



Policy No.: TIADPolicy\_H&S\_2021/08

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Policy Reviewed again in April 2021

**Important Note:** The school has adopted Distance Learning Programme (DLP) and Blended Learning Programme (BLP) for the Academic Year 2021-22. This policy is designed for a regular school set-up and will also be integrated during the DLP/BLP.

## **POLICY ON HEALTH RECORD MANAGEMENT AND RETENTION**

### **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

### **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.

### **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**

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**

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

### **General Requirements**

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.

Facility Record Keeping Requirements

- A legible, complete, comprehensive, and accurate health record must be maintained for each student. Each health facility must maintain records and reports in a manner to ensure accuracy and easy retrieval.
- Each healthcare facility shall provide health record storage room or other suitable health record keeping area with adequate supplies and equipment.
- Health records should be stored safely to provide protection from loss, damage, and unauthorized use.

Health Record Contents and Electronic Format

- Health Records must be maintained for every student including newborn infants, admitted for care in the school or treated in the emergency or outpatient services
- 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 student, to justify the diagnosis and treatment and to document the results accurately.
- 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.

**Retention of Health Records**

- Whenever a student transfers to another school at any grade, the original of the complete cumulative school health record shall be transfer at the same time to the health personnel of the school, file of the student is transferring to, or handed to the parent as appropriate.
- The health record shall be maintained in the school for a minimum of 5 years after the student leaves the school or till the student turns 18 years.

**Forms attached:**

- Student health record

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