ARCHIVING



Two time thresholds determine the destination

Keep no-show records in a box during the grace period.

5

DAYS

If the patient does not attend within five days, move the record to the defaulter box.

Archive records dormant for 24 months.

24

MONTHS

Separate lockable storage
No space → provincial or district archive
Scanning allowed to save space; back up at all times

Follow the relevant archiving SOP.



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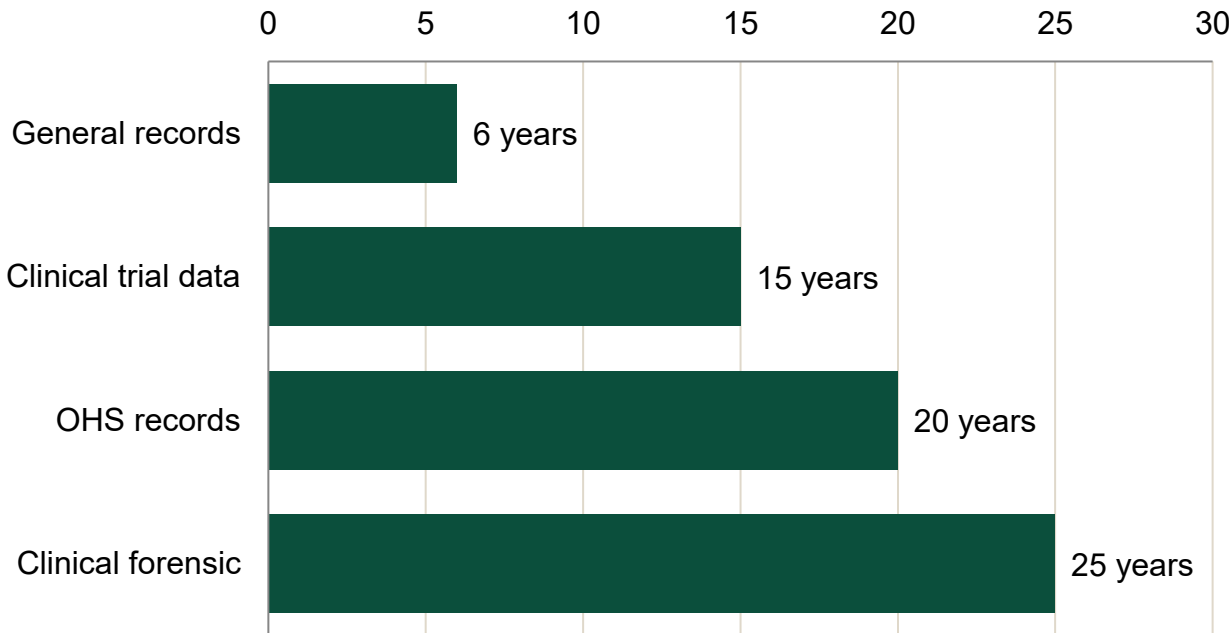


DISPOSAL OF PATIENT RECORDS



Six years is a baseline—not a universal rule

FIXED MINIMUM / INACTIVITY PERIODS



DO NOT APPLY THE SIX-YEAR RULE TO

MINORS + OBSTETRIC

LIFETIME RECORDS

CLAIMS + LITIGATION

SPECIAL CATEGORIES



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DISPOSAL · CATEGORIES OF RECORDS



Keep every retention category separate

EARLIEST DISPOSAL CONDITION STATED IN THE SUPPLIED GUIDANCE

RECORD CATEGORY	DISPOSAL / RETENTION TRIGGER
GENERAL	Dormant for six years
MINORS	Patient has reached 21 and the folder has been dormant for six years
OBSTETRIC	Child has reached 21 and the record has been dormant for six years
OCCUPATIONAL HEALTH & SAFETY	Inactive for 20 years
PSYCHIATRIC	Patient has passed away
CLINICAL TRIALS + DATA	Trial completed at least 15 years before disposal
CLINICAL FORENSIC MEDICINE	Retain for 25 years
LITIGATION	Retain as a separate category; disposal period not stated in the supplied content



THANK YOU



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