



Ministry of Health
Directorate General of Private Health
Establishments

Medical Records Policy

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ISSUE HISTORY

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Definitions & Abbreviations

Patient: A patient is any individual treated or admitted in any private health establishment.

Patient Record: is a documentation of medical service rendered to a patient that is performed at the direction of a physician or other licensed healthcare professionals such as dentists, nurses or other allied healthcare professionals. Patient's records include diagnostic documentations such as x-rays, ECG, lab investigations, etc.

Attending Healthcare Professional: is the healthcare provider or most recently responsible for coordinating the patient care in a facility or in the case of outpatient services, is the custodian of the record of the outpatient service. If the attending healthcare professional is deceased or unavailable, the current custodian of the record shall designate a substitute attending healthcare professional, for purposes of compliance with these guideline.

Designated Representative (Legal Guardian) is a person authorized in writing or by court order to act on behalf of the patient or in front of attending healthcare professional. In the case of a deceased patient, the personal representative or, if none has been appointed, heirs shall be deemed to be designated representatives of the patient.

Custodian of medical record: is that person/department who has “care, custody and control of medical records, for such persons or institutions” that prepare medical records. Persons who could be the custodian of medical records include “a chiropractor, physician, registered physical therapist or licensed nurse,” as well as employee or agent of the same. The definition also includes facilities for convalescent care, medical laboratories and hospitals.

Competent person: Refers to a person legally capable of consenting a medical procedure. Every adult person is 18 years old and above is assumed to be competent to consent for medical procedure (He/she should be fully conscious and aware about his/her condition, able to receive and understand information relevant to their medical care, possible alternatives and consequences, capable to make decisions.

Next of Kin: The person who is authorized to make decision on behalf of the patient (In case of the patient is unconscious, minor or mentally ill), Next of Kin may include: Father, Mother, Adult sons – daughters or brothers / Husband or wife / Legal guardian or the sponsor (if next of kin as per the above mentioned level is not available, then relatives available from the same origin of the spouse's side will be considered as a next of kin.

Minor: any person from the birth to the age of 18 years

Health Information: Patient medical records, reports, registers, identified information.

Registers: Paper-based log book or electronic database



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Indefinite Period of Retention: Storage of records/information in their original form continuously without interruption; when indicated as indefinite, the original information will never be destroyed even if electronic/scanned versions are made available.

Scanning: Process of converting paper documents into electronic formats through document imaging process.

Allied Health Professional: are healthcare practitioners with formal education and clinical training who are credential through certification, registration and licensure. They collaborate with physicians and other members of the health care team to deliver high quality patient care services for the identification, prevention and treatment of diseases, disabilities and disorders.

Abbreviations:

MoH: Ministry of Health

PHEs: Private Health Establishments

DGPHE: Directorate General of Private Health Establishments



1. Purpose

It is one of the essential policies that should be in place to ensure public protection in any private healthcare establishments licensed by Ministry of Health in the Sultanate of Oman. It provides direction on medical records/ health information management, retention and disposal (regardless of the media – paper, electronics, films) and to ensure that medical records/health information are readily accessible, properly maintained as required for patient care purposes and also to meet legal standards, ensure privacy, optimize the use of space, minimize the cost of record retention and to destroy the medical record/information according to decided schedule for disposal as per this policy.

2. Scope

2.1 This policy applies to all Private Healthcare Providers (establishments and Professionals) licensed by MOH.

2.2 This policy applies in addition to other MOH Policies and Standards and the Code of Medical and Nursing Ethics.

3. Target Audience

Medical Records Officers / Technicians, Physicians, Dentists, Nurses, Paramedics and Health Care Establishments' Management

4. Responsibilities

4.1 DGPHE requires that the administration/management of all private health care establishments will be responsible to ensure the implementation of this policy through setting up and maintaining the required medical records system and functions. It is the responsibility of DGPHE to monitor the compliance of this policy by random audits of all types of medical records.

