

MEDICAL RECORDS POLICY

MINISTRY OF HEALTH

July, 2017

2nd Edition

FOREWORD

For some time now there has been great concern about the functioning of Medical Records systems in health institutions in the country. These concerns related not only to the content of the records, but also to the way in which the records are managed. Though several factors could have contributed to the situation, it is generally accepted that the lack of awareness creation of the first Medical Records Policy to provide a framework for managing medical records was a key factor.

The medical records policy was therefore developed by the Ministry of Health in 2008 to guide the management of medical records in all health facilities in the country. The document provides guidelines on aspects such as generation and collection of patients' information (i.e. history taking, clinical observations, reporting of procedures, clinical tests and the results) as well as guidance on production, ownership, proper storage, privacy and confidentiality issues, and accessibility of medical records.

Unfortunately, the document was not widely disseminated as only few copies were printed. There is also very little data on the implementation. It has however become necessary to review and expand the scope of the policy to reflect current developments in medical records management.

This second edition of the policy has taken into consideration the emerging issues of Electronic Medical Records system and also how to manage inactive records. The document will enhance information gathering and use for decision making, improve efficiency in service delivery and contribute to pre-service and in-service training of health workers.

It is our hope that the use of this policy will lead to the improvement in the quality of health information that is needed to make critical health decision.



MINISTER FOR HEALTH
HON. KWAKU AGYEMAN-MANU

ACKNOWLEDGEMENT

The effort in putting this document together involved a lot of MOH Agencies whose contributions cannot be ignored. We acknowledge with much gratitude the effort of all the Task Team Members. We acknowledge the effort of all who put together the First Edition.

The Second Edition received support from Global Alliance for Vaccine Immunisation (GAVI) Support System for which we are most grateful.

We are also very grateful to Mr Isaac Adams, the former Director of Research Statistics and Information Management Division of Ministry of Health (MOH) for his immense contribution to this reviewed document.

The list below is the rest of the Technical Working Group (TWG)

MR DANIEL DARKO	PRIVATE CONSULTANT
DR. ANTHONY OFOSU	GHS/PPME
MS GERTRUDE S. AVORTRI	WHO (Formerly with GHS/ICD)
MRS EMMA HAMMOND	GHS/IME/PPME
MRS GLORIA NTOW-KUMMI	GHS/ICD
MR. DAVID MENSAH	Formerly with RIDGE REGIONAL HOSPITAL
MR. EUGENE K. OPPONG	KORLE-BU TEACHING HOSPITAL
MAJOR OSEI-BOATENG	37 MILITARY HOSP/GAQHI
CAPT KA SARKODIE	37 MILITARY HOSP/GAQHI
MRS VIVIAN ADDO-COBBIAH	NHIA
MR. CHARLES ADJEI ACQUAH	GHS/PPME
MR. HAMMOND NII SARKWAH	GHS/ICT
DR. EBENEZER ODURO-MENSAH	LA GENERAL HOSPITAL
DR. LAWYER EMMANUEL ANKRAH	GHS/MEDICO-LEGAL
MR YAW BROBBEY-MPIANI	GHS/ OFFICE OF DIRECTOR GENERAL
DR. ISAAC C.N. MORRISON	META/SPMDP
DR. MRS BEATRICE HEYMANN	Formerly with GHS/IME/PPME
DR. ERASMUS E.A.AGONGO	Formerly with GHS/PPME
MR ISMAIL OSEI	NHIA
MR IVAN TETTEH. ESSEGBEY	NCHS/CHAG
MR FRANK BORIS-HEMANS	GHS/HASS
BARIMAH AGYEMANG QUANDAHOR	GHS/PPME
MR PRINCE BONI	PRIVATE
DR DINAH BAAH-ODOOM	GHS/ICD
MR KWASI DARKO ANIAGYEI	GAQHI
MR ISAAC AKUMAH	Formerly with GHS/PPME
MR STEPHEN DUKU	GHS/PPME
MR E. OWUSU-ANSAH	Formerly with PPME (MOH)

TABLE OF CONTENTS

ITEM	PAGE
FOREWORD	II
ACKNOWLEDGEMENT	III
TABLE OF CONTENTS.....	IV
1.0 INTRODUCTION	1
1.1 Background.....	1
1.2 Rationale for a Health Records Policy.....	1
2.0 GOALS AND OBJECTIVES OF MEDICAL RECORDS POLICY.....	2
2.1 Goal	2
2.2 Objectives	2
2.3 Guiding Principles	3
2.4 Patient/client rights	3
3.0 PURPOSE OF THE MEDICAL RECORDS SYSTEM.....	4
4.0 CONTENT OF MEDICAL RECORDS.....	5
4.1 Outpatient Services.....	5
4.2 Inpatient Care	6
4.3 Medical Forms/Formats.....	6
4.4 Clinical Observations.....	9
4.5 Reports of Procedures, Tests, and the Results	9
4.6 Blood Donation and Transfusion:.....	10
4.7 Organ Donation and Transplant.....	10
4.8 Conclusions at Termination of Hospitalization.	11
4.9 Medical Records in Emergency Services	12
4.10 Outreach Services	12

