حكومة دبي
GOVERNMENT OF DUBAI

هيئة الصحة بدبي
DUBAI HEALTH AUTHORITY

GUIDELINES FOR MANAGING HEALTH RECORDS

Version 2

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Health Policies and Standards Department

Health Regulation Sector (2019)

INTRODUCTION

Health Regulation Sector (HRS) forms an integral part of Dubai Health Authority (DHA) and is mandated by DHA Law No. (6) of 2018, to undertake several functions including, but not limited to:

- Developing regulation, policy, standards, guidelines to improve quality and patient safety and promote the growth and development of the health sector
- Licensure and inspection of health facilities as well as healthcare professionals and ensuring compliance to best practice
- Managing patient complaints and assuring patient and physician rights are upheld
- Managing health advertisement and marketing of healthcare products
- Governing the use of narcotics, controlled and semi-controlled medications
- Strengthening health tourism and assuring ongoing growth
- Assuring management of health informatics, e-health and promoting innovation

The Guidelines for Managing Health Records aims to fulfil the following overarching DHA Strategic Objectives and Program within the Dubai Health Strategy (2016–2021):

- Objective 1: Position Dubai as a global medical destination by introducing a value-based, comprehensive, integrated and high-quality service delivery system
- Objective 2: Direct resources to ensure happy, healthy and safe environment for Dubai population
- Strategic Program 10: Excellence & Quality, which promotes excellence in healthcare service delivery in Dubai while enhancing patient happiness, experience, satisfaction and trust

ACKNOWLEDGMENT

The Health Policy and Standards Department (HPSD) developed this Standard in collaboration with Subject Matter Experts. HRS would like to acknowledge and thank these professionals for their dedication toward improving quality and safety of healthcare services.

Health Regulation Sector

Dubai Health Authority

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EXECUTIVE SUMMARY

Managing health records is a fundamental pre-requisite for providing safe, effective and high quality healthcare services. Managing health records plays an important role in assuring accurate and timely information is readily available to healthcare providers, payers, researchers, administrators, and patients. The prospect of digitising health records has opened up a number of opportunities to drive efficiency, quality and continuity of care. Electronic data creates new opportunities for detailed and accurate healthcare service analysis to drive improvements within the health system. While the use of Electronic Health Records continues to evolve concerns about patient, privacy and data security remain. Patient privacy and data security must therefore not be ignored and action must be taken to assure the potential misuse of health records through digitisation technologies and ensure they are minimised as far as possible.

This guideline encourages the adoption of best practices for the management of health records. This guideline is not obligatory nor exhaustive; therefore, health facilities are encouraged to determine the best approach for managing health records in their own setting with the provision that they are aligned to best practices and the UAE Laws and regulations.

This guideline was first developed in 2012 under the name of Health Record Guidelines. The revisions are intended to reflect the transformational change across the Dubai Health System. Several amendments and updates have been incorporate into this guideline and include, but not limited to the following:

- Method of documentation
- Management of Health Records as part of business continuity

- Transfer of Paper Based Health Records to Electronic Health Records
- Data Protection and Confidentiality

DEFINITIONS

- **APGAR score** is a rapid test performed on a baby at 1 and 5 minutes after birth. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score tells the doctor how well the baby is doing outside the mother's womb.

- **Attending Healthcare Professional** is the healthcare provider that has the principal responsibility for the coordination of health care needs of a patient admitted to a facility whether as an in-patient or as an out-patient. In these guidelines health professional should refer to a physician, a licensed nurse, a physiotherapist or a TCAM practitioners.

- **Custodian of Health Record** is that person/department who has the responsibility of "care, custody and control of patients' health records, for such persons or institutions" that prepare health records. Persons who could be the custodian of health records include ", physician, licensed nurse or a physiotherapist or TCAM," as well as employee or agent of the same. The definition also includes facilities for convalescent care, medical laboratories and hospitals.

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

- **Electronic Health Record (E-HEALTH RECORDS)** is a systematic collection of electronic health information of an individual patient in a digital format that enables information to be used and

shared over secure networks. It is a more efficient way of maintaining health records as it ensures that data collected is appropriate, accurate and legible with reduced chances of replication.

- **E-Signature** is a piece of software, attached to other data (e.g. an email), which acts in the same way that a written signature does in order to authenticate the origin and integrity of the data.

