NATIONAL GUIDELINE FOR FILING, ARCHIVING AND DISPOSAL OF PATIENT RECORDS IN PRIMARY HEALTH CARE FACILITIES

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PREAMBLE

Health facilities must control and manage records according to the legislation promulgated by government to enable health care workers to have timely access to accurate and reliable patient information. The legislative provisions in section 13 of the National Archives and Records Service of South Africa Act (Act No 43 of 1996) are aimed towards promoting sound records management and thereby promoting accountability and better service delivery.

The purpose of this guideline is to explain to health care professionals and administrative staff what their records management obligations are in terms of the National Archives and Records Service of South Africa Act.

Patient records form an essential part of a patient's existing and future health care needs. As a written collection of information about a patient's health and treatment, they are used essentially for the immediate and continuing care of the patient. If a medical record cannot be located, the patient may come to harm because information, which may be vital for their continuing care is not available. Proper filing and archiving will also reduce the time that patients wait for the retrieval of their records while the correct disposal of records will ensure that only records that are eligible for destruction are destroyed.

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DATE:

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1. INTRODUCTION

The purpose of this guideline 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 guideline gives guidance to staff on archiving and disposal of patient records to ensure that there is sufficient space available for filing of patient records and that regulatory requirements regarding the disposal of records are adhered to.

Provincial and district offices should use this guideline to develop their own provincial or district specific guideline for filing, archiving and disposal of patient records. Where provincial legislation allows for provincial procedures for the filing, archiving and disposal of patient records, the requirements as set out in the provincial procedures must be followed.

2. DEFINITIONS

Patient record: is any relevant record made by a health care professional 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.

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

- any written notes taken by a health care practitioner
- 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, legal, consent, prescription chart and administrative forms
- death certificates and/or autopsy reports.[1]

[1] **Guidelines on the keeping of patient records, Health Professionals Council of South Africa, May 2008, p1.**

Record storage room: is the room where patient records are stored.

Archives: A physical space where patient records that have been dormant/inactive for two years or more (twenty four months from the date of the last entry in the record) are stored

Archiving: The act of determining and removing patient records from the records storage room that have been dormant/inactive for two years or more (twenty-four months from the date of the last entry in the record) to the archives.

Disposal: The action of destroying a record.

Disposal authority: A written authority issued by the National Archivist specifying which records should be transferred into archival custody or specifying which records should be destroyed/deleted or otherwise disposed of.

Disposal authority number: A unique number identifying each disposal authority issued to a specific governmental body.

Record classification system: 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.

Retention period: The length of time that records should be retained by governmental bodies before they are either transferred into archival custody or destroyed/deleted.[2]

[2]**Records Management Policy Manual, National Archives and Records Service of South Africa, First Edition, Version 1.4, October 2007.**

3. STATUTORY AND LEGISLATIVE FRAMEWORK

The statutory and regulatory framework in which sound records management is founded is the following:

3.1 The Constitution, 1996

Section 195 of the Constitution provides amongst others for the:

- effective, economical and efficient use of resources
- provision of timely, accessible and accurate information; and requires that
- the public service must be accountable.

3.2 The National Archives and Records Service of South Africa Act, 1996 (Act43 of 1996) as amended

Section 13 of the Act contains specific provisions for efficient records management in bodies. It provides for the National Archivist to:

- determine which record keeping systems should be used by governmental bodies
- authorise the disposal of public records or their transfer into archival custody
- determine the conditions
  - according to which records may be microfilmed or electronically reproduced
  - according to which electronic records systems should be managed.

The regulations for the Act are set out in the National Archives and Records Service of South Africa Regulations (R1458 of 20 November 2002). Part V: Management of Records contains the specific parameters within which the governmental bodies should operate regarding the management of their records.

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

The purpose of Section 2 of the act is to give effect to the constitutional right to privacy, by safeguarding personal information when processed by a responsible party, subject to justifiable limitations that are aimed at:

(i) balancing the right to privacy against other rights, particularly the right of access to information; and

(ii) protecting important interests, including the free flow of information within the Republic and across international borders.

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

The Promotion of Access to Information Act, 2000 (Act No. 2 of 2000) (PAIA), which flows from section 32 of the Constitution of the Republic of South Africa, 1996, gives effect to the constitutional right of access to any information held by the state and any information held by any other person, provided that such information is required for the exercise or protection of any rights.