4.2 The Medical Records/Health Information Management of PHE is responsible for establishing appropriate record management practices under supervision of a qualified medical record offices/ technician as per the following:

- Implement medical record practices.
- Ensure that record management, retention and disposal procedures are consistent with the policy.
- Educate staff within the department as well as other concerned department's staff in understanding record retention, maintenance and disposal practices.
- Ensure the confidentiality of records/information during the process weeding/transferring to the offsite location.
- Ensure that storage systems (offsite & onsite) are equipped with environmental control, applicable safety & security measures. If commercial storage system is opted for, regular



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site visits to such companies should be arranged to confirm safety & confidentiality aspects.

- All cases of Birth & Death occurred at the your establishments should be notified to the Registrar of Births & Deaths, Royal Oman Police as per the norms of MoH and to furnish data to the statistical Department at MoH periodically.

5. Policy Statement

It is the policy of all private health establishments that the medical record shall contain sufficient information to identify the patient, support the diagnosis, to justify the treatment, document the results accurately and facilitate continuity of care.

6- Procedures

6.1 General Requirements:

- Each healthcare facility must maintain records and reports in a manner to ensure accuracy and easy retrieval.
- All private health establishments should have a legible, complete, comprehensive, and accurate patient record which must be maintained for each patient.
- All information relevant to a patient should be readily available for auditing by authorized officers from MoH.
- Patient information should be treated as confidential and protected from loss, alteration, destruction, and unauthorized or inadvertent disclosure.
- Records should be organized in a consistent manner that facilitates continuity of care.
- Discussions with patients concerning the necessity, appropriateness and risks of procedures, as well as discussion of treatment alternatives, should be incorporated into a patient's patient record as well as documentation of informed consent
- Each healthcare facility shall provide Patient records room or other suitable patient record area with adequate supplies and equipments. Patient records should be stored safely to provide protection from loss, damage, and unauthorized access and use..
- Patient records shall be maintained in the custody of health facility by a qualified medical record officer/technician in the case specialized clinics/centre, polyclinic and hospital; and shall be available to a patient or his/her designated representative through the attending healthcare professional or his/her designated representative at reasonable times and upon reasonable notice.



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- Patient Records must be maintained for every patient, including newborn infants, admitted for care in the hospital or treated in the emergency or outpatient service. Patient records may be created and maintained in written or electronic format, or a combination of both, and must contain sufficient information to clearly identify the patient, to justify the diagnosis and treatment and to document the results accurately and facilitate continuity of care.
- All PHEs should maintain various indices like Master Patient Index, Diagnostic Index, Operation Index, etc, to retrieve information whenever required either in manual or electronic formats.
- All PHEs should maintain Patient Register, Operation Register, Birth & Death Register, etc, either in manual or electronic format.
- Patient records must contain entries which are dated, legible and indelibly verified. The author of each entry must be identified by the name and designation and authenticated. Authentication must include official stamp, signature, written initials, or computer entries that can be validated
- Telephone or verbal orders of authorized individuals are accepted and transcribed by a qualified professional. Telephone or verbal orders must be documented immediately by the professional who receives the order and should be authenticated within 24 hours by the professional who is responsible for ordering, providing or evaluating the service furnished.
- If any changes, corrections, or other modifications are made to any portion of a patient record, the person must note in the record the date, time, nature, reason, correction, or other modification, his/her name and the name of a witness, to the change, correction, or other modification. Electronic form of patient record should have that ability to trace any change, or other modifications in the record with identification of the persons responsible for the change and the time and/or change took place.

6.2 Medical Records Completion & Review:

- Medical records are reviewed, during the abstracting and coding functions, for timeliness and completeness. This process is called the Discharge Analysis. For example, the record is checked to ensure that if the patient has had an operation, an operation report is in the record. In addition, the reviewer needs to check that all progress notes, investigation reports including pathology in case of operated patients, nursing notes etc., are available. There should also be a final discharge note made by the attending doctor indicating to where the patient has been discharged and arrangements to follow-up.



