health
Department:
Health
North West Provincial Government
REPUBLIC OF SOUTH AFRICA

1st Floor, Health Office Park
Private Bag X 2068
MMABATHO
2735

INFORMATION & RECORDS MANAGEMENT

Tel: 018 391 4003
Emai: Okgabi@nwpg.gov.za
www.health.nwpg.gov.za

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STANDARD OPERATING PROCEDURE FOR CREATION, ACCESS TO, STORAGE, FILING, RETRIEVAL, TRACKING AND DISPOSAL OF CLINICAL RECORDS

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Author	INFORMATION AND RECORDS MANAGEMENT DIRECTORATE
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Description	This document defines North West Department of Health' position on standard operating procedures with regard to the management of clinical records' creation and/or receipt leading to their ultimate disposal.
Coverage	This document is applicable to all North West Department of Health institutions.
SOP Number	***I&RM23/SOP01/R26***

Table of Contents

1. Background

This Standard Operating Procedure (SOP) ensures compliance to the requirements as set by the Procedure Manual for Managing Clinical Records and other related prescripts.

2. Purpose

The purpose of this document is to provide instruction on proper creation and/or opening, storage, filing, retrieval, tracking and disposal of both clinical files and records.

3. Related Legislation

The following are the documents that may be referred to in case any clarity and/or detailed information is required: -

a) The Constitution of South Africa.
b) National Archives and Records Service of South Africa act (Act No. 43 of 1996 as Amended)
c) National Health Act (Act 61 of 2003).
d) Children's Act (Act No. 38 of 2005).
e) Access to Information Act (Act No. 2 of 2000).
f) Choice on Termination of Pregnancy Act (Act No. 92 of 1996).
g) Records Management Policy Manual.
h) Departmental Records Management Policy.
i) Departmental Procedure Manual for Managing Clinical Records.
j) HPCSA Guidelines on the Keeping of Patient – Booklet 14 of 2008.
k) Standard Operating Procedure for Filing, Archiving and Disposing of Patient Records in Primary Health Care Facilities.

4. Procedure

4.1 Creation of Records and/or Opening of Files

a) Clinical records must be created by both clerical staff and health professionals.

b) All files containing clinical records must be opened and referenced using patients' date of birth starting with the year, month, date and the first three letters of the surname **e.g. 830626 GOM (Gomolemo).**

c) All particulars (i.e. personal information) of the patient including the reference number must be written on the outside of the file as well as on all associated records; and be captured in the electronic system, where such system is available.

d) For filing and retrieval purposes, the reference number and the patient's names should be highly visible on the file cover.

e) There must be a register of opened files. Each and every official who opens a file must record in that register. The register would facilitate easy retrieval of files when the system is down, and also assist the officials to avoid duplicates.

f) In case the system is down, manual registration of patients must proceed; so that the information can be captured electronically when the system is up.

g) There must be a register in which outgoing files will be recorded. These files will be collected back by messengers from service points and will be reconciled or recorded back in the register. If some files are missing, the register would assist officials to trace them.

h) Create one file for each patient, in which all relevant documents are kept even if the patient re-attends after a long period, the same file should be used.

4.2 Access to Records

a) Medical records must be kept under the care and control of all institutions/facilities within the department.

b) Access to such records shall be subject to compliance with the requirements of the Access to Information Act and such conditions as may be approved by the superintendent.

c) Staff members who need access to files in storage area shall place a request for the files at the counter or telephonically.

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

i. A clinical record shall be provided to 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)).

ii. 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 (Access to Information Act (Act No. 2 of 2000)).

iii. 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)).

iv. No official 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 61 of 2003)).

e) A clinical record may only be made available to a third party without the written authorisation of the patient or his or her legal representative under the following circumstances:

I. Where a court orders the records to be handed to the third party;

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

III. Where the department 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).

IV. 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)).

V. Access to any records by external clients and/or stakeholders may be subjected to a fee as stipulated in the Uniform Patient Fee Schedule or any other legislative prescription.

4.3 Storage of Records

a) Clinical/patient records should ideally be stored in a singled location that is in close proximity to the patient registration desk.

b) The patient record storage rooms must meet all requirements set in Paragraph 4 of the National SOP for Filing, Archiving and Disposing of Patient Records in Primary Health Care Facilities.

c) All records must be stored in a safe and secure records storage area to safeguard their physical integrity and confidentiality.

d) The records in the storage area are under the management of the Chief Registry Clerk who is mandated to ensure that they are managed properly.

e) The storage area must always be locked when it is not in operation.

f) TB patients' files (and all other infectious diseases) must be kept and handled separately from all other files for infection control purposes.