- **Health Record** is a single record of all data on an individual health status from birth to death.

- **Minor** is any person under the age of 18 years.

- **Next of Kin** is the person authorized to make decision on behalf of the patient (In case of the patient is un-conscious, minor or mentally ill). Next of Kin may include Father, Mother, Adult sons/daughters, brothers/spouse/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)[1].

- **Patient** is any individual who receives medical attention, care or treatment by any healthcare professional or is admitted in a health facility.

- **Scanning** is the process of converting paper documents into electronic format through image processing.

[1] Further information on minors and next of kin is available in Federal Law number (5) of 1985 and the Federal Law number (1) of 1987

ABBREVIATIONS

CTG	:	Cardiotocography
DHA	:	Dubai Health Authority
DSC	:	Day Surgical Center
HRS	:	Health Regulation Sector
ICU	:	Intensive Care Unit
IV	:	Intravenous
PICU	:	Pediatric Intensive Care Unit
PKU	:	Phenyl Keto Urea
MICU	:	Medical Intensive Care Unit
NICU	:	Neonatal Intensive Care Unit
Rh	:	Rhesus factor determination
SBCU	:	Special Baby Care Unit
SOAP	:	Subjective Objective Assessment Plan

1. BACKGROUND

A health record is a legal document that should accurately outline the total needs, care and management of patients. It represents the written collection of information about a patient's health and treatment and can be used for the present and future care of the patient. Health records facilitate communication, decision-making and evaluation of care in addition to protecting the legal interests of the patient, healthcare professionals and the health facility. Health records cannot be managed unless there is a system to assure different records are managed to meet the service needs. An effective records management system ensures that information is properly managed and is available whenever and wherever there is a justified need for that information to:

- Support patient/client care and continuity of care
- Support service provision
- Support day-to-day business which underpins the delivery of care
- Support evidence-based clinical practice
- Assist clinical/professional and other types of audits
- Support improvements in clinical/professional and service effectiveness through research and also to support archival functions by taking account of the historical importance of material and the needs of future research
- Support choice and control of patients and clients over treatment and services
- Support sound administrative and managerial decision making, as part of the knowledge base for DHA
- Meet legal requirements, including requests from the patients, DHA and the Courts

2. PURPOSE

2.1. The purpose of this guideline is to encourage the adoption of best practice for managing health records by all DHA licensed health facilities.

3. SCOPE

3.1. Management of health records within DHA licensed health facilities.

4. APPLICABILITY

4.1. All DHA licensed healthcare health facilities and services.

5. **RECOMMENDATION ONE:** CONTENT OF HEALTH RECORDS

5.1. Each patient health record should contain the following information, but not limited to:

5.1.1. Three unique patient identifiers (DOB, emirates ID number, full name and address)

5.1.2. A unique identifier for the health record

5.1.3. A system to alert staff of patients with the same name

5.1.4. Time and date of where the patient was last seen

5.1.5. Full Patient History which includes but is not limited to: chief complaint, present illness, social and psychological review, medication allergies, family history of illnesses, present complaint and previous complaints, past medical history, physical examination and system review

5.1.6. Admission diagnosis

5.1.7. All pathology/laboratory and radiology reports

5.1.8. Properly executed informed consent form(s)

5.1.9. Physicians order(s) including medication, referrals, sick leave

5.1.10. Pain assessment

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

5.1.12. Histopathology and tissue reports

5.1.13. Progress notes of all disciplines

5.1.14. Transcriptions

5.1.15. Discharge summary

5.1.16. Discharge card: should be given to the patient on discharge without charge

5.1.17. Autopsy findings; and death certificate (in case of death)

5.1.18. Advanced Directives (if available)

5.1.19. Patient education and goals

5.1.20. Vaccination/immunization records

5.2. It is the attending healthcare professional's responsibility to flag a patient's record denoting any medication allergies, or any special information/needs like HIV, Hepatitis, blindness, disability etc.

6. **RECOMMENDATION TWO:** METHOD OF DOCUMENTATION

6.1. All healthcare professionals should document their notes in the patient's health records by adopting an organised method of documentation, which is unified for the health facility. This will facilitate communication between various healthcare professionals, health facilities and DHA.