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- Sort the forms into the correct order as per the prescribed order. If the patient has been in hospital before, the older records are retrieved and the latest admission forms are added by placing them behind the appropriate admission divider.
- Check if the doctor has completed the diagnosis column in the front sheet. That is the main condition has been recorded along with any other condition treated while in the hospital.
- Check that if an operation or other surgical procedures were performed that they are recorded and the doctor has signed the front sheet. The signature of the doctor is important as it shows that the doctor has completed the medical record and takes the responsibility of the content.
- With the completion of the discharge analysis, two important procedures need to be undertaken. They are clinical coding and the collection of health care statistics.
- Medical Records are to be coded by the qualified coders to enable the retrieval of information on diseases and injuries, as per the latest revision of International Classification of Diseases (ICD), World Health Organization.
- Coded data are used to compile institutional morbidity and mortality statistics, for planning health care facilities at the respective healthcare facility and furnishing information to the MoH.
- A closed medical record review is done monthly on a representative sample of all practitioners by representatives of the medical staff.
- Aggregated reports of findings from the Medical Records staff and medical record reviews are forwarded to the Performance Management Committee (only for hospitals) on a quarterly basis.

6.3 Collection of Health Care Statistics

- Each facility obliged to furnish the monthly/annual Statistical Report as per the booklet supplied by the MoH.
- All supporting registers and diagnostic indexes as per ICD-10 are to be maintained to support furnished statistics.

6.4 Protection & Availability of Medical Records

- Records shall be kept on all patients admitted or accepted for treatment.



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- The medical record is the property of the facility and is maintained for the benefit of the patients, the medical staff and the facility.
- All required records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon request by:
 1. The attending physician
 2. The facility or its medical staff or any authorized officer, agent or employee or either:
 3. Authorized representatives of the DGPHE
 4. Any person authorized by law to make such a request
- Access to medical records is restricted to authorized personnel and medical staff.
- The facility shall safeguard the information in the medical record against loss, defacement, tampering or use by unauthorized persons.
- Controlled, locked access to the inactive medical record storage files is maintained.
- The Medical Records Department shall remain locked at all times when Medical Records personnel are not present. During such times, the Nursing Supervisor shall control access.
- The facility shall provide adequate measures and the maintenance of means to physically safeguard the medical record from loss by fire, water and foreseeable sources of potential damage.
- Medical Records shall be filed in an easily accessible manner in the facility or in an approved medical record storage facility off the facility premises.
- Records will be removed from the facility premises only by legal orders.
- Written consent by the patient or his/her legally qualified representative is required for release of information from the medical record.
- Records shall be signed out when removed from the Medical Records Department.
- Records needed for reasons other than patient care, (i.e., case studies, committee review) must be returned to the Medical Records Department before it closes. Records signed out for readmissions must be returned to Medical Records within 24 hours after patient's discharge.



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- Records shall be readily accessible at all times in the Medical Records Department or on the nursing unit while patient is in the facility. (Exception: Designated legal cases will be maintained in locked file cabinet.)
- When certain portions of the medical records are so confidential that extraordinary means are considered necessary to preserve their privacy (such as the treatment of some psychiatric disorders), those portions may be stored separately, provided the complete record is readily available when required for current medical care or follow-up, for review functions or for use in quality assessment activities. The medical record shall indicate that a portion has been filed elsewhere, in order to alert authorized reviewing personnel of its existence.

6.5 Legibility of Medical Records Documentations

It is the policy of DGPH to set legibility standards for medical record documentation and to monitor compliance with these standards as part of the performance improvement and medical error reduction activities. And this policy is applicable to all documentations within the medical records.

- Whenever possible, all consultations, histories and physicals, interpretations of diagnostic testing, and post operative/procedure results shall be dictated/recorded.
- Only approved abbreviations will be allowed to be used in medical records documentation. Abbreviations should not be used while writing diagnostic statements. They could be used only in clinical notes.

Note: Refer to the Annex I : Approved list of abbreviations and Annex II: Unaccepted use of abbreviations.

- Medication Orders:
 1. Should include a brief notation of purpose.
 2. All prescription orders are to be written in the metric system.
 3. “Units” should be spelt out.
 4. The order must include drug name, exact metric weight or concentration and dosage form.
 5. A leading zero must precede a decimal expression of less than one.