3.5 Provincial Archives and Records Acts

Eight of the nine provincial departments have a Provincial Archives and Records Act. The following provincial departments have provincial acts in place:

3.5.1 Eastern Cape Province
Provincial Archives and Records Service Act of the Eastern Cape, 2003 (Act 7 of 2003)

3.5.2 Free State Province
Free State Provincial Archives Act, 1999 (Act 4 of 1999)

3.5.3 Western Cape Province
Provincial Archives and Records Service of the Western Cape Act, 2005 (Act 3 of 2005)

3.5.4 Gauteng Province
Gauteng Provincial Archives and Records Service Act, 2013 (Act 5 of 2013)

3.5.5 Northern Cape Province
Northern Cape Provincial Archives and Records Service Act, 2013 (Act 7 of 2013)

3.5.6 KwaZulu-Natal Province
KwaZulu-Natal Archives and Records Service Act, 2011 (Act 8 of 2011)

3.5.7 Mpumalanga Province
Mpumalanga Archives Act, 1998 (Act 14 of 1998)

3.5.8 Limpopo Province
The Limpopo Province Archives Act,2001 (Act 5 of 2001)

4. VALUE OF RETAINING PATIENT RECORDS

Patient record must be retained in order to:

- provide clinical data
- further effect the diagnosis and/or ongoing clinical management of the patient
- conduct clinical audits
- promote teaching and learning
- be kept as direct evidence in litigation or for occupational disease or injury compensation purposes
- be used to further research by providing research data
- promote good clinical and laboratory practices
- make case reviews possible.[3]

5. 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 5.1 to 5.4.

5.1 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.
- Monitor that certificates of destruction are submitted to the National Archivist as prescribed.
- Report to the National Archivist without delays all cases of serious damage, loss or unauthorized destruction of that body's records.
- Appoint a Departmental Records Manager to ensure that the province-wide policy/protocol for record management is implemented.

[3] **Guidelines on the keeping of patient records, Health Professionals Council of South Africa, May 2008, p1.**

5.2 District manager

The District manager must:

- Establish a record management support unit to:
  - Give guidance to facilities regarding the management of patient records
  - Assist facilities with the archiving and destroying of patient records
  - Ensure compliance with the Act and all other legislation pertaining to record management .
- Assign the responsibility for records management to a specific official at every facility.
- Assign an official as the designated records manager at every facility.

5.3 Primary Health Care Facility manager

The Facility manager must:

- Ensure that a health record is created and maintained at the facility for every user of the health service.
- 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.
- Take responsibility for the management of the records (filing, archiving and disposal) of the facility.
- Assign administrative staff to manage records at reception and filing.
- Arrange that an annual clean-up of the records storage room takes place by archiving and disposal of the eligible records.
- Ensure that all staff (administrative and clinical) respects the right to privacy and confidentiality when it comes to all patient records.
- Ensure where possible that patients do not carry their own files.

5.4 Administrative staff

The administrative staff assigned to reception and filing must manage records at reception and the records storage room in the following manner:

- Ensure access control to medical records and the confidentiality of patient information is maintained at all time.
- Where an electronic record system is in place, capture the data and follow processes according to the standard operating procedure of the specific electronic record system.
- Retrieve records ahead of time according to patient appointments.

- Issue records and record all folders issued per day.
- Update patient demographic information regularly.
- Monitor returned records and track outstanding records.
- Record, track and merge temporary records.
- Record, track and recover loaned/removed records.
- Issue temporary records when the original is not available/missing.
- Ensure that all shelves and records are properly labelled as per filing system in use.
- Open a continuation record once the current record is full (where booklets are used) or the folder is thicker than 3cm.
- Where folders are used, replace broken folder covers.
- Check the shelves regularly for duplicate or misfiled folders.
- Ensure that the records storage area is regularly tidied and cleaned.
- Undertake the annual clean-up of the records storage room under the supervisions of the Primary Health Care facility manager.

6. REQUIREMENTS FOR STORAGE SPACE OF PATIENT RECORDS

Patient records should ideally be stored in a single location that is in close proximity to the patient registration desk. The location for storing of patient records will hereafter be referred to as patient record storage room.

Patient records must be stored in a safe lockable place, protected from external and internal deterioration and if they are in electronic format, safeguarded by passwords.

The patient record storage rooms must:

- have a security gate
- have a fire –proof door and roof
- have a fire extinguisher
- No water pipes should be in or near the registry or other record storage areas as these may leak, burst or flood the area
- preferably have very small windows, in instances where there are big windows, dark blinds must be installed and be kept closed as sunlight is harmful to records
- have shelves or cabinets that are 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 standardised filing system
- have a counter and or a sorting table
- have proper lighting
- have an air-conditioner to ensure that the temperature is maintained below 18 to 20 degrees Celsius
- be kept clean and dust free as this can be harmful to records
- be free of rodents and other pests.[4]

7. RECORD REGISTRATION SYSTEM

Every facility must have a standardised record 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 or alphabet letters or a combination of the two. The unique number can be generated manually or electronically in cases where an electronic patient registration system is in place.