6.2. Assessment of findings should be documented in a uniform manner and location in the patient's health record.

6.3. An example of a popular documentation method is Subjective Objective Assessment Plan (SOAP). The four parts of SOAP are noted below:

6.3.1. **SUBJECTIVE**: The "S" portion of the SOAP note documentation format consists of subjective observations. These are the recordings of the symptoms that the patient verbally expresses or as stated by someone speaking for the patient. These subjective observations include the patient's descriptions of pain or discomfort, the presence of nausea or dizziness and a multitude of other descriptions of dysfunction, discomfort or illness that the patient describes.

6.3.2. **OBJECTIVE:** "O" is for the objective observation. These objective observations include symptoms that can actually be measured, seen, heard, touched, or felt. These include but not limited to the patients' vital signs such as temperature, pulse, respiration, swelling and the results of diagnostic tests.

6.3.3. **ASSESSMENT:** "A" is for assessment and follows the objective observations. Assessment is the diagnosis of the patient's condition. In some cases the diagnosis may be clear, such as a contusion. However, an assessment may not be clear and could include several diagnosis possibilities.

6.3.4. **PLAN**: The last part of the SOAP note, "P", is the plan. The plan may include ordered medications, laboratory and/or radiology tests, treatments, patient referrals (sending patient to a specialist), patient disposition (e.g., home care, bed rest,

short-term, long-term disability, days excused from work, admission to hospital), patient directions and follow-up directions for the patient.

7. **RECOMMENDATION THREE:** MANAGEMENT OF HEALTH RECORDS

7.1. Health Records should be maintained for every patient, including newborn and infants, and for patients admitted for care in the hospital or treated in the emergency or outpatient services.

7.2. Health records may be created and maintained in written paper form or electronic format, or a combination of both, and should contain sufficient information to clearly identify the patient, to justify the diagnosis and treatment and to document the results accurately.

7.3. Health records should contain entries, which are dated, legible and indelibly verified.

7.4. The author of each entry should be identified and authenticated. Authentication should include: Official stamp, signature, written initials or computer entry.

7.5. Where e-signature is being adopted, the user should be issued with a unique username and password to identify the user.

7.6. Telephone and Verbal Orders

7.6.1. The most error-prone communications are patient care orders given verbally and those given over the telephone. The health facility should develop appropriate policy and procedures for the management of telephone and verbal orders and where necessary, implement clinical protocols to minimise their use.

7.6.2. Telephone or verbal communications by an authorized healthcare professional such as, lab tests should be transcribed and documented (within 24 hours) by a qualified healthcare professional.

8. **RECOMMENDATION FOUR:** INFORMED CONSENT

For information regarding Patient Informed Consent, refer to the DHA Guidelines for Patient Informed Consent.

9. **RECOMMENDATION FIVE:** STORING HEALTH RECORDS

9.1. A legible, complete, comprehensive and accurate health record should be maintained and stored by the health facility for each patient in English or Arabic language.

9.2. Health Records should be stored to ensure easy retrieval.

9.3. Each health facility should provide a temperature controlled health record storage room or other suitable health record keeping area with adequate supplies and equipment.

9.4. Health records should be stored securely to provide protection from loss, damage, unauthorized use and theft.

9.5. Health records should be maintained in the custody of the health facility and should be available to the treating physician and or the patient or his/her designated representative at reasonable times and upon a reasonable notice period.

9.6. Health facilities may consider the option of scanning paper based health records into electronic format records (e-health records) or establish primary electronic records with adequate back up and retrieval functionality to improve the efficiency and management of patient information.

9.7. When paper based health records are scanned and saved as e-health records, they may be placed in a designated secondary storage area other than the health facility.

9.8. Handling and transferring health records should be achieved in a manner to ensure information security and patient confidentiality.

9.9. The health facility should have in place policy and procedures for data security and protection, confidentiality, handling, storage, archiving and destruction of both paper and e-health records.

10. RECOMMENDATION SIX: INPATIENT HEALTH RECORDS

10.1. Inpatient health record contents are applicable only to health facilities providing inpatient care such as Hospitals and Day Surgical Centre (DSC) setting.