5.0 MANAGEMENT OF MEDICAL RECORDS	13
5.1 Medical Records Committee	13
5.2 Committee’s Function	13
5.3 Security and Access.....	13
5.4 Storage and Protection.....	15
5.5 Maintenance of Medical Records	15
5.6 Documentation of Patients Encounter	16
5.7 Electronic Medical Records (EMR)	17
5.8 Retention and Disposal of Medical Records.....	17
6.0 MEDICAL RECORDS DEPARTMENT	18
7.0 ROLES AND RESPONSIBILITIES	18
7.1 National Level	18
7.2 Regional Level.....	18
7.3 District Level	19
7.4. Health Facilities	19
8.0 REPORTING AND PUBLICATIONS OF THE MEDICAL RECORDS	20
8.1 Facility Level.....	20
8.2 District and Regional Level	20
8.3 National Level	21
9.0 DISASTER PREPAREDNESS OF THE MEDICAL RECORDS DEPARTMENT.....	21
10.0 POLICY IMPLEMENTATION	21
11.0 DEFAULT	21
12.0 INCEPTION DATE.....	21
13.0 REVIEW PERIOD.....	21

1.0 INTRODUCTION

1.1 Background

Information on health services inputs, processes, outputs and outcomes are usually expressed through patient utilization statistics within health institutions and outreach points. Over the years a lot of concerns have been raised about the quality of such information generated in health facilities across the country. These concerns range from inadequate documentation of patient data to lack of information about patient and the treatment processes as well as the storage of patients records. Although efforts have been made to improve records keeping on several occasions through training, there has been a consistent lack of improvement in health facility data management and health information reporting. This has created a significant gap in analysis of sector performance regarding service delivery.

1.2 Rationale for a Medical Records Policy

In Ghana, a number of factors have contributed to the inability of Health Information Management Personnel to collect, analyse and disseminate accurate information on patients and the outcome of services rendered to them. The first major constraint is the lack of uniformity in the details of information collected on patients. In a lot of cases there is no standard structure or framework to guide the content and management of medical records.

A review of the medical records management system showed lack of standards as a key contributory factor in the quality of information on health statistics. In addition there is a problem of timeliness of reporting even at the regional level. Another weakness is the Centre for Health Information Management's lack of focus in the monitoring of medical records management system at service delivery points. A lot of effort is put into analysis of data from facilities leading to large volumes of data deposited at the centre which in reality should have been analysed at the regional and district level.

The management of patient record is also fraught with problems of storage and access to information about patient and treatment processes. The basic problem again has been the lack of a clear framework to guide the management of medical records as well as for the training of staff involved in the handling of patient information. There is therefore the need to outline structured system of documenting the health information management processes across the entire spectrum of health care delivery from prevention, promotion, treatment and rehabilitation.

Public Records and Archives Administration Act, 1997 (ACT 535 section 9) also mandates all heads of public institutions to ensure that records management systems are in place to document

government business and preserve organisational memory in accordance to standards directed by the office.

It is against this background that a Medical Records Policy has been developed for use in the sector.

For the purpose of this policy, a health facility shall be defined as any health facility whether wholly or partially owned by government, missions, private individuals, corporate organisations or Non-governmental organisations and which is licensed to provide such services that can be described as health care or diagnostic services or both.

2.0 GOALS AND OBJECTIVES OF MEDICAL RECORDS POLICY

2.1 Goal

The main goal of the Medical Records Policy is to direct the organisation, management and the use of client and hospital records for the provision of quality health services.

2.2 Objectives

The overall objective is to provide standards for the management of medical records in relation to its creation, maintenance, use and disposition.

The specific objectives are to provide standards and guidelines for:

- I. Classification systems, Control processes, Indexing and retrieval. Retention and Disposal and Performance Auditing.
- II. Strengthen the role of health statistics in planning and budgeting in the health sector.
- III. Provide guidance to the use/dissemination of health information.

2.3 Guiding Principles

The medical records management system shall operate on the following principles:

- i. Every health provider, regardless of ownership, shall maintain a Medical Records Department as an essential part of the organization.
- ii. The Medical Records Department shall be adequately accommodated and appropriately located to allow for easy access by patients and other users of medical and health information.
- iii. There shall be adequate space and facilities for managing active Medical Records.
- iv. There shall be a records centre within the medical records department to provide a secondary storage for the storage of semi-active medical records.
- v. There shall be at least two medical records decongestion exercise within the department yearly depending on the size of the records department guidelines.
- vi. The Medical Records Department shall be manned by qualified personnel.
- vii. Every health provider shall maintain medical records that are accurate, complete, and timely available and accessible.
- viii. Every health facility regardless of ownership shall participate in health information reporting by providing information requested by the Ministry of Health on regular basis. Reference Annex HEFRA Act, 2011 (ACT 829).
- ix. Physical integrity of the medical records shall be protected and preserved. Under no circumstance shall there be alteration or destruction in documentation.

