

# STANDARD OPERATING PROCEDURE FOR FILING, ARCHIVING AND DISPOSING OF PATIENT RECORDS IN PRIMARY HEALTH CARE FACILITIES



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## 1. INTRODUCTION

The purpose of the Standard Operating Procedure (SOP) for filing, archiving and disposal of patient records is firstly to give guidance to staff in Primary Health Care facilities on the procedures to follow to ensure that patient records are stored safely and filed in a systematic and orderly manner so that it can be retrieved in the most efficient manner possible. Secondly the SOP give guidance to staff on archiving and disposal of patient records to ensure that there is sufficient space available for filing of patient records.

A patient record is any relevant record made by a health care 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.

A record storage room is the room where patient records are stored.

The following documents can be regarded as the essential components of a patient record:

- any written notes taken by a health care practitioners,
- patient discharge summary or summaries,
- referral letters to and from other health care practitioners,
- laboratory reports,
- laboratory evidence such as histology sections, cytology slides and printouts from automated analysers, X-ray films and reports, ECG traces, etc.
- audiovisual records such as photographs, videos and tape-recordings,
- clinical research forms and clinical trial data,
- other forms completed during the health interaction such as insurance forms,
- death certificates and autopsy reports<sup>1</sup>.

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<sup>1</sup> Guidelines on the keeping of patient records, Health Professionals Council of South Africa, May 2008, p1.

## 2. VALUE OF RETAINING PATIENT RECORDS

Patient record must be retained in order to:

- Further the diagnosis and or ongoing clinical management of the patient;
- conduct clinical audits;
- promote teaching and research;
- be kept as direct evidence in litigation or for occupational disease or injury compensation purposes;
- be used as research data;
- promote good clinical and laboratory practices;
- make case reviews possible.<sup>2</sup>

## 3. RESPONSIBILITIES

Various responsibilities must be assigned to staff to ensure the effective management of patient records that include the archiving and disposal of records. These responsibilities are set out in sections 3.1 to 3.4.

### 3.1 Provincial Head of Health

The Provincial Head of Health must:

- Take responsibility for ensuring that all records receive appropriate physical care, are protected by appropriate security measures and are managed in terms of the standing orders of the relevant Department of Health.
- Comply with all directives and instructions issued by the National Archivist.
- Submit to the National Archivist a certificate of destruction as prescribed by the National Archivist whenever records are destroyed in terms of a disposal authority, unless an exemption from this obligation has been received from the National Archivist.
- Report to the National Archivist without delays all cases of serious damage, loss or unauthorized destruction of that body's records.
- Ensure that the records classification system has been approved by the National Archivist.

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<sup>2</sup> Guidelines on the keeping of patient records, Health Professionals Council of South Africa, May 2008, p1.

- Report to the National Archivist such body's intention to microfilm records or to introduce an electronic records system and such notification shall follow procedures set out by the National Archivist<sup>3</sup>.

### 3.2 District Office

The District Office must:

- Assign an official as the designated records manager. The designated records manager must in terms of section 13(5) of the Act comply with the following:
  - be in possession of an appropriate university or technikon, qualification and/or have appropriate professional experience;
  - have successfully completed the National Archives' Records Management Course;
  - possess a thorough knowledge of the body's organizational structure, functions and records system; and
  - be responsible for promoting the effective, efficient and accountable management of the district's records and ensuring, by inspections and other means, the district's compliance with the Act and all other relevant legislation.
- Give guidance to facilities in regard to management of patient records.
- Assist facilities with the archiving and destroying of patient records.

### 3.3 Facility manager

The Facility manager must:

- take responsibility for the management of the records (filing, archiving and disposal) of the facility.
- assign administrative staff to management records at reception and filing.
- arrange that an annual clean-up of the records storage room take place.

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<sup>3</sup> Regulations of the National Archives and Records Service of South Africa act (ACT NO. 43 OF 1996) as amended, 20 November 2002, No. R. 1458

### 3.4 Administrative staff

The administrative staff assigned to reception and filing must:

- manage records at reception
- manage records in the records storage room
- assist the facility manager during the annual clean-up of the records storage room

## 4. REQUIREMENTS FOR STORAGE SPACE OF PATIENT RECORDS

Patient records should ideally be stored in a singled location that is in close proximity to the patient registration desk. Patient records must be stored in a safe lockable place, protected from external and internal deterioration.