10.2. Inpatient Health records may include, but is not limited to the following:

10.2.1. Patient contact details

10.2.2. Date and time of admission and discharge

10.2.3. Adequate identification - sociological data (including hospital number assigned to patient)

10.2.4. A signed informed consent by the patient or his/her designated representative

10.2.5. History, physical, special examinations, and diagnosis recorded prior to operation

10.2.6. Admission diagnosis

10.2.7. Care plan

10.2.8. Reports of consultation by consulting physicians, when applicable

10.2.9. Identification of correct site of surgery

10.2.10. Verify pre-operatively the correct site, correct procedure and the correct patient and counterchecked by the treating physician as well as the attending Registered Nurse (timeout procedure)

10.2.11. Anaesthesia record, including post-anaesthetic condition signed and stamped by the anaesthesiologist, or surgeon

10.2.12. Signed permission for surgery, anaesthesia, autopsy and other procedures when necessary

10.2.13. Complete description of operative procedures and findings including post-operative diagnosis recorded and signed and stamped by the attending surgeon promptly following the operation

10.2.14. Histopathology report on all tissues removed at the operation

10.2.15. Admission diagnosis, final diagnosis, secondary diagnosis, complications and condition on discharge

10.2.16. Signature and official stamp of attending physician.

10.2.17. Operative procedures and complications during surgery (if any) and any other relative information such as amount of blood loss during operation, etc.

11. RECOMMENDATION SEVEN: NURSING RECORDS

11.1. Nursing records should include but not be limited to:

11.1.1. Initial Nursing Assessment Form

11.1.2. Nursing Care Plan

11.1.3. Nurses Notes Form (progress notes)

11.1.4. Temperature, Pulse, Respiration and Blood Pressure Chart

11.1.5. Pediatric Observation and Assessment Charts (where applicable)

11.1.6. Twenty four (24) Hour Nursing Report (if applicable)

11.1.7. Medication Chart (Drug Chart)

11.1.8. Pain Assessment

11.1.9. Patient/family education

11.1.10. Fall Assessment

11.2. Special Nursing forms should include but is not limited to:

11.2.1. Special Observation Chart

11.2.2. Pre-operative checklist

11.2.3. Labor record

11.2.4. Weight Chart

11.2.5. Fluid Balance Chart

11.2.6. Diabetic Chart

11.2.7. New-born identification form

11.2.8. Nursing assessment of the new-born in SBCU (special baby care unit)

11.2.9. ICU (intensive care unit) Chart

11.2.10. Infection chart

11.2.11. MICU (medical ICU)/PICU (pediatric ICU) flow chart

11.2.12. NICU(neonatal ICU) chart

11.2.13. Neonatal intensive care unit/Intravenous (IV) fluid intake/output chart

11.2.14. Feeding chart

11.2.15. Investigation flow sheet

11.2.16. Partial exchange transfusion chart

11.2.17. Pediatric peritoneal dialysis

11.2.18. Anticoagulant drug chart

11.2.19. Conscious sedation

11.2.20. Hemodialysis profile

11.2.21. Manual peritoneal dialysis chart

11.2.22. Diabetic ketoacidosis chart

11.2.23. Out and pass forms

11.2.24. Transfer slips.

12. RECOMMENDATION EIGHT: OBSTETRIC RECORDS

12.1. In addition to the requirements of health records, records of all obstetric patients should include the following information, but not limited to the following:

12.1.1. Record of previous obstetric history and pre-natal care including blood serology and Rhesus factor determination (Rh).

12.1.2. Admission, obstetric examination, report describing condition of mother and fetus, including ultrasound report or any other related tests

12.1.3. Complete description of progress of labor and delivery, including reasons for induction and operative procedures

12.1.4. Records of anaesthesia, analgesia, and medications given during the course of labor and delivery

12.1.5. Cardiotocography Records (CTG) of contraction and fetal heart rate records

12.1.6. Signed reports of consultants when such services were obtained

12.1.7. Progress notes including description of involution of uterus, type of lochia, condition of breast and nipples, and report of condition of infant following delivery

12.1.8. Names of assistants/midwives present during delivery.

13. RECOMMENDATION NINE: NEWBORN RECORDS

13.1. Records of newborn infants should be maintained as separate records and should contain the following, but not limited to:

13.1.1. Date and time of birth, birth weight and length, period of gestation, sex, APGAR score and blood group

13.1.2. Parents' names and addresses

13.1.3. Type of identification placed on the infant in the delivery room.

13.1.4. Description of complications during pregnancy or delivery which includes (but not limited to) premature rupture of membranes; condition at birth including colour, quality of cry, method and duration of resuscitation.

