MEDICAL RECORDS

DHCR Policy

Department: Quality Improvement

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INTRODUCTION

The purpose of the Dubai Healthcare City Authority- Regulatory Medical Records Policy and Guideline to specify the essentials of maintaining medical records, to support decision making, enhance the continuity of patient care, and improve patient care and outcomes. This policy also provides Healthcare Professionals with requirements and procedural guidelines in keeping with current regulations and standards to maintain a record-keeping system that is functional, practical and sustainable.

1- APPLICABLE TO:

1.1	This policy is applicable to all DHCC Healthcare Operators and Healthcare Professionals in hospitals, outpatient clinics and day surgery centers.
1.1	For medical records related to research, this policy should be adopted in conjunction with all relevant laws, rules, regulations, standards and ethical codes applicable to health related research.

2- RESPONSIBILITY:

2.1	It is the responsibility of the HCO to create and implement an internal medical records policy related to records management, content, confidentiality, security, storage, retention and destruction.
2.2	It is the responsibility of all Healthcare Professionals and other individuals identified in the HCO's internal medical records policy as those authorized to have access and to make entries in the medical records to adhere to the policy. Access is to be consistent with organization confidentiality and security policies.
2.3	It is the responsibility of the leadership of the HCO to designate a Custodian of Medical Records as well as sufficient staff and other resources to maintain a sustainable record keeping system.

3- POLICY:

3.1	All DHCC HCOs are required to initiate, maintain and secure a medical record in accordance with the requirements and procedural guidelines described in this document for every patient who registers for care and who may be assessed, treated and provided care or services by the HCO or HCP.
3.2	Each HCO is to have an internal medical records policy, supported by additional policies, procedures and processes as necessary, that is in compliance with: 3.2.1 The minimum requirements for medical records stated in this policy.

	3.2.2 The CPQ Outpatient Clinic Quality Standards. 3.2.3 The DHCC Health Data Protection Regulation. 3.2.4 The standards of the CPQ approved accreditation organization for Hospitals. 3.2.5 All other applicable rules, regulations and standards that are or may come in to effect. 3.2.6 The mission of the organization.
3.3	As a regulatory authority, DHCR reserves the right to request data included in the medical records for statistical purposes.

4- GUIDELINE:

4.1 Organization, Completion and Content of Medical Records

4.1.1 A medical record is initiated and maintained for every individual including newborn infants, who is assessed or treated as an inpatient, outpatient, or emergency patient of a HCO.

4.1.2 Medical records are created and maintained in written or electronic format, or a combination of both.

4.1.3 Retained images and recordings including digital images and recordings obtained as part of a patient's care, or which illustrate a patient's condition or an aspect of treatment are part of the medical record.

4.1.4 Healthcare Operators are to assign one medical record for each patient with a unique identification number.

4.1.5 At a minimum, both the patient name and the medical record number appear on each form in the medical record. Double-sided or multi-page forms are to contain the patient's name and medical record number on each page.

4.1.6 Information in the medical record is dated and kept in a chronological and systematic manner. Each and every visit of patient should be properly recorded in his/her individual medical file.

4.1.7 All entries in the medical record are to be in English. Documents, including photocopies or electronic versions of documents written in a language other than English submitted as part of a medical record is to be translated in English and notarized by an acceptable legal translation service.

4.1.8 All entries in the medical record are legible to individuals who access the record and not only to the author of the entry. Handwritten entries should be made with permanent black or blue ink such that electronic copies, scans or faxes remain legible.

4.1.9 Standardized diagnosis codes, procedure codes, definitions, and symbols, are used.

4.1.10 Abbreviations are explained the first time they are used in a medical record, with the full wording followed by the abbreviation within brackets.

