MINISTRY OF HEALTH
SINGAPORE

MH 78:04/4-2_V15 MOH Circular No. 84/2022

19 July 2022

Licensees / Managers of PHMCA-licensed institutions

AMENDMENTS TO THE NATIONAL GUIDELINES FOR RETENTION PERIODS OF MEDICAL RECORDS

Since the issuance of the national guidelines for retention periods of medical records in 2015, MOH has received several queries and feedback from licensed healthcare institutions. In consultation with the medical community, MOH has assessed the feedback and updated the guidelines to address the operational challenges faced by the healthcare institutions in complying with these guidelines and provide healthcare providers with a better and clearer understanding of the records retention practices.

2. This circular informs all licensees under the Private Hospitals and Medical Clinics Act (PHMCA) of the amendments to the national guidelines for retention periods of medical records. The revised guidelines will take effect from the date of issuance.

3. Please refer to Annex A for the revised guidelines, and Annex B for the Table of Amendments and Rationale for the revised guidelines.

4. Healthcare institutions will need to develop or update your internal processes with these updated guidelines as a reference.

5. For avoidance of doubt, all existing PHMCA and Healthcare Services Act (HCSA) licensees will be subject to the same requirements laid out in Annex A in the form of guidelines under the PHMCA and Licence Conditions under the HCSA. Should you require any further information or clarification, please email us at eLis@moh.gov.sg.

A/PROFESSOR KENNETH MAK
DIRECTOR OF MEDICAL SERVICES
MINISTRY OF HEALTH

Ministry of Health, Singapore
College of Medicine Building
16 College Road
Singapore 169854
TEL (65) 6325 9220
FAX (65) 6224 1677
WEB www.moh.gov.sg

Cc CEO of Agency for Integrated Care
Heads / Directors of AMS, CFPS, CMSS, HSA, PSS, SNA
MOH CMIO

Ministry of Health, Singapore
College of Medicine Building
16 College Road
Singapore 169854
TEL (65) 6325 9220
FAX (65) 6224 1677
WEB www.moh.gov.sg

Annexes

Annex A	REVISED GUIDELINES FOR THE RETENTION PERIODS OF MEDICAL RECORDS
Annex B	TABLE OF AMENDMENTS AND RATIONALE FOR REVISED GUIDELINES

Ministry of Health, Singapore
College of Medicine Building
16 College Road
Singapore 169854
TEL (65) 6325 9220
FAX (65) 6224 1677
WEB www.moh.gov.sg

ANNEX A

REVISED GUIDELINES FOR THE RETENTION PERIODS OF MEDICAL RECORDS

Application

1. The guidelines on the retention periods of medical records apply to all licensees licensed under the Private Hospitals and Medical Clinics Act.

Definitions

2. In these LCs, unless the context otherwise requires:

(a) "**Assisted Reproduction (AR) Records**" means:
   (i) registers of children conceived through AR procedures and delivered in Singapore, identified by their birth certificate numbers; and
   (ii) medical records of AR procedures (whether resulting in a live birth or otherwise), including the investigations carried out before the start of the AR treatment, indications for undergoing AR, treatment protocols, data captured from the start of the cycle till the end (e.g. in the case of a fresh cycle: from the date of ovarian stimulation till the confirmation of clinical pregnancy), as well as the outcome and any complications of the AR treatment.

(b) "**Computerised / Electronic Medical Records**" means all Medical Records entered into an electronic system and paper Medical Records which have been digitised into an electronic format. This includes information and/or data that is generated electronically and entered into Medical Records.

(c) "**Diagnostic Images**" means film/paper-based images.

(d) "**High Risk Patients and/or Cases**" includes (i) patients who suffered complications during treatment, (ii) pending complaint cases, and (iii) patients who lacked mental capacity, or are suspected to have lacked mental capacity, at the time of the consultation or treatment.

(e) "**ILTC**" means Intermediate & Long-Term Care.

(f) "**Inpatient Records**" means Medical Records for inpatient stays at healthcare institutions including acute hospitals, community hospitals and residential ILTC institutions. This includes dental records and hardcopy Diagnostic Images which are stored as part of the Inpatient Record.

(g) "**Lifetime**" means a patient's actual lifetime or 110 years where the actual time of death of the patient is unknown.

(h) "**Outpatient Records**" means Medical Records for outpatient visits at and/or services rendered by healthcare institutions including Accident & Emergency departments (A&E), polyclinics, General Practitioners clinics, private specialist

Ministry of Health, Singapore
College of Medicine Building
16 College Road
Singapore 169854
TEL (65) 6325 9220
FAX (65) 6224 1677
WEB www.moh.gov.sg

clinics, dental clinics, ambulatory surgical centres, renal dialysis centres and emergency ambulance and medical transport services. This includes records of teleconsultations and Diagnostic Images which are stored as part of the Outpatient Record.