13.1.5. Record of prophylactic instillation into each eye at delivery

13.1.6. Results of Phenyl Keto Urea (PKU) tests

13.1.7. Report of initial physical examination, including any abnormalities, signed by the attending physician

13.1.8. 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.

14. RECOMMENDATION TEN: DISCHARGE SUMMARY

14.1. Each health facility should provide a discharge summary/card to the patient upon discharge, which should include, but not be limited to the following details:

14.1.1. Date and time of admission and discharge

14.1.2. Adequate identification (including record number assigned to patient)

14.1.3. Admission diagnosis

14.1.4. Final diagnosis, secondary diagnosis, complications

14.1.5. Operative procedures (if applicable)

14.1.6. Condition on discharge with medication

14.1.7. Follow up plan

14.1.8. Signature and official stamp of attending physician.

14.2. When a patient has been advised to seek additional care for further assessment, treatment, and follow-up, the patient's health record will contain documentation of the given advice.

14.3. Assessment findings should be integrated and documented in the patient's health record and readily available to those responsible for the patient's care.

14.4. Relevant findings from assessments performed outside the health facility should be included in the patient assessment process and health record.

14.5. The organization defines the process for obtaining and using outside assessment findings and reports.

15. RECOMMENDATION ELEVEN: ACCESS/RELEASE OF PATIENT INFORMATION

15.1. Health records can only be accessed by the patient or designated representative under supervision of attending physician or other responsible healthcare professional.

15.2. The patient or designated representative has the right to request copies of medical reports, or a copy of the previous reports, but not the original health record. The health record should be maintained by the health facility.

15.3. No fees should be charged by a healthcare professional for health records request received from another healthcare professional for continuing medical care to the patient.

15.4. The health facility may supply a written interpretation by the attending healthcare professional or his/her designated representative of records, such as x-rays, which cannot be reproduced without special equipment. If the requestor prefers to obtain a copy of such records, he/she should pay the actual cost of such reproduction.

15.5. Copies of health records in the custody of emergency rooms of health facility should be available to other health facilities, patients or their designated representatives upon request.

15.6. Health facilities seeking to close services must ensure arrangements are made for patient records to be transferred to the appropriate provider upon patient consent.

16. RECOMMENDATION TWELVE: RECORDS WITH NEGATIVE IMPACT

16.1. It is the attending healthcare professional's responsibility to flag if any part of the patient's health record may contain information that has a significant negative psychological impact on the patient. The recorded information should not be released to the patient and/or designated representative without the consent and knowledge of the attending physician.

17. RECOMMENDATION THIRTEEN: RECORD COMPLETION

17.1. Examination, diagnosis and assessment findings should be integrated and documented in the patient's health record and readily available to those responsible for the patient's care.

17.2. Timeframes should be established for completing patient history, physical and psychosocial examinations, discipline-specific assessments and when appropriate, reassessments. Periods for initial assessments and reassessments may differ according to setting, unit, service (such as surgery, dental, etc.), and patient acuity.

17.3. All orders for diagnostic procedures, treatments and medications should be signed and stamped by the physician submitting them and entered in the patient health record. The prompt completion of a patient record should be the responsibility of the attending physician.

17.4. Rubber stamp should include physician name, specialty and license number.

17.5. Authentication may be acceptable through written signature and stamp, identifiable initials or computer key. The use of stamp signatures is acceptable under the following conditions:

17.5.1. The physician using the rubber stamp signature is, the only person authorized for the possession of the stamp and is the only one who may use it.

17.5.2. The physician places in the administrative office of the hospital a signed statement to the effect that he is the only one who has the stamp and is the only one who uses it.

18. RECOMMENDATION FOURTEEN: MODIFICATIONS OF HEALTH RECORD

18.1. If any changes, corrections, or other modifications are made to any portion of the patient's health record, the healthcare professional should note in the record the date, time, nature, reason, correction, or other modification in addition to his/her name and the name of a witness to the change, correction, or other modification done unto the health record.

18.2. The use of correctors (white ink) or any form of erasable pens should not be used.

18.3. Electronic form of health records should have that ability to trace any change, or other modifications in the health record with identification of the person who did the change or modification.