2.4 Patient/client rights

The medical records management system shall observe the following rights of every patient regardless of age, gender, medical or physical conditions and social, economic or ethnic background:

- i. A patient may have his or her medical records read only by individuals directly involved in his/her management or the monitoring of its quality.
- ii. Patient by written consent shall authorise any other individual/agent to access his/her medical records.
- iii. All communication and documentation on any patient shall be treated as confidential.
- iv. Medical records of patient shall be in the custody of the health facility's Medical Records Department.
- v. Patients' records should not be given out to be sent home.

- vi. With regard to pregnant women a folder and Maternal Health Records book shall be issued. All documentation in the Maternal Health Records book shall be entered in the woman's folder.
- vii. The Maternal Health Records book shall be retained by the woman while the folder is kept at the health facility.
- viii. A patient has the right of access to a complete and current information concerning diagnosis, treatment, any known prognosis and indicated cost of treatment as contained in his/her medical records Patients shall abide by the regulations and guidelines regarding the handling of patient records.

3.0 PURPOSE OF THE MEDICAL RECORDS SYSTEM

The purposes of the medical record shall be to:

- i. Maintain adequate medical record for every individual who is evaluated or treated as an inpatient, outpatient, emergency patient, or who receives services on outreach clinics or on an extended healthcare facility administered home care programme.
- ii. Serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.
- iii. Furnish documentary evidence of the course of the patient's medical evaluation, treatment and change in condition during the healthcare facility stay, during an outpatient or emergency visit to the hospital, or while being followed on outreach services.
- iv. Document communication between the responsible practitioner and any other health professional contributing to the patient's care.
- v. Assist in protecting the legal interest of the patient, the healthcare facility and the practitioner.
- vi. Provide data for use in performance assessment, continuing education and research.
- vii. Provide data for planning, budgeting, monitoring and evaluation of health services.
- viii. Provide data for billing and reimbursement.

4.0 CONTENT OF MEDICAL RECORDS

Accurate medical record shall be maintained for every client receiving medical care provided by the outpatient department, in-patient and emergency service.

4.1 Outpatient Services

. The complete outpatient service medical records shall include:

- i. Demographic and Administrative data, such as client identification, address, name and contact person or nearest relative, client registration number, name of health insurance provider and unique membership identification number.
- ii. Identification of other sources of medical care, dates and times of visits where possible.
- iii. Clinical data, clinical problems, medical history, family history, immunization record, screening tests, allergy records, and nutritional evaluation; birth and neonatal history for paediatric patients; special needs of other vulnerable groups.
- iv. Written notes on physical examination findings.
- v. Records on diagnostic investigations, including reports from laboratory services, radiology service, and other investigation as applicable.
- vi. Provisional diagnosis, treatment, prescription and instructions, such as diet and self-care.
- vii. Every page of the record shall be numbered, shall bear key identifiers such as name, age, sex and identification number of the patient.
- viii. Written record of preoperative and postoperative instructions; operative reports on out-patient surgery; anaesthesia record relating to outpatient surgery, including pre-anaesthesia evaluation, and type of anaesthesia, techniques and dosages used.
- ix. Discharge summary, disposition; signed consent forms and signed patient release forms.
- x. Copy or abstract of referral record, and clinical data from other providers, where applicable.
- xi. Upon referral of a patient from the outpatient service to another physician, or upon admission to a hospital or other facility, all information necessary for ongoing treatment shall be sent promptly, to the receiving physician, hospital, or other facility.
- xii. All entries in the patient's folder should be signed with date and time.**
- xiii. The content of this document also apply to all Electronic Medical Records**

4.2 Inpatient Care

The inpatient medical record shall contain sufficient information to accurately:

- i. Identify the patient.
- ii. Support the diagnosis.
- iii. Justify the treatment.
- iv. Document the results.

All clinical information pertaining to a patient management shall be incorporated in the patient's medical record. These records include Discharge Summary, the Operative Notes, and the Pathology/laboratory Report.

All medical information obtained on request from outside sources shall be filed with the patient's medical records, but not necessarily be considered as a part of the records, such information shall be available to professional staff concerned with the care and treatment of the patient. Information on babies accompanying their mothers on admission shall be recorded accordingly. If the baby requires clinical care then he/she should have a separate folder.

