Group :6 Medical records Retention and Destruction

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What is a medical record?

- A record of a patient's medical information(as medical history, care, or treatment received, test results, diagnosis and medications taken)

Objective elements in maintaining medical records:

- Every medical record has a unique identifier
- Organization identifies those authorized to make entries in MR
- Every MR is dated and timed.
- The author of the entry can be identified.
- The contents of medical record are identified and documented.
- The record provides an up to date and chronological account of patient care
- The medical record contains information regarding reasons for admission, diagnosis, and plan of care

Objective elements in maintaining medical records:

- Operative and other procedures are incorporated in MR.
- Documented policies and procedures exist for maintaining confidentiality , security and integrity of information.
- Privileged health information is used for purposes identified/required by law and not disclosed without patient's authorization.
- Documented policies exist for retaining MR, data and information.

Objective elements in maintaining medical records:

- The retention process provides expected confidentiality.
- The destruction of medical records according to laid down procedure.

Documented policies for retention time of records, data and information

- Hospital has to define the time frame for retention of records, data, registers(birth register, death register, MLC, admissions etc..)copies of certificate issued, blocks, slides etc..

Documented policies for retention time of records, data and information

- Retention time should be in consonance with the state, national laws and other regulations.
- The retention period can be kept higher than the prescribed time frame but cannot be less than the prescribed time frame.

Guidelines for retention period

MCI guidelines:

- Every physician shall maintain the medical records pertaining to his / her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard preform laid down.

- If any request is made for medical records either by the patients / authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

- A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued.

- He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report.

- The OPD records should be retained for a period of two years.
- The records that are the subject of medico-legal cases should be maintained until the final disposal of the case even though only a complaint or notice is received.
- If a child is delivered/treated in your hospital, then it is essential to maintain his/her records till the time the child reaches 18 years of age.

- Section 29 of the PNDT Act, 1994 requires that all the documents be maintained for a period of 2 years or until the disposal of the proceedings.
- The PNDT Rules, 1996 requires that when the records are maintained on a computer, a printed copy of the record should be preserved after authentication by the person responsible for such record.

From the law point of view

How long medical Records to be preserved?

CPA demands maintenance of the Medical Records for three years. But they can condone and give extension for delayed filing.

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What about legal Validity of medical records?

- Medical Records are acceptable as useful evidence by court as per section 379 Indian Evidence Act 1872 amended in 1961 as it is agreed that documentation of facts during the treatment of a patient is genuine and unbiased
- Medical Records that are written after the discharge or hours after death do not have any legal value.
- Erasing of entries is not permitted and is questionable in court.

In the event of alteration, the entire line or word should be scored and rewritten with date and time.

Electronic records

- According to the latest act **DISHA Act**(Digital Information Security In Health Care, Act) electronic records are not to be deleted at least for 10-15 years as of now.
- It extends to the whole of India except Jammu and Kashmir

When are the medical records asked for in court?

- Criminal cases .
- Road traffic accident cases .
- Labour courts in relation to the Workmen's Compensation Act.
- Insurance claims to prove the duration of illness and the cause of death.
- Medical negligence cases.

Documented policies and Procedures to maintain confidentiality, security integrity of records

- Limited access to MRD
- List of those who can access is available in MRD
- Photocopy to patients given within 72 hours after written authorization.
- Access and editing rights clearly defined for electronic records.
- Audit trails should be available in case of E-records.

- In e-records copying of patient records can be restricted by authorized staff.
- Tracer method to track movement of chart in and out of MRD.
- Can be handed over to clinical dept on authorization for research purpose.
- MLC cases are kept blunder lock and key.
- MRO is the overall supervisor.
- Adequate back up for e-records.
- Protection from fire, pest, floods, software malfunction.
- 24 hours access to records by appropriate mechanism ensuring accountability.

Mandatory information to be shared

- MLC reporting
- Death and birth
- Notifiable diseases
- Child, adult or domestic abuse
- Judicial and administrative proceedings.
- The Hospital shall maintain health information and statistics in respect of national programmes, and emergencies/disasters/ epidemics and furnish the same to the district authorities .

Destruction of medical records:

- Medical records will be destroyed in a manner that does not allow for the information to be retrievable, recognizable, reconstructed or practically read.
- The destruction of medical records is in accordance with the laid down procedure

Protocol for destroying medical records:

- Identify the records to be destroyed
- Approval procedure for destruction
- Notification before destruction if required
- Method of destroying the records
- Information of destroyed records

  Manual record should be shredded and disposed

  The records of destructed medical records with date of destruction should be maintained.

HDPSA ACT

- Health and family welfare department is has proposed the HDPSA (Health data privacy and security Act) in INDIA.
- It has drawn a lot from HIPAA(Health insurance portability and accountability act) and HITECH act(Health Information Technology for Clinical and economic health act)

“Poor records mean poor defence, no records mean no defence”