MEDICAL AND DENTAL PRACTITIONERS COUNCIL OF ZIMBABWE

RECORD KEEPING POLICY

Background

A medical record is a powerful tool that enables doctors to track the patient's medical history and problems that assist in deciding course of health care. The primary purpose of medical records is to enable doctors to provide quality care to patients. It is a living document that tells the story of health care of patient and facilitates each encounter with health professionals in providing care to patients. Medical records are also critical in that they provide **evidence in litigation** on care provided to a patient. Doctors as well as institutions have an ethical duty of maintaining accurate up to date patient records which can easily be assessed upon request. Complete and accurate medical records meet legal regulatory and auditing requirements and also facilitates research ***(IAMRA 2004).*** In general practice poor clinical notes and inadequate recoding are common ingredients for a medical disaster with serious legal consequences. (***Feltoe & Nyapadi 1989.)***

Introduction

Section 30 (1) (i) of the Health professions Act (Chapter 27:19) mandates the council to define and enforce ethical practice. The purpose of this Policy is to provide guidelines for record keeping to health institutions as well as educate the profession on the importance of record keeping.

- Good medical recording keeping is part of providing best quality medical care.
- Accurate and complete documentation in the medical record is critical in facilitating and enhancing communication in collaborating patient care models.

POLICY

The MDPCZ expects all doctors and institutions to keep medical records that are consistence with their legal obligations and expectations set out in the Policy. The guidelines set herein are mandatory:-

1. Organisation Of Medical Records

- **Legibility**

  Medical records shall be legible. This is achieved through legible writing.

  Information in a medical records should be understood by other health professionals.

- **Documentation**

  - Every patient encounter and all patient related information must be documented.
  - A practitioner / institution should keep a clean accurate up-to-date patient record system.

- Where there is more than one health practitioner making entries in a patient's record, the professional's entry must be identifiable and entries recorded as soon as possible following the encounter with the patient.
- The record must report on :

    - Relevant clinical information;
    - decisions made and reasons for them;
    - Information given to patients;
    - The proposed plan;
    - Any drugs or other treatment prescribed;
    - Date and time.

2. Recording Keeping Health Institutions

- Health Institutions should establish standardized registration for tracking medical records.
- Records on cases of death / trauma within 24 hours of operative procedure should be collected by a Police Officer and transmitted to the office of the Clinical head of the institution the notes as soon as the death occurs.
- The clinical head of an institution should devise a system of record keeping for hospital records as well as the notes on medico legal cases.
- All medical records should be kept indefinitely.
- An institution should keep medical records for a period of ten (10) years and thereafter they should be sent to the National Archives.

3. Retaining Medical Records

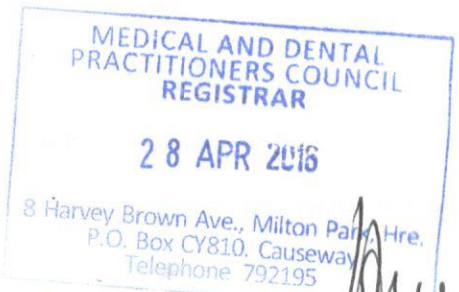
- Doctors should keep records for 10 years from date of last entry.
- Patients who are children, records should be kept until 38 years. ***(CPSO Canada)***
- Doctors who cease to practice medicine must transfer the records to another person taking over the practice.

4. Patients Access To Records

- A doctor can charge the patient a fee for making copies of the records but they must not charge a consultation fee.
- The doctors keep the original records.
- Doctors cannot refuse to grant patients access of copies of their medical records.

5. Patient's Request For Transfer

Should a patient seek a second opinion, this should take place in a timely fashion together with the patient's record. The attending doctor can provide a summary as opposed to the transmission of the entire record. The doctor is obligated to keep the entire record.



CPSO
General Medical Council
New Zealand Medical Council

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