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6. A terminal zero is not to be used after a decimal.
 7. Prescribers are to avoid the use of abbreviations for drug names and Latin directions for use.
 8. The age and weight of the patient (especially geriatric and pediatric patients) should be included where appropriate.
- If a healthcare professional writes an order that is not legible, the order must be clarified with the healthcare professional prior to implementation.
 - Clarification of orders will be documented on the order sheet as a “clarification”, timed and dated and signed by the healthcare professional receiving the clarification.
 - Failure to clarify an illegible order will result in employee counseling.
 - Legibility will be monitored via concurrent and retrospective medical record review:
 - Unresolved legibility issues with physicians and allied healthcare professionals will be forwarded to the Information Management and/or Credentialing Committee.
 - Unresolved legibility issues with other healthcare professionals will be forwarded to their respective department managers and will be included as part of the annual review process.

6.6 Verbal and Written Orders (General)

- Orders for patient treatment and medications, including the administration of medications, to be carried out only when given by a qualified physician, surgeon, dentist, podiatrist or other person duly licensed or authorized to prescribe by MoH and who has been approved as a member of the medical staff of that PHE. All orders of medication and treatment shall be written into the medical record of the patient or, if appropriate, on a prescription form if taken by a Pharmacist.
- All orders for medications shall include the date and time of the order, the name of the drug, the dosage, the route, frequency of administration, age and weight of the patient, known allergies, the reason the medication is ordered for the patient and the name of the prescriber.
- All orders for treatment shall include the type of treatment, specific requirements of the treatment (such as wet or dry dressings, etc.) and the frequency of treatment.



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- **Written Orders:**

- These shall be filled when written as stated above and signed by the practitioner.

- **Verbal/Telephone Orders:**

- Only verbal/telephone orders from an approved licensed physician will be taken.
- Verbal/telephone orders of medication shall be received and recorded by the Pharmacist or licensed nurse. This does not preclude the taking of a verbal/telephone order by a specialty technician within the scope of their specialty allowed by law, which includes the Respiratory Technician, Physical Therapist, Imaging/Radiology Technician and Nuclear Medicine Technician.
- The order will be written on the physician order sheet by the person receiving the order and noting the date and time received, the name of the Physician issuing the order and the receiver's name and title.
- Record the verbal/telephone order immediately in the patient's medical record or, for pharmacists, on a prescription form as appropriate.
- A "read back" process will be conducted by the individual receiving the order, whereby the individual will read back, to the physician, the frequency and/or all instructions for use in the non-abbreviated format. Example: If an order is received for BID frequency, the receiver will read back the order to the prescriber as "to be administered or performed twice daily, or two (2) times per day". The physician shall verbally confirm that the order is correct.
- Indicate either telephone or verbal order in the written record.
- Sign the written record and indicate level of licensure.
- The prescribing practitioner, or another practitioner responsible for the patient's care, must date, time and authenticate the verbal/telephone order within 48 hours of giving the order (or in a time frame that complies with state regulation).
- The healthcare professional implementing the verbal or telephone order will document that the order was implemented in the appropriate portion of the medical record.



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- **Pre-printed Order:**
 - Pre-printed orders will be accepted if they have been approved by the Pharmacy and Therapeutics Committee of PHE.
 - The Pharmacy and Therapeutics Committee will review and update pre-printed order sheets as needed. This review will ensure pre-printed orders are clear, accurate and safe.
- **New Orders:**
 - New orders must be written for the patient upon transfer into and out of the ICU/CCU, postoperatively and at each facility admission, regardless of frequency of admission.
- **Blanket Orders Prohibited:**
 - The use of blanket orders is prohibited. Blanket orders that are prohibited include, but are not limited to:
 - Continue previous medications
 - Resume preoperative orders
 - Resume orders from floor
 - Discharge on current medications
 - All orders that are a resumption or continuation of previous orders must be rewritten in their entirety by the prescribing physician.
 - All orders for treatment or medications for discharge must be rewritten in their entirety by the prescribing physician.

