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RECORDS OF PATIENTS: RESPONSIBILITIES OF RADIOGRAPHERS

Radiographers are required to keep accurate records of patients in terms of legislation. It is the responsibility of every radiographer to be fully conversant with all current relevant legislation and regulations.

Records of patients have to be kept for a minimum of six years from when a patient was last treated by a healthcare practitioner. There are exceptions however as the records of some patients have to be kept for more than six years.

Examples of relevant legislation are presented below. Legislation does get amended from time to time therefore it is essential for health practitioners to consult the relevant documents for current information.

- Obligations to keep records of patients as well as access and safekeeping thereof are in Chapter 2 of the National Health Act 61 of 2003.
- Regulations concerning the control of electronic products (11.6 f in the Public Health Amendment Act 42 of 1971) underscore that the records of every patient exposed to radiation must be preserved for a period of five years from date of last entry.
- South African Health Products Regularity Authority (SAHPRA) (12 September 2022) guidelines on the request for medical x-ray examinations list several requirements.
    - "3.1.1 all requests must be in writing and signed by the person requesting the examination(s)"
    - "3.1.2 the clinical indication for the examination(s) must be indicated"
    - "3.2.4 Keeping of accurate records". The latter includes images produced from the use of medical X-rays.

- HPCSA Guidelines on patient recordkeeping (revised 10 November 2022) defines a patient health record as follows: "…... is the longitudinal collection of an individual's personal and health information, recorded by a healthcare practitioner or at the directive of the healthcare practitioner, regardless of the form or medium used to make such a record". The guidelines include a checklist in section10, namely:
    - Records should be complete, but concise, and should be consistent.
    - Self-serving or disapproving comments should be avoided in patient records. Unsolicited comments should be avoided (i.e., the facts should be described, and conclusions only essential for patient care made).
    - A standardised format should be used (e.g., notes should contain in order the history, physical findings, investigations, diagnosis, treatment, and outcome.).
    - If the record needs alteration in the interests of patient care, a line in ink should be put through the original entry so that it remains legible; the alterations should be signed in full and dated; and, when possible, a new note should refer to the correction without altering the initial entry.
    - Copies of records should only be released after receiving proper authorisation.
    - Billing records should be kept separate from patient care records.

- Attached documents such as diagrams, laboratory results, photographs, charts, etc. should always be labelled. Sheets of paper should not be identified simply by being bound or stapled together – each individual sheet should be labelled.

- The purpose of patient health records is presented in 2 of the guidelines; content of patient health records is presented in 3 of the guidelines; rules related to patient health records are presented in 4 of the guidelines; privacy and security of patient health records (see 6 of the guidelines as this includes backing-up of electronic data); retention of patient health records is presented in 7 (see 7.1 to 7.2.5 below); ownership of patient records is in 8 (see 8.1 to 8.4 below); and access to health information and to patient health records is in guideline 9 (see 9.2 to 9.3.5 below)

  - **Retention of patient health records**

  "7.1 Patient health records should ideally be stored indefinitely particularly if this can be done. If not then … a patient health record should be stored for at least a minimum of six (6) years as from the date that a patient health record has become dormant (dormancy commences at the time when a patient was last treated by a healthcare practitioner)."

    - There are exceptions to the minimum of six years.

  "7.2.1 For patients who were under the age of 18 years, when they were cared for (including obstetric care), the patient health records should be kept at least until the patient's 21st birthday, as legally, minors have up to three years after reaching the age of 18 years to make a claim against a health practitioner or health care establishment.
  7.2.2 For mentally incapacitated patients, the patient health records should be kept for the duration of the patient's lifetime.
  7.2.3 In terms of the Occupational Health and Safety Act (Act No. 85 of 1993) patient health records falling under this act must be kept for 20 years after treatment.
  7.2.4 Several other factors require that patient health records are kept for longer periods. For instance, certain health conditions that take a long period to manifest, (e.g. asbestosis). Patient health records of patients, who may have been exposed to the risk of developing such conditions, should be kept for a sufficient period to allow such patients equitable access to the care they may require at a later stage. The recommendation is that this period should not be less than 25 years.
  7.2.5 When statutory obligations prescribe the period for which patient health records should be kept, a practitioner must comply with these obligations."

  - **Ownership of patient records**

  "8.1 A patient health record is owned by the health practitioner or the entity generating such a patient health record.
  8.2 A patient is entitled to have access and obtain the information contained in such a record (see section 9).
  8.3 In the case of state institutions, where records e.g., radiographs are the property of the institution, original records and images should be retained by the institution. Copies must, however, be made available to the patient (or referring

health practitioner) on request for which a reasonable fee may be charged in terms of the Promotion of Access to Information Act (Act No. 2 of 2000).
8.4 In cases where patients are required to pay for records and images (e.g., private patients or patients in private hospitals) such patients must be allowed to retain such records

- ❖ unless the health practitioners deem it necessary to retain such records for purpose of monitoring treatment for a given period. Should the patient however require the records and / or images to further or protect an interest (e.g., such as consulting with another practitioner) he or she must be allowed to obtain the originals for these purposes."

- ➢ **Access to information of patient records**

"9.2 In terms of the law the following principles apply in regard to access to information in patient health records:
9.2.1 A health practitioner shall provide any person of age 12 years and older with a copy or abstract or direct access to his or her own records regarding medical treatment on request (Children's Act (Act No. 38 of 2005)).
9.2.2 Where the patient is under the age of 16 years, the parent or legal guardian may make the application for access to the records, but such access should only be given on receipt of written authorization by the patient (Promotion of Access to Information Act (Act No. 2 of 2000)).
9.3 A health care practitioner may make available the patient health records to a third party without the written authorisation of the patient or his or her legal representative under the following circumstances:
9.3.1 Where a court orders the patient health records to be handed to the third party;
9.3.2 Where the third party is a health care practitioner who is being sued by a patient and needs access to the records to mount a defence.
9.3.3 Where the third party is a health practitioner who has had disciplinary proceedings instituted against him or her by the HPCSA and requires access to the patient health records to defend himself or herself.
9.3.4 Where the health practitioner is under a statutory obligation to disclose certain medical facts, (e.g., reporting a case of suspected child abuse in terms of the Children's Act,(Act No. 38 of 2005)).
9.3.5 Where the non-disclosure of the medical information about the patient would represent a serious threat to public health (National Health Act (Act No. 61 of 2003)."

- **<u>Records should be securely backed up</u>**

It is strongly recommended that all digital images should be routinely backed up. It is important that patient records are not lost in the event of a disaster. There are several options to back up digital images and patient records.

- ➢ External hard drive
- ➢ Cloud storage
- ➢ Cloud-based PACS

References

- National Health Act No. 61 of 2003, South Africa. https://www.gov.za/documents/national-health-act
- Public Health Amendment Act 42 of 1971. South Africa.

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- Revised record keeping guidelines / healthcare records (Booklet 9). 10 Nov 2022. HPCSA. https://cover4profs.co.za/hpcsa-revised-recordkeeping-guidelines-health-care-records-november-2022/
- South African Government. Promotion of Access to Information Act 2 of 2000. https://www.gov.za/documents/promotion-access-information-act
- South African Government. Children's Act 38 of 2005. https://www.gov.za/documents/childrens-act
- Protection of Personal Information Act 4 of 2013, South Africa. https://www.gov.za/documents/protection-personal-information-act

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President-elect