4.3 Medical Forms/Formats

While the format and forms in use in the medical records may vary among specialties, all medical records shall contain the following information:

- i. Patient Identification data.
- ii. Medical history of the patient.
- iii. Patient's Family Medical History
- iv. Report of relevant physical examination.
- v. Diagnostic and therapeutic orders.
- vi. Treatment Plan.
- vii. Evidence of appropriate informed consent; when consent is not obtainable, reason shall be entered in the records.
- viii. Clinical observations, including results of therapy.
- ix. Reports of procedures, tests and their results.
- x. Conclusions at termination of hospitalisation or evaluation/treatment.
- xi. Relevant information for costing and reimbursement.

4.3.1 Identification data shall include:

- a. Name of patient.
- b. Folder identification number.
- c. Sex.
- d. Traceable residential address.
- e. Telephone number, if available.
- f. Email if available.
- g. Date of birth/age.
- h. Place of birth.
- i. Name, address and contact number of contact person or nearest relative.

NB: The patient's folder identification number shall be unique and shall identify only one person in a particular health facility. In identifying the patient use any of these: National Identification, Social Security, Drivers' Licence and National Health Insurance if available.

4.3.2 The medical history of the patient shall include:

- i. The major complaint/s.
- ii. Other complaints.
- iii. Details of the present illness.
- iv. Relevant past medical history, social history including religion and ethnic background, family, occupational and medication histories.
- v. Specific enquiry about self-medication (including use of herbal preparations) and adverse drug reactions.
- vi. Functionality of relevant body systems.
- vii. Known allergies and current medication.
- viii. Obstetric records shall include all prenatal information, number of previous pregnancies and their outcome. It shall also include number of induced and spontaneous abortions.
- ix. When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical records provided the original information is readily available. The medical records shall document the current physical examination prior to the performance of surgery.

Wherever possible the medical history shall be obtained from the patient. Opinions of the interviewer shall not ordinarily be recorded in the body of the history. The report of a physical examination shall reflect a comprehensive current physical assessment. The recorded physical examination must be authenticated by a physician member of the medical staff.

4.3.3 Diagnostic and Therapeutic Orders

- I. Diagnostic and therapeutic orders shall include those written by medical staff members, by physicians and dentists in training status, and by other practitioners accredited to perform the task and shall be signed with date and time.
- II. Verbal orders of authorised practitioners shall be accepted and transcribed by qualified personnel who shall be identified by title or category in the medical staff rules and regulations. The medical staff shall define any category of diagnostic or therapeutic verbal orders associated with any potential hazard to the patient; the responsible practitioner shall authenticate these orders within 24 hours.
- III. All prescriptions dispensed and therapeutic orders performed shall be recorded by the nurses or appropriate staff and shall be signed with date and time.

4.3.4 Evidence of Appropriate Informed Consent.

The medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which a written consent is needed. This information shall include:

- i. Identity of the patient.
- ii. Date of procedure.
- iii. Procedure or treatment to be rendered in layman's terminology where possible.
- iv. Authorization for anaesthesia if indicated.
- v. Alternative means of therapy and the possibility of risks or complications that have been explained to the patient.
- vi. Authorization for disposition of any tissue or body parts as indicated.
- vii. Signature or thumbprint of the patient or other individual empowered to give the consent. The signature or thumbprint shall be witnessed by a relation or a person appointed by the patient and not a health facility staff.
- viii. Where required, verbal consent shall be entered in the folder.
- ix. Accredited practitioner who informs the patient and obtains the consent shall be identified in the medical record by name, rank and signature.

A healthcare facility policy and procedure, consistent with legal requirements, shall be developed to apply in certain procedures such as abortion or sterilisation, or in situations where appropriate informed consent cannot be given, such as in the case of a patient who is unconscious, medically challenged or an unaccompanied minor.

The need for documentation of special aspects of consent, such as patient photographs, observation

of a surgical procedure, and for other educational purposes, shall be determined by the patient and shall be consistent with any legal requirements.

4.4 Clinical Observations

As regards clinical observations:

- i. Progress notes made by the medical staff shall give a chronological report of the patient's management in the healthcare facility and shall reflect any change in the condition and the results of treatment. Progress notes shall also be made by others so authorized by the medical staff, such as house officers, individuals who have been granted clinical privileges and specified professional personnel.
- ii. Each consultation report shall contain a written opinion by the prescriber that reflects, where appropriate, an actual examination of the patient and shall be recorded in the patient's medical records.
- iii. Clinical observation of unconscious patients shall include determination of the patient's level of consciousness on entering and leaving the unit; the vital signs; and, where applicable, the status of infusions, surgical dressings, tubes, catheters, drains and twitch chart.
- iv. Notes by all health professionals shall contain appropriate observations and information.
- v. Nursing records and reports shall reflect the patient's progress and the planned nursing care. These records and reports shall demonstrate adherence to the objectives of the nursing service. To contribute to continuity of patient care, the nursing notes shall be significant, accurate and concise and shall be part of the patient medical records.
- vi. Opinions requiring medical judgement should be written or authenticated only by medical officers and other individuals who have been accredited. All clinical and nursing notes should be signed with date and time.