(i) "**Medical Records**" means a record containing the personal data and medical information of a patient that is maintained by a Licensee in relation to the provision of a healthcare service licensable under the PHMCA to the patient, and includes all clinical encounters and original inpatient and outpatient records generated at the time of admission or outpatient attendance.

(j) "**Persons who lack mental capacity**" means a person who lacks mental capacity as defined in section 4 of the Mental Capacity Act 2008.

(k) "**Retention Period**" means the period of time that the Medical Records should be kept for, following:

(i) the last day of consultation or treatment, whichever is later;
(ii) the patient's death,
as applicable and stipulated in these LCs.

Minimum Retention Periods of Medical Records

3. Licensees shall ensure that all original Medical Records are retained for the corresponding minimum Retention Period as provided in Table 1 below.

Ministry of Health, Singapore
College of Medicine Building
16 College Road
Singapore 169854
TEL (65) 6325 9220
FAX (65) 6224 1677
WEB www.moh.gov.sg

Table 1: Retention Period of Medical Records

S/N	Category	Retention Period
1.	**COMPUTERISED / ELECTRONIC RECORDS**	
	Computerised / Electronic Medical Records	Lifetime +6 years
2.	**PAPER RECORDS (subject to paragraph 7)**	
2.1	**Inpatient Records (includes acute hospitals, community hospitals and all residential ILTC institutions)**	
(a)	Adults	15 years from last day of: (i) stay in the facility, or (ii) consultation or treatment (if applicable), whichever is later
(b)	Minors	Until the patient is 24 years of age; or 15 years from last day of: (i) stay in the facility, or (ii) consultation or treatment (if applicable), whichever is later
(c)	Persons who lack mental capacity	Lifetime +6 years;
2.2	**Outpatient Records**	
	Outpatient Records	6 years from last day of consultation or treatment, whichever is later (unless High Risk Patients and/or Cases)
2.3	**Assisted Reproduction Records**	
(a)	Where a child was successfully born via AR treatment: (i) Register of children conceived through AR procedures; (ii) Medical Records of AR procedures	(i) Register of children conceived through AR procedures: Child's Lifetime +6 years; (ii) Medical Records of AR procedures: Child's Lifetime +6 years
(b)	Medical Records for AR treatments that did not result in a live birth	(i) Where treatment was carried out in *inpatient* settings: 15 years from last day of consultation or treatment, whichever is later; (ii) Where treatment was carried out in *outpatient* settings: 6 years from last day of consultation or treatment, whichever is later (unless High Risk Patients and/or Cases)

Retention of Computerised / Electronic Medical Records

4. Where it is impractical to store electronically generated information and/or data entered into Medical Records in its entirety, Licensees shall ensure that representative data of

Ministry of Health, Singapore
College of Medicine Building
16 College Road
Singapore 169854
TEL (65) 6325 9220
FAX (65) 6224 1677
WEB www.moh.gov.sg

sufficient granularity is entered into the Medical Records and retained for the minimum Retention Period for purposes of documentation, care provision and review.

Retention of Paper Medical Records

5. Licensees shall develop appropriate retention and archival strategies for the storage of paper Medical Records.

6. Licensees may cull paper Medical Records after four years of retention. In the event that Licensees elect to cull paper Medical Records, Licensees must retain at least the following records for the remainder of the relevant Retention Period set out in Table 1:
   (a) Inpatient/ outpatient discharge summary;
   (b) Operation reports;
   (c) All consent forms;
   (d) X-ray reports;
   (e) Histopathology investigation reports;
   (f) Maternity records;
   (g) Neonatal records which are enclosed in the mother's case notes;
   (h) Labour records;
   (i) Work Injury Compensation reports;
   (j) Insurance forms;
   (k) Medical and other medico-legal forms;
   (l) Treatment and progress notes (including doctors, nurses and allied health professionals);
   (m) Inpatient medication charts;
   (n) Prescription orders; and
   (o) Blood transfusion records.

7. Where Licensees convert original paper Medical Records into a digitised form through processes such as scanning or microfilming, such digitised records are to be regarded as Computerised / Electronic Medical Records. Licensees shall ensure that such digitised records are retained for the remainder of the relevant Retention Period for Computerised / Electronic Medical Records.

Maternity Records

8. Licensees shall retain maternity records relating to a minor, including pregnancy and delivery records, as part of the mother's Medical Records, for the relevant Retention Period applicable to the records of that minor.

Outpatient Records

9. Licensees shall classify A&E Medical Records as Outpatient Records where the patient is not admitted into the same healthcare institution for inpatient treatment.

10. Where an outpatient patient is admitted into the same healthcare institution for inpatient treatment, Licensees shall retain Medical Records relating to the patient's outpatient and inpatient treatment. Such Medical Records shall be regarded as Inpatient Records for the purposes of these LCs.