4.1.11 Authentication of each entry is by official stamp and signature or official stamp and written

	initials. Electronic medical records are authenticated by electronic signature or computer-generated signature code. The first time an author makes an entry in an individual medical record, official stamp and full signature is used. 4.1.12 Entries into the medical record are made as close to the time of the medical encounter as possible to ensure accuracy and comprehensiveness of data, and within a timeframe specified by the HCO in Policy. 4.1.13 Transcribed telephone or verbal orders are recorded in the medical record and countersigned by the ordering HCP within the timeframe specified by the HCO in Policy. 4.1.14 Record keeping for phone call conversations and e-mail communications takes similar format as normal patient encounters. 4.1.15 The HCO keeps records of the patient non-compliance or failure to attend appointments. 4.1.16 All HCOs shall have a process to review the medical records periodically to ensure completion in a timely, accurate, authenticated and legible manner.
4.2	**Content of Medical Records:** 4.2.1 The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment, and promote continuity of care among healthcare providers. All medical records include the following at minimum: 4.2.1.1 Name, address (including which Emirate), contacts telephone numbers and date of birth of the patient. 4.2.1.2 Proof of Identity: Copy of Emirates ID, GCC ID, or Passport 4.2.1.2 Medical Record Number 4.2.1.3 For consultations, name and address of the Primary Care Physician and of any HCP who referred the patient. 4.2.1.4 List of allergies with associated drug reactions or note of 'No Known Drug Allergies' or 'None Known' to be prominently documented. 4.2.1.5 Any written report received from another healthcare professional referring the patient. 4.2.1.6 Date of each professional encounter with the patient. 4.2.1.7 Record of the patient assessment by the healthcare professional, including: 4.2.1.7.1 History 4.2.1.7.2 Particulars of each medical examination 4.2.1.7.3 Note of any investigations ordered and results of the investigations, and 4.2.1.7.4 Any informed consents obtained from the patient 4.2.1.7.5 A record of the disposition of the patient, including: 4.2.1.7.6 Indication of each treatment prescribed or administered 4.2.1.7.7 Professional advice given 4.2.1.7.8 Particulars of any referral made by the healthcare professional 4.2.1.7.9 Any other appropriate and relevant information as required by the HCO policy

	4.2.2 The content of medical records after each patient encounter reflect the following, where applicable: 4.2.2.1 Appropriate relevant history 4.2.2.2 Appropriate physical examination 4.2.2.3 Provisional diagnosis, and treatment plan 4.2.2.4 Any other appropriate relevant information (i.e. patient plan of care)
4.3	**Special Considerations for Medical Records in Hospital-Based / Day Surgery Centers Environments:** 4.3.1 Discharge Summary All patients have discharge summaries filed into their medical records. These include at minimum the following: 4.3.1.1 Identifying information (author's name and status, name of most responsible physician, name of patient, Medical Record number 4.3.1.2 Admission and discharge dates and times 4.3.1.3 Admitting diagnosis 4.3.1.4 Pertinent physical examination findings and laboratory results 4.3.1.5 Procedures and co-morbidities while in hospital 4.3.1.6 Discharge diagnosis / diagnoses and complications 4.3.1.7 Discharge medications 4.3.1.8 Active medical problems at discharge 4.3.1.9 Arrangements for continuing care (follow-up plan) and discharge instructions 4.3.1.10 Signature and official stamp of attending physician 4.3.2 Operative Note All patients for whom an operative / invasive procedure has been performed have an operative note placed in the medical record by the surgeon prior to the patient being moved to the recovery area. The note includes at minimum the following: 4.3.2.1 The names of the surgeon and assistant(s) 4.3.2.2 Date of procedure 4.3.2.3 Pre-operative and post-operative diagnosis 4.3.2.4 Procedure performed 4.3.2.5 Estimated blood loss 4.3.2.6 Condition of patient at conclusion of operative procedure 4.3.2.7 Type of Anesthesia & Operation site. 4.3.3 Anesthesia Record

	4.3.3.1 The pre-anesthesia assessment and the pre-induction assessments are performed by a qualified individual(s) and are documented in the medical record. 4.3.3.2 The anesthesia care plan is identified and documented. 4.3.3.3 Prior to being transferred to the recovery area, a comprehensive anesthesia record must be included in the patient's chart. This record includes at minimum the following: 4.3.3.3.1 Identifying information (Anesthesiologist Name, Anesthesia Assistants Name, Name of Patient, Medical Record number, etc.) 4.3.3.3.2 Date of procedure 4.3.3.3.3 Documentation of the anesthesia agent , dose and anesthetic technique used (including ease of mask ventilation, ease of intubation). 4.3.3.3.4 Documentation of the monitoring of physiological status according to policy and procedure, including fluid administration, estimated blood loss (if not mentioned in operative report) and any blood products administered. 4.3.3.3.5 Condition of patient upon transfer out of the operating room to the recovery area. 4.3.4 Documentation of the monitoring during the post-anesthesia recovery period according to policy, and including time recovery started and ended is documented in the medical record. 4.3.5 Discharge from the recovery area by a qualified healthcare professional in accordance with established criteria is documented in the medical record.
4.4	**Modification of Medical Records** 4.4.1 The HCO has an explicit policy related to the modification of medical records. 4.4.2 When changes, corrections or other modifications require to be made to the medical record, the incorrect information is clearly labeled as incorrect and remains legible. 4.4.3 The date, time, nature, reason and correction or other modification are documented in the record by drawing a single line through the error. 4.4.4 Electronic forms of medical records have the ability to trace any changes or modifications in the record with identification of the person.
4.5	**Security and Storage of Medical Records** 4.5.1 The HCO maintains medical records in a manner to ensure accuracy and easy retrieval. 4.5.2 Medical records are stored safely to provide protection from loss, destruction, potential fire/ water damage, tampering, theft, unauthorized access, use, modification, or disclosure and other misuse. 4.5.3 A back-up of electronic medical records should be maintained to prevent electronic piracy or any source of loss.