18.4. Any change in the documentation or patient information done on purpose and without proper documentation will be considered unethical and should bear legal consequences.

18.5. Initials should never be used to authenticate assessments or narrative documentation.

19. RECOMMENDATION FIFTEEN: DATA PROTECTION AND CONFIDENTIALITY

19.1. Health facilities should carefully monitor staff on who accesses patient health records.

19.2. Health facilities should have stringent policy for maintenance, data protection, privacy and confidentiality of health records.

19.3. Systems and software products should include protections against modification and unauthorised editing and should be aligned Federal Law No. (2) of 2019 regarding the use of ICT in health fields and Health Information Interoperability Standards.

19.4. The health facility should apply administrative safeguards for protection of e-signatures supported by in-house policies, protocols and procedures.

19.5. A data guardian should be nominated by the health facility to ensure all necessary protections are in place and are fit for purpose from internal and external breaches and risks.

19.6. The health facility should put in place controls for data access including securing controls, authorization rules, duration and extent of access.

19.7. Health information should be anonymized and pseudonymised where possible to reduce the risk of data manipulation by unauthorized access.

19.8. Agreements of understanding should be in place where data is regularly being shared across one or more healthcare providers for patient continuity of care.

20. RECOMMENDATION SIXTEEN: RETENTION OF HEALTH RECORDS

20.1. In in-patient, health facilities such as Hospitals and Day Surgical Centers, custodian of health record should be in the following order, Staff/Unit/Section and are responsible for the retention of patient health records, data and information.

20.2. In ambulatory care setting and diagnostic centers, the Medical Director should be the responsible person for the retention of patient health records, data and information.

20.3. Paper based Health Records of UAE national patients should be retained for up to ten (10) years following the most recent patient visit/admission to the health facility. Such records may then be entered into the Image Processing System. Decision to maintain original records beyond this period is subject to the health facility management's decision and legal advice.

20.3.1. Retention after this period is subject to the type of record and special circumstances for example VIP cases. In such cases, it is advisable for the health facility to seek legal advice.

20.4. Paper based Health Records for expatriate patients should be retained up to five (5) years after the most recent patient visit/admission to the health facility. Such records may then be entered into an Image Processing System. Decision to maintain original records beyond this period is subject to the health facility management's decision and legal advice.

20.5. Paper based Dental records should be stored for ten (10) years for both UAE nationals and expatriate patients after the most recent patient visit/admission to the health facility. Such records may then be entered into an Image Processing System. Decision to maintain original records beyond this period is subject to the health facility management's decision and legal advice.

20.6. The health care facilities should retain the following records in the original form for the period specified:

20.6.1. Paper based health records of medico-legal cases should be retained by the health facility up to twenty (20) years; such records may then be entered into the Image

Processing System. Decision to maintain original records beyond this period is subject to the facilities decision and legal advice.

20.6.2. Files of deceased patients should be retained by the health facility up-to (5) years, such records may then be entered into the Image Processing System. Decision to maintain original records beyond this period is subject to the health facility management's decision and legal advice.

20.6.3. The patient health records of certain major diseases and incidents selected by the administrations and requested by the consultants for academic, research and administrative purposes may be retained for longer periods than specified. Decision to maintain original records beyond the recommended periods noted in this section is subject to the health facility management's decision and legal advice.

20.7. Digital/ICT health information and data should be retained for a minimum period of twenty five (25) years from the date of the last health procedure.

21. RECOMMENDATION SEVENTEEN: DESTRUCTION OF HEALTH RECORDS

21.1. The health facility should establish procedures for notifying patients whose original health records are to be destroyed prior to their destruction.

21.2. The sole responsibility for the destruction of all health records should reside with the health facility. A legal representative for the health facility should be consulted prior to the destruction of health records.

21.3. Original health records may be destroyed only when they are in excess of the retention period and have satisfied the requirements as mentioned above.

21.4. A record of what was destroyed should be maintained by the health facility and where necessary verified through the Image Processing System where it is being kept electronically.

21.5. In order to ensure the patient's right of confidentiality, health records should be destroyed or disposed of by shredding, incineration, electronic deletion, or another equally effective protective measure.