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

[4] **Records Management Policy Manual, National Archives and Records Service of South Africa, First Edition, Version 1.4, October 2007.**

8. FILING OF PATIENT RECORDS

8.1 Access to the records room

The records room must be locked at all times and only staff that is authorised to access the record storage room may enter the room.

8.2 Labelling of shelves

Patient records must be filed on labelled shelves or in cabinets according to the unique registration number.

8.3 Filing and tracking of patient records

It is the responsibility of 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, see **Annexure A** as an example.

All electronic records must be saved and backed-up as stipulated in the standard operating procedure of the specific health information software applications in use at the facility.

8.4 Handling of patient records 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 following must be done:

Report the incident to the facility manager. The facility manager must ensure that the following is done (can delegate a staff member to do the task but facility manager must receive a report):

- 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, for some reason, 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 removed the record from the facility, he/she must be requested to return the record to the facility within one day.
- If the patient, for some reason, 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 facility manager must 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.

8.5 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 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 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.

9. ARCHIVING OF PATIENT RECORDS

The filing system must be cleaned up on an annual basis. All records that are dormant/inactive for two years (twenty-four months from the date of the last entry in the record) must be archived in a separate lockable storage space at the facility if there is storage space available. If there is no storage space available, the records must be taken to the provincial/district archives. This will allow auditors access to the records when and if needed.

The process to be followed:

- All records must be sorted, listed, batched and packed.
- Sort the records according to the type of record as set out in section 9 for the register for disposal of patient records e.g. general, minor, obstetric records
- 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.[5] See **Annexure B** for an example of a register for archived records.
- The registers should be kept in one file in each Primary Health Care facility and stored in the patient record storage room.

10. DISPOSAL OF PATIENT RECORDS

Disposal of records refers to the action of destroying a record. Shredding is considered the best method of disposal of confidential documents.

Patient records that are dormant for six years (from the date of the last entry in the record) should be destroyed.

There are however the following exceptions:

10.1 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 21stbirthday 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 of age.
- For mentally incompetent patients including those who have been declared State patients by the Courts, the records should be kept for the duration of the patient's lifetime.
- Records where patient was involved in an Occupational Health and Safety incidents must be kept for 20 years (Occupational Health and Safety Act, 1993 (Act 85 of 1993).
- Records of patients that work under conditions that take a long period to manifest themselves and may have an impact on their health, e.g. mining and asbestosis,

[5] **National Archives and Records Service of South Africa act (ACT NO. 43 OF 1996) as amended.**

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 may arise must be kept until the matter has been finalized.
- Records of patients that have been enrolled in clinical trials at that facility must be kept for 15 years.
- Records of patients who accessed Clinical Forensic Medicine services must be kept for not less than 25 years for any future request by the Criminal Justice system.

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.[6]

Destruction must take place regularly, but at least once a year. A complete register must be kept of records that are destroyed, see **Annexure C** as an example.

10.2 Categories of records

The files should be grouped together on the register according to the category of the file using the following headings:

- General record (that has been dormant for 6 years)
- Records for minors (under the age of 18 year where the patient has reached the age of 21 years and the folder that has been dormant or 6 years)
- Obstetric records (where the child has reached 21 years and the record has been dormant for 6 years)
- Occupational Health and Safety records (that have been inactive for 20 years)
- Psychiatric records (where the patient has passed away)
- Litigation records (where the case has been finalised and the record has been dormant for 6 years)
- Clinic trial records and data (where the trial has been completed at least 15 years prior to disposal)
- Clinical Forensic Medicine (to be retained for 25 years)

[6] **Guidelines on the keeping of patient records, Health Professionals Council of South Africa, May 2008, p8.**

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.[7] A general disposal authority number has been issued by the National Archivist for the disposal of patient records (referred to as clinic patient files in the authorisation), therefore the archivist does not need to approve every application for the destruction of records, it just requires that the original copy of the destruction certificate be submitted to the provincial archivist. For health facilities governed by Local Government the general disposal authority number PAK4 and for provincial health departments the general disposal authority number AK2 has been issued[8]. See **Annexure D** for a copy of the destruction certificate. The following information must be completed on the certificate:

- Linear metres (Measure the folders in metres (of shelving space))
- Disposal Authority Number (for Local Government the number PAK4and for provincial health departments the number AK2 must be used.)
- Name of the Health Facility
- Name of applicant
- Telephone Number
- E-mail address
- Date
- Signature
- Description of the folders e.g. general records
- Period covered by these folders

As stated above the original destruction certificates must be submitted to the respective provincial archivist and a copy must be kept and filed by the facility. It is good practice that the provincial or district office keeps records of the destruction certificates and takes on the responsibility of submitting it to the provincial archivist, instead of letting individual facilities submit their own certificates to the archivist. Proof of receipt by the provincial archivist must also be kept. The register for disposal of patient records must be filed at the facility together with the destruction certificate for each batch of records that is destroyed.

