Alpha Clin™ CLINICS Inc.

Guideline

Record Keeping

1. Introduction:

Accurate and complete record keeping principles are imperative as described in both The Good Pharmacy Practice and SANC Regulation 767 Oct 2014: Acts and Omissions.

The Good Pharmacy Practice in South Africa 2010, 2.13.1.2. Documentation and record keeping, states:

h) The following information must be kept for a period of at least three years:

1. *A complete record of patient information;*
2. *The kind of test used;*
3. *The batch number of the testing material;*
4. *The test result; and*
5. *A record of advice given to patients.*

In accordance with SANC Regulation R767 Oct 2014: Acts and Omissions, disciplinary action may be taken against a person for:

"5. Wilful or negligent omission to keep clear and accurate records of all actions which he performs in connection with the patient."

2. Objective:

- Provide core requirements and guidance to ensure that accurate and complete records are kept for all Clinic Services rendered.
- Ensure appropriate referral to treatment.

3. Purpose:

The purpose is to describe the process to follow when recording a patient's information.

4. Scope:

This Guideline covers the process for record keeping during consultation using both Allegra and Manual records.

5. Responsibility:

It is the responsibility of the PCDT - pharmacist, pharmacist and Registered Nurse to:

- Understand and implement the process in this guideline correctly.

- Adhere to the legal record keeping principles set out in the Good Pharmacy Practice of South Africa Guideline and SANC Regulation 767: Acts and Omissions.

6. Procedure:

Always adhere to the following Record keeping principles, regardless of what service is rendered:

- Note the principle: If it is not recorded, it is not done.
- If using Allegra, each User should have his or her own Username and Password.
- Complete paper records in black ink and handwriting should be clearly legible.
- Sign and date any additions or corrections to manual records, individually.
- Only use recognized abbreviations.
- Use scientifically correct terminology.
- Indicate any/all Allergies and Medical history.
- Provide comprehensive and concise information with regards to the service and care rendered, including:
- The reason for the visit.
- The physical appearance of the patient.
- Tests performed/Observations done.
- Results of the tests/observations done and interpretation of data gathered.
- Injection / Immunisation administered, route and site of injection.
- Actions taken such as Referral to doctor, education/advice given.
- Maintain confidentiality of all patient records.
- Records should be kept for 3 - 5 years, in accordance with Good Pharmacy Practice of South Africa.

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