6.7 Documentation of Operative and Other High Risk Procedures

- Reports of operative and other high-risk procedures will be dictated for inclusion in, or written in, the medical record immediately after the operative or other high-risk procedure.
- The comprehensive operative report must contain:
 - Preoperative diagnosis



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- Procedure(s) performed
 - Description of the procedure(s)
 - Clinical findings
 - Any specimens removed
 - Disposition of each specimen
 - Estimated blood loss
 - Postoperative diagnosis
 - Postoperative plan
 - Discharge details
 - Name of the primary surgeon, assistants and the anesthetist, if anesthesia was provided
- In the event the operative report is not available immediately following surgery, an operative progress note shall be entered into the patient's medical record containing pertinent information that may be required for anyone to care for the patient.
 - An operative report that has been dictated and transcribed must be authenticated by the surgeon and placed in the medical record within 24 Hours of the procedure.



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- In the event the operative/procedure report is not available immediately following the operative or high-risk procedure, an operative/procedure progress note shall be entered into the patient's medical record containing pertinent information that may be required for anyone to care for the patient. This progress note may be a more condensed, less detailed version of the comprehensive operative/procedure report; however, it should contain comparable information to the full report.
- **At a minimum the operative /procedure progress note must contain:**
 - Procedure(s) performed
 - Findings
 - Technical procedures used
 - Specimens removed
 - Disposition of each specimen
 - Estimated blood loss
 - Postoperative diagnosis
 - Name of primary surgeon and any assistants
- Operative and other high-risk procedure reports and/or progress notes will be dictated and/or written and authenticated by the individual performing the procedure.

6.8 Post-Operative Documentation

- Following surgery, the patient is monitored by qualified registered nurses for an appropriate period of time, prior to discharge. Documentation of this recovery period includes:
 - Patient's vital signs and level of consciousness
 - Medications and IV fluids
 - Any blood or blood products administered
 - Any unusual events or complications and management of those events
- A physician qualified in resuscitative techniques is immediately available until all patients have been discharged.



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- Patients are either discharged by the responsible licensed practitioner or by criteria approved by the medical staff of PHE.

6.9 Tracking and Locating of Medical Records

- The Medical Records Department is responsible for tracking the location of each medical record.
- Records must be signed out of the department and an “outguide” is filed in its place. The outguide should include the following information:
 - Patient name
 - Medical record number
 - Date requested
 - Name of person requesting the medical record
 - Where the record was sent
- Medical records are to be returned to the department within 24 hours.
- A list of medical record requests and locations is kept and updated daily

7. Component of Patient Records

7.1 Registration record content:

The registration section/department is responsible for collecting sufficient information to identify the patient. The information is documented on the face sheet, which is a permanent part of the patient's record. Sufficient information includes, but may not be limited to:

- Patient's file number
- Patient's full name
- Gender
- Patient's full Address
- Date of birth / Age
- Contact details
- Allergies

7.2 Outpatients' visit's record content:



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An individual clinical record is established for each person receiving care and will follow an established format as per this medical records policy.

- Date of visit
- Complete medical history including: chief complaint, known medical conditions, past surgeries, drugs allergies and known adverse drugs reactions.
- Clinical findings
- Diagnosis or impression
- Investigations ordered
- Plan of management including: therapies administered, prescriptions, referrals, admissions, etc.
- All reports of diagnostic and therapeutic procedures, tests and their results are documented and authenticated in the medical record.
- Documentation of missed/canceled appointments and follow-up
- All medications ordered.

7.3 Medications Record

Medication administration is documented in the patient's medication record which includes:

- Strength
- Dose, rate of administration
- Route
- Administration devices used
- Practitioner name and title

Note: Documentation of all care and treatment, medical and surgical, signed and stamped by attending physician.