4.5 Reports of Procedures, Tests and Results

All diagnostic and therapeutic procedures shall be recorded authenticated and incorporated in the medical records. These may also include any reports from facilities outside of the healthcare facility in which case the source facility shall be identified on the report.

Reports of surgical operations both major and minor shall be written in the medical records immediately after surgery and shall contain:

- i. Pre-operative diagnosis.
- ii. Pre-operative procedures.
- iii. Technical procedures used and any difficulties encountered.
- iv. Description of operative findings.
- v. Specimen removed and record of what happened to the specimen.
- vi. Post-operative diagnosis.
- vii. Name of the primary surgeon/authorised person, scrub nurse/assistants and anaesthetist(s).
- viii. Date, time and signature of primary surgeon/authorised person, scrub nurse and anaesthetist(s).
- ix. Post-operative treatment/management.

The completed operative report comprising reports of the surgeon's, the anaesthetist's and scrub nurses' shall be filed in the medical records immediately after completion of the procedure.

Reports of pathology, clinical laboratory, radiology and nuclear medicine examinations or treatment, anaesthesia records, and any other diagnostic or therapeutic procedures shall be completed promptly and filed in the medical records folder within 24 hours of completion.

4.6 Blood Donation and Transfusion:

There is a comprehensive National Blood Policy for the Health Sector which provides for blood donation and transfusion services. The provisions apply to this policy.

4.7 Organ Donation and transplant:

In terms of organ donation and transplant, when:

- a. An organ is obtained from a donor for transplant purposes, the medical records of the donor and the recipient shall fulfil the requirements for any surgical patient medical records.
- b. The medical records of donor organ if obtained from a brain-wave-dead patient shall include:
 - i. the date and time of brain-wave-death.
 - ii. documentation of the identity of the physician who determined the death
 - iii. the method of transfer and machine maintenance of the patient for organ donation as well as an operative report.

- c. A cadaver organ is removed for purposes of donation, there shall be an autopsy report that includes a description of the technique used to remove and prepare or preserve the donated organ.

Reference shall be made to the relevant legislation on anatomical gifts. Organ for Anatomy Act, 1965 (ACT 280 Section 9).

4.8 Conclusions at Termination of Hospitalization.

Conclusions at termination of hospitalization shall include all the diagnoses: provisional principal and additional or associated diagnoses, or reason(s) for admission, the clinical resume or progress note, and, where applicable, autopsy report:

- a. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, shall be recorded using acceptable disease and operative terminology that includes topography and aetiology as appropriate.
- b. The clinical resume shall state concisely the reason for hospitalisation, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family as appropriate.
- c. Consideration shall be given to instructions relating to physical activity, medication, diet, and follow-up care. The condition of the patient on discharge shall be stated in terms that permit comparison with the condition on admission. When written instructions are given to the patient or family, a copy shall be filed in the patient medical records.
- d. If authorised in writing by the patient or a legally qualified representative, a copy of the clinical summary may be sent to any known medical practitioner and /or medical facility responsible for the subsequent medical care of the patient.
- e. A final progress note may be substituted for the clinical resume or progress note in the case of patients with problems of a minor nature that require less than a 48-hour period of hospitalisation; and in the case of normal new-born infants; and uncomplicated deliveries. The final progress note shall include any instructions given to the patient and/or family.
- f. In the event of death, a summary statement shall be added to the patient's medical records either as a final progress note or as a separate resume. This final note shall indicate the reason for admission, the findings and course in the hospital, and events leading to death, and the date and time of death.
- g. When an autopsy is performed, a provisional report on the findings and diagnoses shall be entered in the patient's medical records within three days after the autopsy. The medical records shall be returned to the medical records department/unit. The consent form for autopsy shall include permission for specimen to be removed for post mortem histological examination.

4.9 Medical Records in Emergency Services

- a. A register that adequately records details of all persons requiring emergency care shall be maintained at the emergency unit/department.
- b. A medical record shall be maintained on every patient requiring emergency care and shall be incorporated into the patient's medical records.
- c. All prior patient medical records, documentation, including previous visits to the emergency service shall whenever possible, be promptly made available when requested by the attending physician or other authorised individuals.
- d. For each visit to the emergency department/Unit , the medical records shall contain the following:
 - i. Patient identification. (When not obtainable, any physical identifiers such as sex, complexion, anybody mark, height, etc.) must be stated.
 - ii. Date, time and means of arrival.
 - iii. History of the illness or injury, and physical findings, including the patient's vital signs.
 - iv. Treatment given to the patient prior to arrival at the health facility.
 - v. The Ambulance record of the patient shall be available to the practitioner providing emergency care and filed with the patient's medical records.
 - vi. Diagnostic and therapeutic orders.
 - vii. Clinical observations.
 - viii. Reports of procedures, tests and results.
 - ix. Diagnosis or clinical impression.
 - x. Conclusion at the termination of evaluation/treatment, including final disposition, patient's condition on discharge or transfer, and any instructions given to patient and/or family for follow-up care.
 - xi. Discharge against medical advice (if requested).
- e. The medical records shall be authenticated by the practitioner who shall be responsible for patient's care.