The patient record storage rooms must:

- have shelves that is made of coated metal. Wooden shelving should be avoided, as it can release harmful vapours, can contribute to the spread of fire and may harbour insects. The lowest shelf should start at least 150 mm off the floor to prevent flood damage, the top of the shelving should not be less than 320 mm from the ceiling to allow airflow,
- have aisle and shelves labelled correctly according to the approved standardise filing system,
- have a security gate,
- have a counter and or a sorting table,
- have proper lighting,
- have an air-conditioner to ensure that the temperature is below 22 degrees Celsius,
- preferably have very small windows, in instances where there are big windows, dark blinds must be installed and be kept closed as light may be harmful to records,
- be kept clean and dust free dust as dust can be harmful to records,
- be free of rodents.<sup>4</sup>

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<sup>4</sup> Records Management Policy Manual, National Archives and Records Service of South Africa, First Edition, Version 1.2, April 2004, page 27.

## **5. FILING REGISTRATION SYSTEM**

Every facility must have a standardised filing registration system. Any of the following methods can be used to generate a unique registration number for each patient record:

- surname of patient,
- Identity Document number or date of birth of patient,
- or a set of numbers.

The unique registration number must be clearly indicated on every patient record.

## **6. FILING OF PATIENT RECORDS**

It is the responsibility of all administrative staff working at reception to file-back patient records into the filing system after the designated person has consolidated all patient records used for the day. Each record must be checked against the day's patient registration list to ascertain the return of each record to reception.

### **6.1 Handling of patient record that were not returned to registration/reception**

In the event of a patient record that has not been returned to reception by the patient, the administrative staff must report the incident to the facility manager.

The administrative staff must do the following:

- Contact the patient telephonically (if patient has a telephone/cell phone), to determine why the patient record has not been returned to reception.
- If the patient has left the record in some other area in the facility, he/she must explain exactly the location in the facility where the record has been left.
- If the patient has removed the record from the facility, he/she must be requested to return the record to the facility within one day.
  - In cases where the patient is unable to come to the facility to return the record within one day's time or does not return the record after agreeing to do so, arrangements must be made with the ward-based outreach team (WBOT) member responsible for

the area where the patient resides, to retrieve the record from the patient's home and return it to the facility.

- In the event of a patient that cannot be reached by phone or who refuses to return the record to the facility, the police must be contacted to retrieve the record from the patient.
- If the patient refuses to hand over the record to the police, the administrative staff must inform the facility manager that must then report the incident to the District Manager via his/her supervisor, in the form of a written report. The District Manager must lay a formal charge of theft against the patient at the police station.

## **6.2 Handling of pre-retrieved records of patients who did not turn up for their appointment**

- The pre-retrieved records of patients who did not turn up for their appointments will enter a grace period of 5 days. The records must be kept in the box (clearly marked as not having honoured their appointment) with pre-retrieved records should the patients turn up at the clinic during the grace period.
- The records must be placed into the Defaulter box should the patient not turn up at the clinic during the grace period so that Ward Based Primary Health Care Outreach Team can make a follow-up on the patients. Such records must then be filed back into the filing system.

## **7. ARCHIVING OF PATIENT RECORDS**

The filing system must be cleaned up on an annual basis. The facility manager must arrange and oversee this process. All records that are dormant for two to three years (counting from the date of the last entry in the record) must be archived in a separate storage space at the facility if there is a storage space available or the records must be taken to the district or provincial archives.

Records as stipulated in section 8.1 of this SOP must preferably be kept at the facility, separate from active records and clearly marked as being an exception on the rule of disposing patient records after six years. The area where these records are kept must also be cleaned up on an annual basis. If there is no space available at



the facility it must also be sent to the district or provincial archives but it must be marked clearly that these records may not be disposed of after six years.