22. RECOMMENDATION EIGHTEEN: BUSINESS CONTINUITY

22.1. Health facilities should have a documented business continuity policy and plan that can be activated in a timely manner to retain or retrieve health records in case of service discontinuation in the event of a disaster.

22.2. There should be clear policies and procedures for managing health records.

22.3. Health facilities should identify competent and trained staff responsible for health records retention and retrieval in case of service discontinuity including:

22.3.1. Natural and environmental threats e.g. earthquakes, hurricanes, extreme weather, floods, fire, etc.

22.3.2. Human factors involvement e.g. technology failures, terrorism, bio-terrorism and chemical, radiological or nuclear events.

23. RECOMMENDATION NINETEEN: TRAINING AND QUALITY ASSURANCE

23.1. It is important for health facilities to train staff appropriately and provide updated training on a regular basis for the management of health records, their creation, use, storage, privacy, confidentiality, retention, retrieval and destruction.

23.2. All new staff should be given health records training as part of their induction process.

23.3. All training must be documented and supported by staff end user agreements for managing health records.

23.4. Health facilities need to ensure that their staff are fully trained in health records and have an understanding of:

23.4.1. What they are recording and how it should be recorded.

23.4.2. Why they are recording it.

23.4.3. How to validate information with the patient or carers or against other records to ensure that staff are recording the correct data.

23.4.4. How to identify and correct errors so that staff know how to correct errors and report errors if they find them.

23.4.5. The use of information in order for staff understand how patient records are used and therefore why timeliness, accuracy and completeness of recording is important.

23.4.6. How to update information and add in information from other sources.

23.4.7. Who to report any observed concerns with regards to managing health information.

REFERENCES

1. Aneurin Bevan University Health Board (2015). Health Records Management Policy. Available on : http://www.wales.nhs.uk/sitesplus/documents/866/ABHB_IMT_0165%20Health%20Records%20Management%20Policy_Issue%203.pdf (accessed 25/03/19).
2. Federal Law No. (2) Of 1996, Concerning Health Private Establishments.
3. Federal Law No. (10) Of 2018, Concerning Medical Liability.
4. Federal Law No. (11) Of 2008, Concerning Licensing Fertility Centers.
5. Federal Law No. (2) Of 2019, Concerning use of ICT in health fields.
6. Federal Law No. (2) Of 2019, Concerning the Use of Information and Communications Technology (ICT) in Healthcare.
7. Government of Canada (2015). Personal Information Protection and Electronic Documents Act. Available on : http://laws-lois.justice.gc.ca/eng/acts/P-8.6/page-1.html (accessed 25/03/19).
8. Information Governance Alliance (2016). Records Management Code of Practice for Health and Social Care 1, 1-80. Available on : https://digital.nhs.uk/article/1202/Records-Management-Code-of-Practice-for-Health-and-Social-Care-2016 (accessed 25/03/19).
9. Joint Commission International (2017). Joint Commission International Accreditation Standards for Hospital, 5, 1-72. Available on : https://www.jointcommissioninternational.org/assets/3/7/Hospital-5E-Standards-Only-Mar2014.pdf (accessed 25/03/19).

10. Medical Encyclopedia (2017). Apgar score Medline Plus. Available on : http://www.nlm.nih.gov/medlineplus/ency/article/003402.htm (accessed 25/03/19).

11. National Health Service (NHS) Digital (2017). Data security and information governance. Available on : https://digital.nhs.uk/data-security-information-governance (accessed 25/03/19).

12. National Institute for Health and Care Excellence (2017). Surgical Care. Available on : https://www.nice.org.uk/guidance/service-delivery--organization-and-staffing/surgical-care (accessed 25/03/19).

13. Smith E (2017). Managing Health Information during Disasters. Health Information Management Journal, Version 2. Available on : http://www.himaa.org.au/members/journal/HIMJ_35_2_2006/Smith_Macdonald.pdf (accessed 25/03/19).

14. Tracy Gunter (2005). The Emergence of National Electronic Health Record Architectures in the United States and Australia: Models, Costs, and Questions. Available on : https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1550638/ (accessed 25/03/19).

15. University of Connecticut (2015). Policy: Retention, Storage and Disposal/Destruction of Medical Records. Available on : https://health.uconn.edu/policies/wp-content/uploads/sites/28/2015/07/policy_2014_06.pdf (accessed 25/03/19).