4.10 Outreach Services

- a. Outreach services data shall be included in the routine report of the facility. Records shall be maintained on services rendered on outreach and at Community Health and Planning Services (CHPS) compounds. The records shall include patient identification data, provisional diagnosis, patient's complaint, treatment, immunization and advice given. Where a patient is referred, this shall be indicated in the medical records.

- b. Record of services on outreach clinics shall be lodged with the medical records department of the overseeing health facility within 48 hours for incorporation into the facilities records. Records of CHPS compounds shall be submitted to the overseeing Sub-district health administration on monthly basis.

5.0 MANAGEMENT OF MEDICAL RECORDS

5.1 Medical Records Committee

There shall be a medical records committee in all health facilities. Composition of the committee shall comprise where appropriate representatives from:

- i. Clinical Care.
- ii. Nursing.
- iii. Health Information.
- iv. Pharmacy.
- v. Administration.
- vi. Allied Health.
- vii. Information Technology.

5.2 Committee's Function

The committee shall, among other things:

- i. Ensure compliance to policy and standards for medical records management.
- ii. Recommend the conduct of quality assurance reviews.
- iii. Support the medical records department in the performance of its functions (refer to chapter 6.0 of the policy document).
- iv. Evaluate documents in the medical records.
- v. Identify inadequate documentation and other procedural issues.

5.3 Security and Access

- a. Medical records shall be confidential, secure, current, authentic, legible, and complete.
- b. The materials used to record / capture medical records should be durable.
- c. Written consent of the patient or his/her legally qualified representative is required for release of medical information to persons not otherwise authorised. This shall not be interpreted to mean that patient's written consent is required for the impersonal use of the medical records for any of the following:

- i. Automated data processing of designated information.
 - ii. Use in patient care evaluation studies, such as retrospective audit and medical staff monitoring functions.
 - iii. Departmental review of work performance.
 - iv. Official surveys for healthcare facility compliance with accreditation, regulatory, and licensing standards.
 - v. Educational purposes and research programmes.
- d. When a patient is under the age of 18 years or person who is intellectually challenged or unconscious or deceased, the parent or legal guardian or next of kin as stated in the medical records or as legally admissible may make application for access to the records.
- e. Medical record may be made available to a third party without the written authorisation of the patient or his/her legal representative under the following circumstances:
 - i. Where a court orders the record to be handed over to the third party.
 - ii. Where the facility is being sued by a patient and needs access to the record to mount a defence.
 - iii. Where the third party is a facility employee who has had disciplinary proceedings instituted against him/her and requires access to the record to defend him/herself.
 - iv. Where the facility employee is under a statutory obligation to disclose certain medical facts reporting a case of suspected child abuse Act, 1998 (ACT 560).
 - v. Where the non-disclosure of the medical information about the patient will present/pose a serious threat to public health.
- f. There shall be written standing orders that medical records may be removed from the hospital's jurisdiction for safekeeping only in accordance with a court order, subpoena, or statute. Any other restrictions on medical records removal shall be in addition to this basic requirement.
- g. Medical records shall at all times be protected against unauthorised access and tampering.
- h. No member of staff shall remove medical records from the facility without the explicit permission of the head of the facility.
- i. An effective file tracking system shall be developed and implemented to manage the movement of medical records.
- j. Medical records storage areas shall at all times be protected against unauthorised access. The storage area shall be locked when not in use.

5.4 Storage and Protection

- a. The medical record is the property of the health facility and shall be maintained for the benefit of the patient, the medical staff, and the health facility. It is the responsibility of the health facility to safeguard both the record and its content against loss, defacement, tampering, or use by unauthorised individuals. Particular emphasis should be given to protection from damage by fire or water.
- b. The medical records department shall be provided with sufficient space to store both active and inactive medical records and equipment, and to enable personnel to function effectively.
- c. Medical records shall be stored in a purpose-built storage room fitted with burglar proof, air-conditioner, fire extinguisher and any other item that may be required for security.
- d. All closed registers shall be stored in a secured cabinet.
- e. With regards with electronic medical records, patient data shall be protected in accordance with Data Protection Act, 2012 (ACT 843)

5.5 Numbering and Filing of Medical Records

Numbering system and filing system of health records go hand in hand since the numbering of the record determines the position of the record within the file storage segment.

Filing is the action of storing a record. A record may be stored in hard copy or electronic. Healthcare facilities shall use either Terminal Digit or Straight Numeric Filing System.

