FAQs for the Licence Conditions on the Retention Periods of Patient Health Records

1. When do the retention period "kick in"?

- Retention periods "kick in" only after the last day of consultation or treatment, or following patient's death. This ensures that the majority of patients who have chronic medical conditions, or are likely to require their health records in the future, will have access to them.

2. Why do I need to maintain patient health records for the stipulated periods?

- Due to the importance of patient health records in resolving medico-legal cases, and the sizeable impact (including consequence to individuals and/or monetary costs) that such disputes may have, the stipulated retention periods ensure that licensees have access to complete health records, especially in cases which are (i) deemed as "high risk", (ii) may require internal investigations, or where (iii) legal action has been or might be taken against the healthcare.

3. Do I need to keep all paper records after converting them to electronic records?

- No, original paper records may be destroyed upon digitisation of medical records, as long as the copies are accurate and comply with all applicable legislation (e.g Evidence Act) where applicable.
- Licensees are encouraged to digitise paper records using processes that are compliant with applicable legislation (e.g. the Evidence Act), where necessary.
- Thereafter, the digitised electronic records will be retained as per retention periods of all electronic patient health records.

4. Why can culling of paper patient health records be done only after four years?

- This is to preserve the paper records in the event of any patients' complaint(s) and the four-year time period is based on the fact that a patient can commence proceedings in Court on the 3rd year and have a further 12 months to inform the licensees of the proceedings.
- However, if these health records have been digitalised, then the original paper records may be destroyed, as long as the copies are accurate and comply with all applicable legislation (e.g Evidence Act) where applicable.

5. What is meant by "persons who lack mental capacity"?

- Under the Mental Capacity Act, a person lacks mental capacity in relation to a matter if, at the material time, he is unable to make a decision for himself or herself in relation to the matter because of an impairment of, or a disturbance in the function of, the mind or brain. (Please refer to Section (4) of the Mental Capacity Act).
- Mental capacity can be determined by a SMC registered psychiatrist, a medical practitioner who is accredited by the Public Guardian or an advocate and solicitor of the Supreme Court who has in force a practising certificate under the Legal Profession Act. (Please refer to Section 7(1) under the Mental Capacity Regulations)

6. Why is the duration for outpatient patient health records shorter than the 15-year general overriding time limit under the Limitation Act?

- This is because (i) many outpatients may not require their medical records past this timeframe and (ii) some outpatient healthcare providers may experience difficulties in storing medical records longer than 6 years. However, healthcare providers are advised to retain the complete outpatient medical records for up to 15 years, in cases which are (i) deemed as “high risk”, (ii) may require internal investigations, or where (iii) legal action has been or might be taken against the healthcare provider.

7. Is there anything I need to do specifically for records in legal proceedings?

- Operationally, licensees may choose to tag these records e.g. electronically, by stamping the words “Medico-Legal case”, or otherwise appropriate, prominently on the case folder/records.
- In addition, licensees are encouraged to apply appropriate risk management strategies, and high-risk case records should be retained following inpatient secondary medical records retention guidelines, based on age i.e. adult or minor.

8. What are the requirements pertaining to cancer records?

- Retention periods applied to cancer records should follow those of the relevant patient care settings.
- In addition, relevant information should be reported to and reside in the National Cancer Registry, as required by the National Registry of Diseases Act.

9. What are some examples of dental records?

- Dental Records” means records of a patient’s dental care and treatment, including but not limited to the following:

- Database information e.g. name, birth date, address, contact information, medical and dental histories, notes and updates;
- Treatment notes made by clinicians and staff;
- Diagnostic records including reports, charts, casts, photographs, radiographs, tracings and measurements;
- Treatment plan notes;
- Consent forms;
- Laboratory work order forms;
- Referral letters and correspondence with referring or referral dentists and/or physicians; and
- Patient complaints and resolutions.

10. [Updated on 17 Jul 2022] With reference to paragraph 6 of LCs, what would be considered "representative data of sufficient granularity"?

- We recognize that raw data generated by the source systems (e.g. X-ray, CT scanners) are often massive, and it is impractical and costly to store the raw data in its entirety. Licensee should determine what is deemed part of the patient health record and then apply the guidelines to all that is in that patient health record.
- Please note that the retention guidelines only apply to the information that is transferred into the patient's medical record and does not apply to the raw data. In determining what needs to go into the medical record, the licensee should assess its business needs (operational, medicolegal, etc).
- Using the example of a video recording of a laparoscopic operation, licensees may choose to capture selected frames of the video recording and include those as part of the official operation report (where applicable) instead of keeping the video recording of the entire procedure.

11. [Updated on 17 Jul 2022] Would consent forms for financial counselling and means testing constitute a part of "Patient Health Records" or can we interpret these documents as financial records with retention based on business needs?

- We wish to clarify that financial counselling forms would constitute a part of the "Patient Health Records" and should be retained in accordance with the respective categories (whether inpatient, outpatient or computerized/electronic records).

12. [Updated on 17 Jul 2022] With reference to paragraph 18 of the LCs, are we still obligated to provide lifetime storage for these images in electronic

form if medical images are routinely given to all our patients in the form of films?
• If there are electronic copies of these images as part of the patient's electronic health records, these images would need to be retained for the corresponding time periods. With electronic images, the ability to duplicate the images onto removable media is more easily achievable. We recognize that radiological images can be large and clinics should determine the amount of information required for their operational/medicolegal purposes and store the appropriate information in their patient's medical record. The retention requirement of "lifetime+6" does not apply to the rest of the raw information that is not entered into the medical record.