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GOVERNMENT OF DUBAI

هيئة الصحة بدبي
DUBAI HEALTH AUTHORITY

Health Regulation Department

Health Record Guidelines

2012

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1. Scope

These guidelines apply to all licensed healthcare facilities operating under the Dubai health Authority establishment law. These health facilities include governmental, semi governmental and private health facilities.

These guidelines may be amended from time to time, and will be referred to as the Health Records Guidelines

2. Purpose

These health record guidelines are not intended to be all-inclusive, but rather to outline the essential requirements should be in place to ensure proper management of health records by healthcare professional and health facilities in the Emirate of Dubai.

3. Definitions

Patient: A patient is any individual who receives medical attention, care or treatment by any healthcare provider or admitted in a healthcare facility

Health Record is a record of a patient's long-term and aggregate health information generated by one or more encounters in any care delivery setting. The health record connects the physicians and other caregivers. Included in this information are patient demographics, progress notes, problems, medications, medical history, immunizations, laboratory data, and radiology reports.

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 shall refer to a physician, a licensed nurse, a physiotherapist or a TCAM practitioners.

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 shall be deemed to be designated representatives of the patient.

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.

Competent person: is a person legally capable of giving consent to a medical procedure. Every adult who’s 18 years old and above is assumed by law to be competent to give consent. However, He/she should be fully conscious and aware about his/her condition, should be able to receive and understand information relevant to their medical care, given possible alternatives and consequences and capable of making decisions.

Next of Kin: The person who is 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 or 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]

Minor: any person from the birth to the age of 18 years.

[1] For further information regarding Next of Kin, Minor please see the Civil Federal Law number 5 for the year of 1985 and the Civil Federal Law number 1 for the year of 1987

4. Acronyms

DHA	:	Dubai Health Authority
HRD	:	Health Regulation Department
CGO	:	Clinical Governance Office
DAMA	:	Discharge Against Medical Advice
HRD	:	Health Regulation Department
ICU	:	Intensive Care Unit

SECTION ONE: GENERAL REQUIRMENTS

The health record is a legal document that should accurately outline the total needs, care and management of patients. It facilitates communication, decision making and evaluation of care in addition to protecting the legal interests of the patient, healthcare professionals and the health facility.

1. Facility Record Keeping Requirements

1.1 A legible, complete, comprehensive, and accurate health record must be maintained for each patient. Each health facility must maintain records and reports in a manner to ensure accuracy and easy retrieval.

1.2 Each healthcare facility shall provide health record storage room or other suitable health record keeping area with adequate supplies and equipment.

1.3 Health records should be stored safely to provide protection from loss, damage, and unauthorized use.

1.4 Health records shall be maintained in the custody of the health facility and shall be available to a patient or his/her designated representative through the attending healthcare professional or his/her designated representative at reasonable times and upon reasonable notice.

2. Health Record Contents and Electronic Format

2.1 Health Records must be maintained for every patient, including newborn infants, admitted for care in the hospital or treated in the emergency or outpatient services.

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

2.3 Health records must contain entries which are dated, legible and indelibly verified. The author of each entry must be identified and authenticated. Authentication must include: official stamp, signature, written initials, or computer entry.

3. Telephone or Verbal Orders

3.1 The most error-prone communications are patient care orders given verbally and those given over the telephone. The health facility shall implement clinical protocols which minimize the use of verbal and telephone orders

3.2 Telephone or verbal communications by an authorized healthcare professional such as report back of clinical laboratory critical tests results are accepted and shall be transcribed by a qualified healthcare professional.

3.3 The health facility shall develop a policy and/or procedures that address the accuracy of verbal and telephone communications. The policy must specify the situations when verbal and telephone orders are accepted.

3.4 Telephone or verbal communications must be documented immediately by the healthcare professional that receives the order and should be authenticated within 24 hours by the healthcare professional that is responsible for ordering or evaluating the service furnished

4. Methods of Documentation

4.1 All healthcare professionals should document their notes in the health records by adopting an appropriate method of documentation. This will facilitate communication between various healthcare professionals, health facilities and DHA.

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

4.3 An example of a popular documentation method is SOAP. The four parts of a SOAP note include:

4.3.1 **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.

4.3.2 **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.

4.3.3 **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.

4.3.4 **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

SECTION TWO: SPECIFIC HEALTH RECORDS REQUIRMENTS

5. Health Records Contents

5.1 Each patient health record must contain at least (but not limited to) the following information (where applicable):

5.1.1 Identification data

5.1.2 A unique identifier for health records

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

5.1.4 Time and date of seeing the patient

5.1.5 Full Patient History which includes but 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)

5.1.6 Physical examination and system review

5.1.7 Admission diagnosis

5.1.8 All pathology/laboratory and radiology reports

5.1.9 Properly executed informed consent forms

5.1.10 Physicians orders

5.1.11 Pain assessment

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

5.1.13 Histopathology and tissue reports

5.1.14 Progress notes of all disciplines

5.1.15 Discharge summary

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

5.1.17 Autopsy findings; and death certificate

5.1.18 Advanced Directives (if available)

5.1.19 Patient education

5.1.20 Vaccination records (for paediatric patients)

5.1.21 Police care clearance.

5.2 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.