Maintenance of Medical Records

All medical records, regardless of form or format must be maintained in their entirety, and no document or entry may be disposed of without disposal authority from Public Records and Archives Administration Department (PRAAD).

The following shall be considered for maintenance of medical records:

- i. All medical records should be content indexed.
- ii. Worn-out folders must be replaced regularly.
- iii. All medical record registers should be made available and maintained.
- iv. There shall be no eating, smoking and drinking in medical records storage areas.
- v. There shall be regular environmental cleaning and effective pest/rodent control measures of the medical records storage areas.

- vi. There should be effective and efficient illumination and aeration system in medical records storage areas.
- vii. Care should be taken to ensure that flammable cleaning materials are not used in medical records storage areas.
- viii. With the electronic system regular back-up must be done. At least once a week.

5.6 Documentation of Patient's Encounter

- a. Entries in medical records may be made only by individuals given this right as specified in health facility and medical staff policies. All entries in the records must be dated and authenticated. A method shall be established to identify the authors of entries. Such identification may include written signatures, initials, or computer key. All entries in the records should have date, time and signatures of personnel.
- b. When rubber stamp signatures are authorized, the individual whose signature the stamp represents shall place in the administrative offices of the hospital a signed statement to the effect that he/she is the only one who has the stamp and is the only one who will use it. There shall be no delegation of the use of such stamps to another individual.
- c. The parts of the medical records that are the responsibility of the medical practitioner shall be authenticated personally. For example, when specified professional personnel have been approved for such duties as taking medical history, documenting some aspects of a physical examination, such information shall be appropriately authenticated by the responsible physician or specified professional.
- d. The responsible medical staff's own pertinent observations and significant physical findings shall be added wherever necessary, and may record the history and physical examination of the patient.
- e. When members of staff and other specified professional personnel are involved in patient care, sufficient evidence shall be documented in the medical records to substantiate the active participation and supervision of the patient's care by the responsible attending practitioner.
- f. Any entries in the medical records by staff or any other specified professional that require countersigning by supervisor or attending medical staff shall be defined in the rules and regulations of medical staff.
- g. To avoid misinterpretation, symbols and abbreviations used shall conform to standards.
- h. Medical records shall ordinarily be considered complete when the required contents are assembled and authenticated, including any required clinical resume or final progress notes.
- i. No medical staff shall be permitted to complete medical records on a patient he/she is not responsible for initialling without specific authorisation as defined by the health facility's rules. Any actions to be taken by the individual charged with medical records responsibility

in the event of medical records deficiencies or delinquency shall be defined in health facility policy.

- j. Medical records duly completed shall be filed in accordance with agreed filing procedures that promote good practice.

5.7 Electronic Medical Records (EMR)

- a. All electronic medical records shall be managed in accordance with Act 772 (Electronic Transactions Act, 2008 (ACT 772)).
- b. Access to server rooms and storage areas for electronic medical records shall be protected against unauthorised access.
- c. Where electronic registration systems are available, patients' registration database must be created and stored on server with on and off site backup system. The backup system should be encrypted.
- d. The EMR should be equipped with passwords for logging on and controls that restrict access based on user roles and responsibility.
- e. All EMR systems shall meet nationally approved inter-operability standards.
- f. All EMR Systems used in health facilities should be able to provide at least the following functions:
 - i. Master Patient Index.
 - ii. Disease and Procedure Index.
 - iii. Admissions, Transfer and Discharge/Death System.
 - iv. Automated Record Tracking System.
 - v. Medical Record Completion System.
 - vi. Discharge Summary Reporting System.
 - vii. Periodic Reports as mandated by the Health Sector.
 - viii. Extensible Mark-up Language (XML) feature for electronic claims transfer.
 - ix. ICD10 code and Standard Treatment Guidelines (STG) should be embedded in the EMR.

5.8 Retention and Disposal of Medical Records

- a. No medical records shall be destroyed, erased or otherwise be disposed of without the prior written approval from PRAAD.
- b. All disposal actions shall be guided by the medical records retention schedule and shall be authorised by the head of the facility.
- c. The period of retention of medical records shall be dependent upon the need for their use in continuing patient care and for legal, research, and educational purposes. However, medical records in use shall remain active. Inactive medical records (when folder has not been used

for five years) shall be kept in inactive storage for an additional five years before moving it into the Records Centre of Public Records and Archives Administration Department (PRAAD).

6.0 MEDICAL RECORDS DEPARTMENT

- a. The medical records department shall be provided with adequate authority, personnel and resources to perform all required functions.
- b. A qualified Medical Records Officer, responsible to the Head of Facility or his/her designee, shall be employed or posted, in consonance with the needs of the health facility.
- c. Health Records Personnel shall be staff accredited by Allied Health Council.
- d. Health records personnel shall be involved in educational programmes related to their activities, including regular in-service training. In addition, supervisory and management personnel shall participate in off-site workshops, professional association/organisational meetings and pertinent or relevant continuous professional development programme.
- e. Educational achievement shall be documented for each individual.