7.4 Prescription sheet content:

- Name of clinic
- Address of clinic
- No. of clinic license
- Name of doctor, No. of doctor license and specialization
- Treatment.
- Name of the drug and form
- Strength
- Dosage
- Route of administration
- Duration of treatment

7.5 Patients' Sick Leave Certificates



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- Name of Health care Facility
- Full name of the patient
- Nationality
- Place of work
- Medical record number
- Date of visit
- Date of Inpatient and Discharge
- Diagnosis including reason for granting the sick leave
- Date of start of sick leave and end
- Name of doctor, designation , license number and signature
- Stamp of facility

7.6 Patients' Referral Files (Forms)

- Clinic name, license number and contact address
- Name of Doctor, license's number and specialiazation
- Patient's full name *I* tribe *I* family, age and sex
- Date of examination
- Laboratory and radiography tests
- Diagnosis
- Treatment
- Referred to
- Person coordinated referral within the receiving institution
- In case patient refuse referral and/or use of ambulance such refusal is documented
- Doctor's signature and clinic stamp

7.6 In-Patients Medical Record:

7.6.1 General Requirements:

- Clinical observations are made daily in the progress notes by the physician. Other persons making observations shall report on designated forms. These progress notes give a pertinent chronological report of the patient's course in the facility and reflect any change in condition, the results of treatment and plan of care revisions when indicated.
- Consultation reports contain a written or dictated opinion by the consultant that reflect an actual examination of the patient, when applicable, and the patient's medical record.
- Nurses' notes and entries by non-physicians contain pertinent and meaningful information and observations. This information is documented on the respective forms as approved by the Hospital Medical Records Committee.



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- Opinions requiring medical judgment are written and authenticated only by the medical staff members in the progress notes or on consultation reports.
- All reports of diagnostic and therapeutic procedures, tests and their results are documented and authenticated in the medical record.
- There is evidence of informed consent in the patient's medical record
- Imaging/Radiology, Anesthesia and any other diagnostic or therapeutic procedure are filed in the medical record within 24 hours of completion.
- All medications ordered are documented in the medical record.
- Medication administration is documented in the patient's medication record to include:
 - Strength
 - Dose, rate of administration
 - Route
 - Administration devices used

7.6.2 Inpatients medical records contents:

- Date and time of admission
- Complete and accurate identification data which include: patient' medical record number, full name of patient, age (date of birth), sex, nationality, martial status, occupation, address and telephone number and next of kin's name and address.
- A through medical history completed within 24 hours of admission
- A physician assessment
- Admission diagnosis
- Final diagnosis, secondary diagnosis, complications
- Plan of care.
- Reports of consultation by consulting physicians, when applicable.
- Evidence of appropriate informed consent
- Reports of all diagnostic and therapeutic procedures
- Reports of pathology, radiology and laboratory examinations
- Operative reports and anaesthesia reports
- Discharge summary.
- Any documentation signed by the patient relating to the treatment e.g. Consent for a procedure /operation
- Signature and official stamp of attending physician.

7.6.2 Progress notes record:



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- The progress notes are written as frequently as may be required or as indicated by the condition of the patient.
- Should provide a summary of the condition of the patient on admission
- The writing should be definite and accurate statement.
- It should include a summary of the patient's general condition.

7.7 Discharge summary record content:

Discharge report: must be given to the patient on discharge without charge, the discharge card should contain the following (where applicable and as per case type):

- Patient demographic information
- Date of admission and discharge
- Diagnosis and allergies
- Any operation or procedure
- Discharge medication and plan
- Name and signature of attending physician with facility name
- Autopsy findings; and death certificate
- Advanced Directives, if available.
- Patient education
- Social and psychological review.
- Vaccination records
- Future treatment plan and follow up requirements
- Police care clearance
- Incident summary report of patient leaving against medical advice (LAMA) Signature and official stamp of attending physician.
- .