The records that are dormant must be kept in a room that is secured with a lockable door until the district office or provincial department collects it from the facility. All the records must be sorted, listed, batched and packed. When records are archived with the possibility to be destructed, minimum information about the patient must be retained, therefore a register should be kept of all patient records that are archived for possible later disposal<sup>5</sup>. See Annexure A for an example of a register for records submitted for archiving and possible disposal. The registers should be kept in one file, stored in the patient record storage room.

## **8. DISPOSING OF PATIENT RECORDS**

Disposal refers to a process of permanently removing records from the custody of the Health Department by either destroying (destruction) them or transferring them to Provincial or National Archives. Shredding is considered the best method of disposing of confidential documents.

Destruction must take place regularly, but at least once a year. According to the National and Records Service of South Africa Act, no public record under the control of a governmental body shall be transferred to an archives repository, destroyed, erased or otherwise disposed of without the written authorisation of the National Archivist<sup>5</sup>. Therefore a prescribed destruction certificate must be submitted whenever archives are destroyed. See Annexure B for an example of a destruction certificate.

The National Archives and Records Service uses different types of disposal instructions to indicate what disposal actions should happen with different records. The disposal instruction is indicated by a disposal symbol. Patient records are classified as *D*. A *D* disposal symbol indicates that the office of origin itself determines the retention period<sup>6</sup>.

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<sup>5</sup> National Archives and Records Service of South Africa act (ACT NO. 43 OF 1996) as amended.

Therefore it is recommended that the guidelines provided by the Health Professionals Council of South Africa (HPSCA) should be followed in regard to the disposing of patient records. The guideline stipulates that health records should be stored for a period of not less than six (6) years as from the date they became dormant. There are however exceptions as listed in section 8.1.

### **8.1 Patient records that must not be disposed of after six years**

- For minors under the age of 18 years health records should be kept until the minor's 21<sup>st</sup> birthday because legally minors have up to three years after they reach the age of 18 years to bring a claim.
- Obstetric records until the child reached 21 years.
- For mentally incompetent patients the records should be kept for the duration of the patient's lifetime.
- Records where patient were involved in Occupational Health and Safety incidents must be kept for 20 years (Occupational Health and Safety Act (Act No. 85 of 1993))
- Records of patients that work under conditions that might have an impact on their health, e.g. asbestosis. These health conditions take a long period to manifest themselves, should be kept for a sufficient period of time. The HPCSA recommends that this should not be less than 25 years.
- Records where possible claims against the state must be kept until the matter has been finalized.

Health records kept in PHC facilities shall only be destroyed if such destruction is authorised by the Head of Health. The Head of Health can assign this responsibility to another designated staff member.

Where statutory obligations were issued by the relevant Provincial Department of Health that prescribe the period for which patient records should be kept, the facility must comply with these obligations.

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'

defense 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<sup>7</sup>.

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<sup>7</sup> Guidelines on the keeping of patient records, Health Professionals Council of South Africa, May 2008, p8.

**ANNEXURE A: REGISTER OF RECORDS TO BE DISPOSED OF**

**Name of facility:** \_\_\_\_\_

Official who may be contacted regarding proposed disposal instructions:

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax No.: \_\_\_\_\_

Cell No.: \_\_\_\_\_

E-mail.: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

UNIQUE PATIENT RECORD NUMBER	NAME AND SURNAME OF PATIENT	PERIOD THAT RECORD WAS ACTIVE

If records were sent to district archiving:

Details of staff member who received the records at district archiving

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax No.: \_\_\_\_\_

Cell No.: \_\_\_\_\_

E-mail.: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## ANNEXURE B: DESTRUCTION CERTIFICATE

I hereby certify that the records listed below which occupied .....linear meters of shelving/storage space were destroyed today in terms of disposal authority/authorities number(s) .....

Name of Office: .....

Name of Records Manager .....

Telephone: .....

Fax: .....

Cell : .....

E-mail: .....

Signature: .....

Date: .....

NUMBER	DESCRIPTION	PERIOD

Where a series of case files is destroyed, e.g. personal staff files, files for institutions, or item files, the listing of individual files is not required, unless the body wishes to compile such a list for its own purposes:

In such a case, only the first and last file numbers and the periods are indicated in the first and third columns, and a comprehensive description of the whole group is recorded in the second column.