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notice your questions on the main MM2H thread...skyline101New member31 December 2019 11:46:12i gotcha. she is pointing to the way most public and private hospitals in Malaysia do preserve their patient records. Existing filing space for the efficient storage of newer records is a common problem, and for most Health Information Management (HIM) / Medical Records (MR) practitioners, it is a never-ending battle against overcrowded files and the struggle to find more space. The need for adequate storage space for newer and older medical records (as you already know, older medical records placed in storage and rarely accessed are called archived records or inactive records) is driven by medical reasons, legal reasons and management reasons. Medical records must be kept for so long as they are necessary to support patient care in the treatment and management of cases. The legal documentation reason has heightened the importance of medical record retention (the length of time a hospital for example will maintain an archived record) from the threat of medical malpractice suits, as patient and their families become more aware of the rights to quality care, and solicitors ever willing to take on medical malpractice suits. Thus, the medical records must be kept for so long as long as the threat of a medical malpractice suit exists. So if the medical records are necessary for the purpose of a court case, the medical records must be kept until the case is concluded, a process which may take many years. A doctor may be in court as a litigant or a witness. Even as a witness in a case which is heard many years after the events in question, the doctor may need to refer to the original medical records. Collection of hospital statistics, disease coding, claims processing, communicable disease reporting, incident reporting, morbidity and mortality reviews are some management reasons. Does this mean that, if at all possible, medical records should be maintained indefinitely? Given the hospitals administrative constraints to provide additional space with additional cost implied versus the statutory mandates to maintain medical records for a defined period for legal reasons, themedical reasons, and the management reasons, a hospital needs a strategic plan for preserving medical records for a definite period of retention. Image credit : silverdane.com The hospital must develop a medical record retention policy and must be guided by its own activities, research and education activities. This policy will dictate how medical records are to be stored (records can be stored on paper, microfilm, magnetic tape, optical disk, or as part of an electronic (or computer) system), where they will be stored, what happens to the medical records that have lapsed the retention period, all of which are guided by statute, regulation, law and guidelines. I shall refrain from posting the methods of storage of newer and older medical records and the destruction of medical records that have lapsed the retention period, as I intend to only discuss on establishing a hospital retention policy for medical reasons and legal reasons but briefly and discuss a little more the quality assurance reasons. HIM/MR practitioners already know that medical records serve for the continuity of medical and nursing care while in hospital, and follow-up care. HIM/MR practitioners also know that medical records must be maintained for specific periods for legal reasons and I like to list the relevant statutes, laws and guidelines that prevail in Malaysia. The statute of limitations, Act 254, cited as the Limitation Act 1953, dated 19 February 1953, is an Act to provide for the limitation of actions and arbitrations (which is the time period during which a person may bring forth a lawsuit including medical malpractice suits), but applies to Peninsular Malaysia only. Section 6(1) of this Act limits actions in tort to commence not more than six years after the occurrence of the damage and unlike laws in Australia, the United Kingdom and in Singapore, does not contain provisions for the discretionary extension or exclusion of the time limit allowed by law in relation to tort or personal injuries. Include in the policy if patient is under a legal disability, that the records should be kept for a minimum of 7 years from the date when the patient's legal disability ceases or the patient's death, whichever is earlier, as provided for under Section 24(1) of this act. Act 629, the National Archives Act 2003 (incorporating all amendments up to 1 January 2006), is an Act to provide for the creation, acquisition, custody, preservation, use and management of public archives and public records (records officially received or produced by any public officer for the conduct of its affairs or by any public officer or employee of a public office in the course of his official duties and includes the records of any Government enterprise) and for other matters connected therewith. The National Archives of Malaysia had supported and agreed to a Ministry of Health Malaysia proposal for a uniform medical records retention and disposal schedule for all public hospitals in Malaysia. Through its letter of approval allowable under Section 27 (1) of the Act 629, the National Archives Act 2003, an approval dated 30 November 2006 was released by the National Archives for a comprehensive and standardised medical records retention and disposal schedule for all public hospitals and health facilities in Malaysia. The retention period for all medical records with the exception of medical records of psychiatric, obstetric and paediatric cases will be retained for a period of seven (7) years from the last date of treatment. A copy of this approval can be obtained from a Ministry of Health Malaysia Guideline Manual on Medical Records Management published by the Medical Development Division and released through a Director General of Health Malaysia directive No. 17 of 2012 (Pekeliling Ketua Pengarah Kesihatan Bil 17/2010, Garispanduan Pengendalian Dan Pengurusan Rekod Perubatan Pesakit Bagi Hospital-Hospital Dan Institusi Perubatan Kementerian Kesihatan Malaysia, Bahagian Perkembangan Perubatan Kementerian Kesihatan Malaysia, a document in Malay). The standardised medical records retention and disposal schedule for all public hospitals and health facilities in Malaysia was circulated through a MoH circular MOH/PAK/121.06.