7.8 Nursing Records

- **Basic Nursing Forms (mandatory):**
 - Initial Nursing Assessment Form
 - Nursing Care Plan
 - Nurses Notes Form (progress notes)
 - Temperature, Pulse, Respiration and blood pressure chart
 - Paediatric Observation Chart
 - 4 Hour Nursing Report
 - Medication chart
 - Pain documentation
 - Patient/family Education
 - Any special dietary requirements
- **Special Nursing forms(when applicable)**
 - Special observation chart



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- Pre operative checklist
- Labour record
- Weight Chart
- Fluid Balance Chart
- Diabetic Chart
- Newborn identification form
- Nursing assessment of the newborn in sbcu(special baby care unit)
- ICU (intensive care unit) Chart
- Infection chart
- MICU(medical ICU) / PICU(paediatric ICU) flow chart
- NICU(neonatal ICU) chart
- Neonatal intensive care unit / IV fluid intake / output chart
- Feeding chart
- NICU/SBCU for high frequency
- Investigation flow sheet
- Partial exchange transfusion chart
- Paediatric peritoneal dialysis
- Anticoagulant drug chart
- Conscious sedation
- Haemodialysis profile
- Manual peritoneal dialysis chart
- Diabetic ketoacidosis chart
- Out and pass forms
- Transfer slip

7.9 Obstetric Content

- Records of all obstetric patients shall include, in addition to the requirements for patient records, the following :
- Record of previous obstetric history and pre-natal care including blood serology, and RH factor determination.
- Admission obstetrical examination report describing condition of mother and foetus.
- Complete description of progress of labour and delivery, including reasons for induction and operative procedures.
- Records of anaesthesia, analgesia, and medications given in the course of labour and delivery
- Records of foetal heart rate and vital signs
- Signed reports of consultants when such services have been obtained
- Progress notes including description of involution of uterus, type of lochia, condition of breast and nipples, and report of condition of infant following delivery
- Names of assistants/midwives present during delivery

7.10 Newborn Records Content



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Records of newborn infant shall be maintained as separate records and shall contain the following:

- Date and time of birth, birth weight and length, period of gestation, sex .
- Parents' names and addresses.
- Type of identification placed on the infant in the delivery room.
- Description of complications of pregnancy or delivery includes premature rupture of membranes; condition at birth including colour, quality of cry, method and duration of resuscitation.
- Record of prophylactic instillation into each eye at delivery.
- Results of Phenyl Keto Urea (PKU) tests.
- Report of initial physical examination, including any abnormalities, signed by the attending physician.
- Progress notes including temperature, weight, and feeding charts; number, consistency, and colour of stools; condition of eyes and umbilical cord; condition and colour of skin; and motor behaviour.

7.11 Operation / Surgical Procedures Record Content:

Records of all patient undergoing surgery shall include, in addition to the requirement for patient record, the following:

- Consent to operation/procedure
- preoperative diagnosis
- name of operation
- full description of findings
- both normal and abnormal of all organs explored
- procedures, ligatures and sutures used
- the technique used
- the tissue removed or altered
- post-operative diagnosis
- the patient condition at the conclusion of the procedure
- the details of tissue removed and sent for histopathological examination
- The pathologist's report on all tissues removed at the operation
- names of all surgeons, anaesthetists and nurses who are involved
- the operation report should be written immediately after the operation and signed by the surgeon and his or her assistants.

7.12 Anaesthesia record:

- preoperative medication given: name, type, dose, date and time
- Techniques used
- Fluid balance and supplementary drugs given
- Vital signs record
- Any complications occurring during surgery.



8. Medical Records Retention and Disposal

This section provides direction on medical records / health information retention and disposal (regardless of the media – paper, electronics, films) and to ensure that medical records/health information are readily accessible, properly maintained as required for patient care purposes and also to meet legal standards, ensure privacy, optimize the use of space, minimize the cost of record retention and to destroy the medical record/ information according to decided schedule for disposal as per policy.

8.1 POLICY STATEMENT

- A medical record shall be retained on all patients admitted or accepted for treatment to private health establishment.
- The medical record is the property of the facility and is maintained for the benefit of the patient, the professional staff and the facility.

8.2 Responsibilities:

All Private health establishments (PHE) are required to maintain medical records/health information for specified period of time. While minimum retention requirements are absolute, there is nothing to prevent a facility from retaining records of periods well beyond the specified minimum. This may be considered appropriate at a local level for ongoing access or future research.