7.0 ROLES AND RESPONSIBILITIES

7.1 National Level

- a. The Research Statistics and Information Management (RSIM) Division of the Ministry of Health (MOH) is responsible for overseeing the implementation of the Policy in the Tertiary level and all other health agencies under it.
- b. The Institutional Care Division in collaboration with Policy Planning Monitoring and Evaluation Division (PPMED) of the Ghana Health Service is responsible for the implementation of the Medical Records Policy across all primary and secondary levels of health service provision.

7.2 Regional Level

- a. The Regional Director of Health Services is ultimately responsible for the medical records keeping and management practices of health facilities in the region in line with the medical records policy.
- b. The Regional Director shall designate the Regional Health Information Officer (RHIO) as the officer responsible for medical records management at the regional level. He will perform such duties as are necessary to enhance the medical records keeping and management practices to enable compliance with legislative and regulatory requirements.

- c. The RHIO shall be responsible for training and supervision of all health information officers at the district level.

7.3 District Level

- a. The District Director of Health Services shall commit to ensure accountability, transparency and improvement of service delivery by ensuring that sound medical records management practices are implemented and maintained in all health facilities.
- b. The District Director of Health Services is responsible for the implementation of this Policy at the District level, and requires each staff member to support the values contained in the Policy.
- c. The District Director and heads of hospitals are mandated to collaborate to ensure the full implementation and success of the policy.

7.4. Health Facilities

The Head of facility

The head of facility shall commit to ensure accountability, transparency and improvement of service delivery by ensuring that sound medical records management practices are implemented and maintained in all health facilities.

The head of facility is responsible for the implementation of this Policy at the District level and requires each staff member to support the values contained in the Policy.

The heads of facility and District Directors are mandated to collaborate to ensure the full implementation and success of the policy.

The degree of participation of medical records personnel in patient care evaluation activities and in other health facility committee functions is dependent on the size of the Health Facility, the services provided by the health facility, the capabilities of the departmental personnel and the requirements of the professional staff.

7.5 Roles of the Medical Records Personnel

The role of medical records personnel includes the following:

- i. Data capture, collation, documentation of reliable data, proper storage and retrieval at all levels.
- ii. Training of clerical personnel in records management procedures.
- iii. The analysis of data and preparation of reports on medical records activities for use by all stakeholders.
- iv. Assessing of medical records for compliance with established standards.
- v. Participation in the design and development of Medical Records forms and format.
- vi. Participation in methods of improving the quality of the primary source data that will facilitate data retrieval, analysis and presentation.
- vii. Performing ongoing surveillance on practice indicators related to medical care at the facility.
- viii. Implementing mechanisms to ensure privacy and confidentiality of patients' records in quality of care.

8.0 REPORTING AND PUBLICATIONS OF THE MEDICAL RECORDS

8.1 Healthcare Facility Level

Medical Records Departments of all health facilities shall compile reports as mandated by National, Regional and Facility Level. The Medical Records Department of all health facilities shall regularly publish quarterly reports, the minimum content of which shall include:

- i. Statistics on utilization of services of the facility by age, **sex** and departments and community.
- ii. Disease conditions reported at outpatients department.
- iii. Disease conditions seen at inpatient department.
- iv. Statistics on antenatal care and deliveries.
- v. Total deaths and their causes in the facility.
- vi. Statistics on work load by service categories.
- vii. Any other analysis that may be required.

8.2 District and Regional Level

The District and Regional Health Directorates shall ensure that such statistics are verified and included in quarterly reports of the sector.

8.3 National Level

As part of its responsibilities, the Centre for Health Information Management (CHIM) shall collate and analyse all data and shall publish annual reports and other periodic reports that may be required on the utilisation and quality of health services. The Ministry of Health shall disseminate the published reports.

9.0 DISASTER PREPAREDNESS OF THE MEDICAL RECORDS DEPARTMENT

All Medical Records Departments shall have a Disaster Plan that will ensure protection of vital information and continuous patient care in times of disaster. These are outlined in the Medical Records Operational Guidelines.

10.0 POLICY IMPLEMENTATION

This document is a national policy and shall be used by all healthcare service providers irrespective of ownership. The policy shall be disseminated and communicated to all service providers in the country. The Ministry of Health shall ensure that appropriate resources are made available for comprehensive dissemination, implementation and monitoring of the policy.

11.0 DEFAULT

Any employee who contravenes and/or transgresses with any of the provisions of this policy shall be guilty of misconduct and the necessary disciplinary measures shall be taken against him or her.

12.0 INCEPTION DATE

The policy shall come into force from the date it is signed by the approving authority and shall remain in force unless withdrawn or amended.

13.0 REVIEW PERIOD

The policy shall be reviewed every five years or whenever a need arises.