(GU), Mac 2007 in March 2007 (Jadual Pelupusan Rekod Perubatan, MOH/PAK/121.06.(GU), Mac 2007 in Malay). Act 586, Private Healthcare Facilities And Services Act 1998 (incorporating all amendments up to 1 May 2006) is an Act to provide for the regulation and control of private healthcare facilities and services and other health-related facilities and services. Section 107, (2), (f) under Power to make regulations requires that the records to be kept of patients and persons treated in the private healthcare facilities or services but does not stipulate a retention policy. I think such private healthcare facilities or services could however plan for a retention policy for the reasons given in second paragraph of this post. The same provision of a minimum period of seven (7) years from the last date of treatment for the retention of all medical records with the exception of medical records of psychiatric, obstetric and paediatric cases could be adopted into a private hospitals retention policy. Likewise other contents of the medical records retention and disposal schedule for all public hospitals and health facilities in Malaysia could be availed and incorporated into its own private hospital medical records retention policy. Act 21, this Act cited as the Age of Majority Act 1971 dated 30 April 1971 is an Act to amend and consolidate the law relating to the age of, states under Section (2) that the minority of all males and females shall cease and determine within Malaysia at the age of eighteen years and every such male and female attaining that age shall be of the age of majority. Since the minimum period for the retention of all medical records with the exception of medical records of psychiatric, obstetric and paediatric cases is seven (7) years from the last date of treatment, then for minors medical records should be retained for another 7 years from the age of majority, that is for 25 years. The Medical Defence Malaysia Berhad (MDMB) website at on this link will open the website page in a new tab in your current window) presents a page on Medical Records: Preservation And Matters Of Evidence. MDMB a not-for-profit company limited by guarantee, functioning as a mutual medical defence organisation that aims to provide support in areas such as medico-legal counselling and the development of educational resources. HIM/MR practitioners must also know that if their hospital is in the process for accreditation of a quality program, then the medical records retention policy must be updated, readily available, complete and relevant. In order to be complete and relevant, I would recommend that this policy be jointly developed with the full knowledge and participation of the medical staff who have contributed to a medical record content. HIM/MR practitioners would provide secretarial support, coordinate the updating and completion of a up-to-date and revised hospital medical records policy. This policy will be measured against the Joint Commission International (JCI) Standard MCI.12 which states that The organization has a policy on the retention time of records, data, and information, if your hospital is on the path to be accredited or is to be re-surveyed for new period of accredited status when adopting the JCI accreditation process. So if your hospital has a policy on retaining medical (patient clinical) records and other data and information, the retention process provides expected confidentiality and security, and all of your records, data, and information are destroyed appropriately after the retention period, then clearly this policy will comply with the JCI Standard MCI.12, ME 1 to ME 3. This is not to imply you only rush to comply with JCI compliance (the JCI Standard MCI.12 merely states this requirement to comply with their standards compliance and accreditation status but does not necessarily mandate record retention schedules) but the policy is relevant for all the reasons as I have given above, once again to reiterate federal and local (if any) retention laws, legal requirements, need for continuing patient care and follow-up, research/educational uses, and management uses. In closing, do take note that a policy on retention of medical records is meant to serve as a guide on the retention periods for medical records, and do get the help of a legal counsel of your hospital or organisation if you are not sure about the Laws and their interpretations to be included in the policy. References: Edna, KF 1983, Medical Records Management, 7th edn, Physician Records Company, Illinois, USA Joint Commission International 2010, Joint Commission International Accreditation Standards For Hospitals, 4th edn, JCI, USA Margaret, AS 2003, Health Information Management, 5th edn, Jossey-Bass, San Francisco, USA World Health Organisation 2006, Medical Records Manual: A Guide for Developing Countries, WHO Regional Office for the Western Pacific, Philippines

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