8.3 Procedures

- Scanning / other reproduction methods and offsite storage systems can be adopted as retention options.
- The offsite storage system should ensure the same level of access, safety and security of the records/information.
- Destruction of records/information should be practiced in accordance with the disposal schedule.
- The inspection will be conducted by DGPHE inspectors to ensure that the private health establishment's management has applied this policy for retention and disposal of medical record and if non compliance is identified then disciplinary action will be taken against that facility.
- Access on behalf of a patient or deceased includes any use of the record concerning the patient or deceased, or access to the record for any purpose such as in the provision of a report to another health care worker or agency or inspection by the patient or deceased's next of kin. Access in response to release of information, requests for research or for the



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education of health professionals would not be counted as “access on behalf of the patient”.

- There must be bi-annual meetings between the management of PHE and outsourced companies (if applicable to the facility) to discuss the ways of destruction of medical record/health information and also ensure improvement in the process.
- The Medical Records/Health Information Management Department is responsible for establishing appropriate record retention and disposal management practices as per the following:
 - Implement record retention and disposal practices
 - Ensure that record management, retention and disposal procedures are consistent with the policy.
 - Educate staff within the department as well as other concerned department staff in understanding sound record retention and disposal practices.
 - Ensure the confidentiality of records/information during the process weeding /transferring to the offsite location.
 - Ensure that storage systems (offsite & onsite) are equipped with environmental control, applicable safety & security measures. If commercial storage system is opted, regular site visits to such companies should be arranged to confirm safety & confidentiality aspects.

Medical Record/Health Information Retention and disposal Schedule (See Annex III)

8.4 Disposal and destruction of records

- The systematic permanent disposal of medical records that have been maintained for the prescribed retention period is the overall responsibility of concern health care facility. The purpose of disposal or destruction is to permanently remove records from active use, with no possibility of reconstructing the information.
- The following steps are must be adopted by the management of health care facilities before the destruction of medical records:
 - Medical record that is scheduled for destruction must be placed in a secure location to guard against unauthorized or inappropriate access until the destruction takes place.
 - Create a record destruction log, individually listing all medical records (i-e individual patient care records) to be destroyed. That log book should include following information:
 1. Patient name and medical record number



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2. Dates of service included
 3. Date of destruction
 4. The name of the company performing the destruction
 5. Signature(s) of individuals witnessing destruction
 6. Method of destruction
- Record destruction logs must be maintained/retained and secured permanently for tracking purposes.
 - There must be planned site visit by health care facility management in coordination with the disposal company to ensure the confidentiality of medical record and to witness that the record has completely destroyed.
 - The methods of destroy such as burning and burial are not reliable. Therefore MoH is not recommending these methods. It is critical that the method of destruction does not compromise the confidentiality and integrity of patient information, either in the short or long term.
 - It is recommended that records which are approved for destruction after completing the retention period be destroyed by methods of shredding, trammeling or pulping.

9. Compliance and Enforcement with this guideline

- All private health facilities licensed by MoH shall submit to DGPHE a copy of their policy and procedure to comply with this guideline and all forms used to implement it, and shall promptly submit to DGPHE any future amendments to such policies and procedures.
- To ensure compliance of these policies, periodic visits will be done by DGPHE audit team.
- DGPHE has full authority to request the original medical records if needed with promising to return it to the facility with its original arrangement.
- Non compliance with these standards and after investigation and verification that the violation of rules and regulations is true, one of the following penalties will apply based on the seriousness' of violation:
 - Warning letter
 - Financial penalties
 - Suspension of duty of physician for no more than 1 (one) year
 - Closing the facility for a period of no more than 60(sixty) days
 - Cancellation of the person's license



10. References

- 1- Ministry of Health, Medical Records Policies & Procedures Manual, 1998
- 2- Dubai Health Authority, Patients Records Guidelines, Draft version.
- 3- Health Authority- Abu Dhabi: Medical Record/Health Information Retention & Disposal Policy, version 1, last revision May 2009.
- 4- World Health Organization, Medical Records Manual: A Guide for Developing Countries, Revised and updated 2006.