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	4.5.4 Medical records are maintained in the custody of the HCO and are available to the patient or his / her representative through the attending Healthcare Professional at reasonable times and upon reasonable notice. 4.5.5 Appropriate measures are taken in maintaining the integrity and confidentiality of the records.
4.6	**Confidentiality and Release of Patient Medical Information** 4.6.1 Medical records are confidential; the release of such records is done only in accordance with the provision of the rules, regulations and standards as defined in 3.2. 4.6.2 The medical record is only accessed by the patient or representative and under supervision of the attending physician or custodian of medical records. 4.6.3 The HCO and all Healthcare Professionals who have access to patient records are not to disclose information about the condition or services pertaining to a patient to another person without the consent of the patient. 4.6.4 The HCO shall have a documented process for managing a breach of patient medical record confidentiality. 4.6.5 The medical record is only disclosed if required by law or as determined by standards of professional healthcare practices. 4.6.6 The HCO should provide DHCR a copy of the Patient's Medical Record for the purpose of clinical complaint investigation and/or Clinical Audit. 4.6.6 The HCO provides a discharge summary to the patient while discharging which includes information as indicated under 4.3.1.
4.7	**Retention, Transfer and Destruction of Medical Records** 4.7.1 Retention of Medical Records 4.7.1.1 The medical records (including dental records) shall be retained for a period of a minimum of fifteen (15) years after the date of last entry into the record for U.A.E Nationals and for Expatriates. 4.7.1.2 For children, records shall be retained for a period of a minimum of fifteen (15) years after the person has reached the age of eighteen (18) years old. 4.7.1.3 The medical records of medico-legal cases shall be retained for a minimum of twenty (20) years and destroyed. 4.7.1.4 The medical records of deceased patients shall be stored for 15 years and destroyed. 4.7.1.5 The medical records of certain major diseases and incidents selected by the administrations and requested by the consultants for research and legal or administrative purposes may be retained for longer periods than specified. 4.7.1.6 For the retention times of medical records used for the purpose of research, refer to relevant regulation for human research. 47.1.7 Medical records cannot be destroyed at the request of a patient or legal guardian.

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	4.7.2 Transfer of Medical Records 4.7.2.1 The HCO maintains the original medical record and may only transfer a copy of the record to others when required. 4.7.2.2 In case of a patient request to transfer the medical record, the HCO provides a copy of the record, or if required, a copy of the summary of records. 4.7.2.3 When a Healthcare Professional relocates or ceases to practice the medical records remain in the custody of the HCO. 4.7.2.4 In case the HCO ceases to exist, the medical records are maintained for a minimum of two years. During that period, the healthcare organization either keeps the records with a designated custodian at the same contact information or notifies the patients to collect their medical records. 4.7.3 Destruction of Medical Records 4.7.3.1 Medical records are destroyed only when they are in excess of the retention requirements specified in 4.8.1. 4.7.3.2 Medical records are destroyed or disposed of by shredding, incineration, electronic deletion, or another equally effective protective measure. 4.7.3.3 The HCO establishes procedures for notification to patients whose records are to be destroyed prior to the destruction of such records.
4.8	**Requirements for Electronic Medical Records** 4.8.1 All the requirements for the paper medical records apply equally to the use of electronic records. 4.8.2 When required and authorized, the HCO shall provide a printout version of the electronic medical record. 4.8.3 When storing the records in a central server or other electronic media, the HCO shall establish restrictive access and security measures and shall ensure regular back up of data. 4.8.4 It is the responsibility of the HCO using electronic medical records to keep the security measures up to date. 4.8.5 Authentication of entries in electronic medical records may be by electronic signatures using passwords, access codes, key cards provided that the following are met: 4.8.5.1 The electronic signature ensures data integrity and protects data from unauthorized or accidental change. 4.8.5.2 The electronic signature will include the name of the author or a unique identifier for the author, and the date and time the entry was authenticated. 4.8.5.3 The HCO has implemented policy that obliges the HCP to sign a statement that the HCP is the owner and the only person who has possession of the Electronic Signature and should be the only individual to use the electronic signature. 4.8.6 When destroying medical records, all electronic copies of the records need to be destroyed using a safe and effective device.