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

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

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

6. Informed Consent

6.1 As per article (7) of the Federal Law number 10/2008 concerning Medical Liability and the Cabinet Decision No. (33) of 2009 promulgating the bylaw of the medical liability law Informed consent shall be obtained by the treating physician from the patient or his Designated representative (as applicable) and after a discussion of the complication, risks, benefits and alternatives of procedures/surgeries (excluding emergency cases).

6.2 If the patients lack the full capacity (e.g. less than 18 years old) informed consent shall be taken from their relatives up to the fourth degree, before the procedure/surgery is performed.

6.3 Consent documentation shall be maintained in the patient's health record.

6.4 Patients shall be provided with comprehensive and accessible information concerning treatment/procedure and alternatives.

6.5 The health facility shall clearly define investigations, treatment and procedures that require patient consent.

6.6 The health facility must develop an internal consent policy and procedures that are consistent with the federal legislation including procedures for individuals lacking the capacity of making informed decisions.

6.7 All consents should comply with the Federal Law number 10/2008 concerning Medical Liability. Click here for further details regarding this law and informed consent requirements or visit the Health Regulation on DHA website www.dha.gov.ae .

6.8 Healthcare professionals working in the health facility shall be educated about the consent policy.

6.9 Where consent is obtained by the visiting community physician, the health facility management shall ensure that the signed consent is received and filed in the patient health record.

7. In Patient Health Records Contents

7.1 Specific in-patient health record contents are applicable only to health facilities providing in-patient care such as hospitals and Day Surgical Centre setting.

7.2 Admission and Discharge Record may include but not limited to the following:

7.1.1 Date and time of admission and discharge

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

7.1.3 Admission diagnosis

7.1.4 Final diagnosis, secondary diagnosis and any complications

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

7.1.6 Condition on discharge

7.1.7 Signature and official stamp of attending physician.

8. Surgical Contents

8.1 In addition to the requirements of patient health records; all health records of patients undergoing surgery shall include (but not limited to) the following:

8.1.1 Date and time of admission and discharge

8.1.2 History, physical, special examinations, and diagnosis recorded prior to operation

8.1.3 Identification of correct site of surgery

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

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

8.1.6 The histopathologist's report on all tissues removed at the operation.

8.1.7 A signed consent form by the patient or his Designated representative

8.1.8 Admission diagnosis, Final diagnosis, secondary diagnosis and any complications

8.1.9 Signature and official stamp of attending physician.

9. Medical Contents

9.1 Plan of care.

9.2 Reports of consultation by consulting physicians, when applicable.

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

10. Nursing Records

10.1 Basic Nursing Forms (mandatory) should include (but not limited to):

10.1.1 Initial Nursing Assessment Form

10.1.2 Nursing Care Plan

10.1.3 Nurses Notes Form (progress notes)

10.1.4 Temperature, Pulse, Respiration and Blood Pressure Chart

10.1.5 Paediatric Observation Chart (if applicable)

10.1.6 24 Hour Nursing Report

10.1.7 Medication Chart

10.1.8 Pain Documentation

10.1.9 Patient/family education

10.2 Special Nursing forms (when applicable) should include (but not limited to):

10.2.1 Special Observation Chart

10.2.2 Pre operative checklist

10.2.3 Labor record

10.2.4 Weight Chart

10.2.5 Fluid Balance Chart

10.2.6 Diabetic Chart

10.2.7 Newborn identification form

10.2.8 Nursing assessment of the newborn in SBCU(special baby care unit)

10.2.9 ICU (intensive care unit) Chart

10.2.10 Infection chart

10.2.11 MICU(medical ICU) / PICU(pediatric ICU) flow chart

10.2.12 NICU(neonatal ICU) chart

10.2.13 Neonatal intensive care unit / IV fluid intake / output chart

10.2.14 Feeding chart

10.2.15 Investigation flow sheet

10.2.16 Partial exchange transfusion chart

10.2.17 Paediatric peritoneal dialysis

10.2.18 Anticoagulant drug chart

10.2.19 Conscious sedation

10.2.20 Haemodialysis profile

10.2.21 Manual peritoneal dialysis chart

10.2.22 Diabetic ketoacidosis chart

10.2.23 Out and pass forms

10.2.24 Transfer slips

11. Obstetric Content

11.1 In addition to the requirements of health records, records of all obstetric patients shall include (but not limited to) the following:

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

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

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

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

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

11.1.6 Signed reports of consultants when such services have been obtained.

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

11.1.8 Names of assistants/midwives present during delivery

12. Newborn Content

12.1 Records of newborn infants shall be maintained as separate records and shall contain (but not limited to) the following information:

12.1.1 Date and time of birth, birth weight and length, period of gestation, sex, Apgar score.

12.1.2 Parents' names and addresses.

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

12.1.4 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.