[7] National Archives and Records Service of South Africa act (ACT NO. 43 OF 1996) as amended.
[8] Records Management Policy Manual, National Archives and Records Service of South Africa, First Edition, Version 1.4, October 2007.

Annexure A: Tracking tool for patient records

No.	Record number	Full name and surname of patient	Comment	Record Retrieved		Appointment Attended (only for scheduled appointments)		Record returned	
				Y	N	Y	N	Y	N
07.30-10.00									
1.	**2468013579**	**Mary Saints**	**CCMDD**	**Y**	N	Y	N	Y	**N**
2.					N	Y	N	Y	N
3.					N	Y	N	Y	N
4.					N	Y	N	Y	N
5.					N	Y	N	Y	N
6.						Y			
7.					N	Y			
8.					N	Y			
9.					N	Y			
10.	**1234567890**	**James Doe**	**FU**	Y	N	Y			
10.15-12.45 (Tea time = 10.00-10.15)									
11.						Y	N		N
12.							N	Y	N
13.							N	Y	N
14.							N	Y	N
15.							N	Y	N
16.	**2345678901**	**Polly Jacaranda**	**LR**				**N**	Y	**N**
17.							N	Y	N
18.							N	Y	N
19.							N	Y	N
20.							N	Y	N
13.30-16.[illegible] (12.45-1.30)									
21.				Y	N	Y			
22.				Y	N	Y			
23.				Y	N	Y			
24.				Y	N	Y			
25.				Y	N	Y			
26.				Y	N	Y			
27.				Y	N	Y			
Missed appointments (*Record all patients who present with 5 working days of a missed appointm*									
28.	**5678901234**	**Zenthembe Ndlovu**		**Y**	N	**Y**	N	Y	N
29.				Y	N	Y	N	Y	N
30.							N	Y	N
31.									N
32.									N

Complete Patient file number

Indicate if the patient's file was retrieved.

Indicate if the patient's record was returned to reception for filing.

Indicate reason for appointment, e.g. laboratory results (LR), referred for doctor consultation (DR), collection of meds only (CCMDD), regular follow-up (6mth FU). This is done at the time that the appointment is being made.

Complete patient's full name and surname

Indicate if the patient attended the appointment (only for scheduled appointment

At the end of the day indicate how many patients attended their appointments, missed their appointments, records retrieved and records returned.

Total number of patients attended		Total number of missed appointments	
Total number of records retrieved		Total number of records returned	

Annexure B: Register of records to be archived

Name of facility: ___________________________

Official that archived the records:

Name: ______________________________

Telephone: ______________________________

Cell No.: ______________________________

E-mail.: ______________________________

Signature: ______________________________

Date: ______________________________

UNIQUE PATIENT RECORD/FILE NUMBER	NAME AND SURNAME OF PATIENT	Category of record (see section 10.2)	PERIOD THAT RECORD WAS ACTIVE	
			Date from	Date to

Annexure C: Register of records for disposal

Name of facility: _____

Official who may be contacted regarding proposed disposal instructions:
Name: _____
Telephone: _____
Cell No.: _____
E-mail.: _____

Signature: _____
Date: _____

UNIQUE PATIENT RECORD/FILE NUMBER	NAME AND SURNAME OF PATIENT	PERIOD THAT RECORD WAS ACTIVE	
		Date from	Date to
General records			
Records for minors			
Obstetric records			
Occupational Health and Safety records			
Psychiatric records			
Litigation records			
Clinic trial records and data			
Clinical Forensic Medicine			

Annexure D: Destruction certificate

I hereby certify that the records listed below which occupied _____ linear meters of shelving/storage space were destroyed on_____(enter date that records were destroyed)

Disposal authority number: _____
Name of Health Facility: _____
Name of applicant: _____
Telephone: _____
Cell number: _____
E-mail: _____

Signature: _____
Date: _____

*DESCRIPTION	DATE ACTIVE FROM	DATE ACTIVE TO

Where a series of case files is destroyed only the first and last date of the group of records is indicated under the date from and to column.

The register for disposal of patient records as indicated on this destruction certificate must be filed together with the destruction certificate at the health facility.

* Description:

- General record (that has been dormant for 6 years)
- Records for minors (under the age of 18 year where the patient has reached the age of 21 years and the folder that has been dormant for 6 years)
- Obstetric records (where the child has reached 21 years and the record has been dormant for 6 years)
- Occupational Health and Safety records (that have been inactive for 20 years)
- Psychiatric records (where the patient has passed away)
- Litigation records (where the case has been finalised and the record has been dormant for 6 years)
- Clinic trial records and data (where the trial has been completed at least 15 years prior to disposal)
- Clinical Forensic Medicine (to be retained for 25 years)