4.4 Filing

a) Records must be filed by authorized and dedicated personnel only.

b) All clinical records must be filed according to patients' date of birth starting with the year, month, date and the first three letters of the surname **e.g. 830626 GOM (Gomolemo).**

c) All the associated patient records such as x-rays, specimens, drug records, etc. should be kept separately from FILES, due to size and format.
d) All records received for filing must bear a file reference number and only the above mentioned referencing system should be used.
e) Colour coding system to be implemented on clinical files utilizing **not less than four** colour coded stickers/labels.

4.5 Retrieval

a) As is the case with filing, clinical records must be retrieved by authorized and dedicated personnel only.
b) Records must be retrieved three days before the appointment date.
c) The retrieved files and reconciliation register must be used to retrieve.
d) All other requested records must be retrieved immediately and distributed within 15 minutes.
e) All retrieved records must be recorded in the relevant register and the file control cards placed on filing shelves if not files themselves before distribution.
f) All retrieved records must be distributed only to requestors and relevant service points.
g) All records that are requested from ICU, High Care, Renal Unit, Casualty and Maternity must be treated as emergency and should be distributed immediately after request.
h) All retrieved records and/or files must be returned to the records storage area within 24 hours; and recorded in relevant registers upon collection from different service points.

4.6 Tracking/Tracing of Unavailable Clinical Record

a) A clinical record is defined as unavailable if it is in use elsewhere and/or cannot be retrieved in time for any of the mentioned purposes; the other reasons may be that records have been misfiled or totally lost.
b) If a file cannot be found after repeated attempts, a duplicate file must be opened by delegated officials and recorded in pencil in the Register for Opened Files. Meanwhile, attempts must still be made to trace the original

file and when found, the contents of the temporary file must be amalgamated to it.

c) All records that are missing or not found in the storage area or filing room must be recorded; and the supervisor and/or facility manager as well as the requester and the patient thereof be notified.

d) Immediate follow ups must be made on all records that are missing or cannot be found; and the clients be advised or notified accordingly.

e) Notwithstanding the above procedure when files are missing; steps stipulated in Paragraph 6.1 of the December 2017 National SOP for Filing, Archiving and Disposing of Patient Records in Primary Health Care Facilities may be followed.

f) All unavailable files must be registered manually and/or captured electronically in the PAAB and/or HPRS system or any other electronic system for further reference and attention by relevant officials.

4.7 Disposal

a) All records that have been inactive for three years must be identified, sorted and separated from the active ones; and recorded in the inactive clinical files register; this must be performed at least once a year.

b) These records should be stored for a period of not less than six (6) years as from the date they became dormant or inactive before they are disposed

c) Patient records that must not be disposed of after six years are:

I. For minors under the age of 18 years health records should be kept until the minor's 21st birthday because legally minors have up to three years after they reach the age of 18 years to bring a claim.

II. Obstetric records until the child reached 21 years.

III. For mentally incompetent patients the records should be kept for the duration of the patient's lifetime.

IV. 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)

V. Records of patients that work under conditions that might have an impact on their health, e.g. asbestosis, should be kept for a sufficient period of time. These health conditions take a long period to be noticeable. The HPCSA recommends that this should not be less than 25 years.

VI. Records where possible claims against the state must be kept until the matter has been finalized.

d) In this whole process, the following must be ensured:

I. The records manager or a delegated official is always available

II. Records are only destroyed if such destruction is authorised by the Head of Health. The Head of Health can assign this responsibility to another designated staff member.

III. A facility no longer requires the records

IV. The records have no special security requirements

V. The records are not subject of a current or pending investigation or access request.

5. Related Registers and Documentation

The following are the registers pertaining to this procedure:-

1. Retrieved Files and Reconciliation
2. Inactive Clinical Records Register
3. Access Control Register
4. Register of Closed Clinical Files & Volumes
5. Register of Opened Clinical Files
6. Destruction Register

6. Glossary

File {Noun}	A folder containing related records together and in order for easy reference.
Record(s) {Noun}	1. For the sake of this document, any information created by, or on behalf of, a health professional in connection with the care of a patient regardless of form or medium 2. May also refer to a file containing such information
Records Storage Area/Registry	1. Office and depository, in which records are created, kept and managed 2. May also refer to offices where files are opened and kept like **ADMISSIONS, OUT-PATIENT DEPARTMENT and RECEPTIONS** in clinics and community health centers and with limited filing space

7. *SOP APPROVAL:*

Recommended/ not recommended

Mr. J. De Beer

Chief Director: Strategy and Systems

23/08/2023

Date

Approved/ not approved

Mr. O. E Mongale

Head of Department

North West Department of Health

23/08/2023

Date