12.1.5 Record of prophylactic instillation into each eye at delivery.

12.1.6 Results of Phenyl Keto Urea (PKU) tests.

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

12.1.8 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.

13. Discharge Summary

13.1 Each healthcare facility must provide a discharge summary/card to the patient upon discharge, which should include (but not limited to) the following details:

13.1.1 Date and time of admission and discharge

13.1.2 Adequate identification (including record number assigned to patient)

13.1.3 Admission diagnosis

13.1.4 Final diagnosis, secondary diagnosis, complications

13.1.5 Operative procedures (if applicable)

13.1.6 Condition on discharge with medication

13.1.7 Follow up plan

13.1.8 Signature and official stamp of attending physician

14. Patient Access and Release of Patient Information

14.1 Health records can only be accessed by the patient himself or designated representative and **under supervision** of attending physician or the most responsible healthcare professional.

14.2 The patient or designated representative has the right to request his/her information through requesting medical reports, or a copy of the previous reports

14.3 No fees shall be charged by a healthcare professional for health records request received from another healthcare professional solely for the purpose of providing continuing medical care to the patient.

14.4 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 must pay the actual cost of such reproduction.

15. Records Detail with Negative Impact

15.1 It is the attending healthcare professional's responsibility to flag a patient's record denoting that any or all portions may contain information that has significant negative psychological impact upon the patient and that the information recorded should not be released to the patient and/or designated representative without the consent and knowledge of the attending healthcare professional.

15.2 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, etc.

16. Emergency Record

16.1 Copies of Health records in the custody of emergency rooms of facility shall be available to patients or their designated representatives as detailed in previous paragraph.

17. Record completion

17.1 Time frames shall be established for completing histories, physical and psychosocial examinations, discipline-specific assessments and when appropriate, reassessments. Time frames for initial assessments and reassessments may differ according to setting, unit, service (such as surgery, dental, etc), and patient acuity.

17.2 Assessment findings should be integrated and documented in the patient’s record and readily available to those responsible for the patient’s care

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

17.4 Rubber stamp shall include physician name, speciality and license number

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

17.5.1 If the physician using the rubber stamp signature is the only person authorized 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.

17.5.3 Initials should never be used to authenticate assessments or narrative documentation; therefore initials should be avoided elsewhere because of difficulty in identifying author, i.e. two persons with same initials.

18. Changes, Corrections, or Other Modifications in Health Record

18.1 If any changes, corrections, or other modifications are made to any portion of the patient’s record, the healthcare professional must 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 is not permissible such as (white ink) or any form of erasable pens.

18.3 Electronic form of health records should have that ability to trace any change, or other modifications in the 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 shall bear legal consequences.

19. Retention of Health records

19.1 In patient health facilities such as hospital and Day Surgical centres, Health Information Staff/Unit/Section shall be responsible for the retention of patient health records, data and information.

19.2 In Ambulatory care setting and diagnostic centres the medical director shall be responsible person for the retention of patient health records, data and information.

19.3 Health Records of UAE national patients must be retained the up to 10 years after the most recent patient visit/admission to the health facility.

19.4 Health Records for expatriate patients must be retained the up to 5 years after the most recent patient visit/admission to the health facility.

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

19.5.1 The health records of medico-legal cases up to 20 years, such records then maybe entered into the Image Processing System and destroyed.

19.5.2 Files of deceased patients to be stored for 5 years, such records then maybe entered into the Image Processing System and destroyed.

19.5.3 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.

19.5.4 Dental records need to be stored for 10 years for both UAE nationals and expatriate patients after the most recent patient visit/admission to the health facility.

20. Destruction of Health records

20.1 The health facility shall establish procedures for notification of patients whose health records are to be destroyed prior to their destruction.

20.2 The sole responsibility for the destruction of all health records shall be in the facility involved, legal consultant may be consulted prior to records destruction.

20.3 Health records may be destroyed only when they are in excess of the retention requirements specified in the previous paragraph.

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

21. Compliance with these guidelines:

21.1 HRD has full authority to request the original health records if needed to be returned to the health facility.

21.2 Health facilities licensed by the DHA shall comply with the Health Records guidelines.

21.3 Periodic visits will be conducted by HRD inspection team to ensure compliance with the guidelines.

References

UAE Federal Law number 2/1996 concerning Private Health Facilities

UAE Federal Law number 10/2008 concerning Medical Liability

The Cabinet Decision number (33) of 2009 promulgating the bylaw of the medical liability law.

UAE Federal Law number 11/2008 concerning Licensing Fertility Centers.

DHA Private Healthcare Standards

Joint Commission International Accreditation Standards for Hospital

EQuIP for Day Surgical Hospital Standards and guidelines of the Australian Council on Healthcare Standard – ACHS

The National Hospital Standards of the Central Board of Accreditation for Health Institutions (CBAHI), Kingdom of Saudi Arabia.