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5- COMMUNICTION: (Check all that apply)

☑	Announcement
☐	Awareness
☑	Training
☑	Other specify: Website Upload

6- DEFINITIONS:

- **Confidentiality:** The restricted access to data and information to individuals who have a need, a reason, and permission for such access. An individual's right to personal and informational privacy, including for his or her health care records.
- **CPQ:** Centre for Healthcare Planning and Quality.
- **Custodian of Medical Record:** person or department who has care, custody and control of medical records.
- **DHCA:** Dubai Healthcare City Authority
- **DHCC:** Dubai Healthcare City.
- **DHCR:** The Regulatory arm of Dubai Healthcare City Authority.
- **Diagnosis:** The nature and identification of an illness, disease or injury.
- **Discharge Summary:** a section of a patient record that summarizes the reasons for admittance, the significant findings, the procedures performed, the treatment rendered, the patient's condition on discharge, and any specific instructions given to the patient or family (for example, follow-up, medications).
- **Electronic Medical Record:** An electronic computerized Medical Record. Electronic Medical Records tend to be a part of a local stand-alone health information system that allows storage, retrieval and modification of records.
- **Electronic Signature:** Any letters, characters, numbers or other symbols in digital form attached to or logically associated with an Electronic Record, and executed or adopted with the intention of authenticating or approving the Electronic Record. A digital signature used on computer based electronic medical records which, assuming effective security procedures, can only be generated by the owner. This is usually a password or access code in the form of a sequence of computer key strokes known only to the owner.
- **Healthcare Operator (HCO):** in DHCC, this is an all-inclusive term meaning a hospital, clinic, laboratory, pharmacy or other entity providing healthcare, engaging in one or more clinical activities.

- **Healthcare Professional (HCP):** in DHCC, a licensed HCP is Healthcare Professional holding a License duly issued by the DHCC Licensing Board in accordance with the Healthcare Professionals Regulations and the applicable Practice Rules.
- **Informed Consent:** A process of communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention. It includes the principle that a physician has a duty to inform his or her patients about the nature of a proposed treatment, procedure, test, or research, the risks and benefits, the likelihood of success, alternative treatment or procedure and the risks involved, and the risks and benefits of not receiving or undergoing treatment.
- **Medical Record:** A written account of a variety of patient health information, such as assessment findings, treatment details, progress notes, and discharge summary. This record is created by physicians and other health care professionals.
- **Operative / Invasive Procedure:** Procedures that involve puncture or incision of the skin, or insertion of an instrument or foreign material into the body. This includes but is not limited to: open surgeries, arthroscopies, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, and endoscopies. Procedures may be conducted in operating rooms, special procedure suites such as endoscopic or interventional imaging, cardiac suites or ambulatory settings.
- **Operative Report:** report intended to include pre and post-operative diagnosis, the procedures performed and described, the operative findings, specimens removed, specific mention of complications or the absence of complications during the procedure, estimated blood loss and the names of the primary surgeon and assistants.
- **Representative:** in relation to a patient, means:

  (a) where the patient is dead – that patient's personal representative

  (b) where the patient is under the age of 18 years – that patient's parent or guardian or;

  (c) where the patient, not being a patient referred to in paragraphs (a) or (b), is unable to give his authorization, or exercise his rights, a person appearing to be lawfully acting on the patient's behalf or in his interests.

7- REFERENCES:

7.1	CPQ Outpatient Clinic Quality Standards- 2nd Edition.
7.2	Department of Health (DH)/Royal College of General Practitioners (RCGP)/British Medical Association (BMA). The Good Practice Guidelines for GP electronic patient records v4
7.3	DHCC Minimum Required Data Submissions
7.4	DHCC Health Data Protection Regulation No 7 of 2013
7.5	DHCC Healthcare Operators Regulation No 4 of 2013

7.6	Dubai Health Authority- Patient Record Guideline
7.7	Joint Commission International Standards for Hospitals
7.8	Joint Commission International Standards for Ambulatory Care
7.9	National Health Services (NHS)-United Kingdom, Records Management: NHS Code of Practice

Revision History

S No:	Summary	Amend Type*	Page	Issue No.	Issue Date
1.	**Placed in new template Statement, reviewed**	**Modify**	**3.3/ 4.2 added**	**4**	**19/11/2018**
2.					
3.					
4.					
5.					
6.					

* Amend Type: New- Add – Modify – Cancel