Ministry of Health, Singapore
College of Medicine Building
16 College Road
Singapore 169854
TEL (65) 6325 9220
FAX (65) 6224 1677
WEB www.moh.gov.sg

Retention of Medical Records In Legal Proceedings

11. Where legal or other dispute resolution (e.g. mediation) or disciplinary proceedings in relation to a patient's consultation or treatment have commenced or where it is reasonably foreseeable to a Licensee that such proceedings may be commenced (e.g. a complaint has been made, there are related criminal investigations or proceedings, etc.), Licensees shall ensure that that patient's complete Medical Records are retained until the conclusion of such proceedings or as per the relevant Retention Period, whichever is later.

12. For the avoidance of doubt, paragraph 11 shall apply to all types of Medical Records.

High Risk Patients and/or Cases

13. Licensees shall develop appropriate retention and proper documentation protocols for High Risk Patients and/or Cases.

14. Licensees shall retain Medical Records of High Risk Patients and/or Cases for a minimum duration of 15 years from the last day of consultation or treatment, whichever is later.

15. Where Licensees decide to retain Medical Records for High Risk Patients and/or Cases for a period longer than the relevant Retention Period, Licensees shall ensure that the decision is supported by clear reasons which are noted in the patient's Medical Records.

Diagnostic Images

16. Licensees shall ensure the proper retention of Diagnostic Images as part of the patient's Medical Records of the relevant care setting (whether inpatient or outpatient), save for Diagnostic Images which have been released to the patient.

Ministry of Health, Singapore
College of Medicine Building
16 College Road
Singapore 169854
TEL (65) 6325 9220
FAX (65) 6224 1677
WEB www.moh.gov.sg

ANNEX B

TABLE OF AMENDMENTS AND RATIONALE FOR THE REVISED GUIDELINES

Category	Medical Record Retention Period		Legal requirement / Rationale for amendment
	2015 Guidelines	Revised Guidelines	
1. Computerised / electronic medical records			
All computerised / electronic medical records	Lifetime +6 years	Lifetime +6 years Removed Explanatory Note 3(d) in 2015 guidelines where "If HCIs keep records for longer than the period of "lifetime+6 years", records should be de-identified, unless otherwise permitted under law."	<u>Rationale</u> To address the operational challenge of de-identifying piecemeal information in the healthcare institution's system as a key design of electronic medical records (EMR) systems is to maintain documentation such that records are not to be deleted and are unique to each individual.
2. Paper medical records			
2.1 Inpatient records (includes at acute hospitals, and community hospitals and all residential ILTC institution)			
a) Adults	15 years	15 years from last day of: (i) stay in the facility, or (ii) consultation or day of treatment (if applicable), whichever is later	<u>Legal requirement</u> The Limitation Act sets out the overriding limit of 15 years[1] for negligence or breach of duty resulting in personal injuries. <u>Rationale</u> To clarify general over-riding time limit stipulated by the Limitation Act.

Category	Medical Record Retention Period		Legal requirement / Rationale for amendment
	2015 Guidelines	Revised Guidelines	
2. Paper medical records			
2.1 Inpatient records includes at acute hospitals, and community hospitals and all residential ILTC institution)			
b) Minors	Until the patient is 24 years of age	Until the patient is 24 years of age; or 15 years from last day of: (i) stay in the facility, or (ii) consultation or day of treatment (if applicable), whichever is later	Legal requirement The Limitation Act also sets out the overriding limit of 15 years[1] for negligence or breach of duty resulting in personal injuries. Rationale In alignment with the retention period of the other settings and with legal requirements.
Intermediate & Long-Term Care records			
Includes all residential ILTC institutions	15 years	To be retained as per the retention period for inpatient records for the relevant category (i.e. adults, minor, lack mental capacity)	The requirement of paper residential ILTC records have been subsumed under the Inpatient Records and is in alignment with the retention period of the other settings and with legal requirements.
2.2 Outpatient records			
Outpatient Records	6 years or longer for "high risk" patients	6 years from last day of consultation or treatment, whichever is later (unless high risk patients and/or cases) Removed Explanatory Note 10(a) in 2015 guidelines where high-risk cases included "patients who underwent procedures to remove foreign bodies"	To clarify that the retention period commences following the last day of consultation or treatment. As the records for "high-risk" patients and/or cases will be retained for a longer duration, these cases should be commensurate with the level of patient safety risk involved.

Category	Medical Record Retention Period		Legal requirement / Rationale for amendment
	2015 Guidelines	Revised Guidelines	
2. Paper medical records			
2.3 Assisted reproduction records			
a) Medical records for AR treatments that did not result in a live birth	NA	Where treatment was caried out in *inpatient* settings: 15 years from last day of consultation or treatment, whichever is later; Where treatment was carried out in *outpatient* settings: 6 years from last day of consultation or treatment, whichever is later (unless high risk patients and/or cases)	To clarify that the retention period of medical records of AR procedure should be retained as per the retention period for the guidelines for that setting.
Others			
Diagnostic images	6 years	To be retained as per the retention period for inpatient records for the relevant category (i.e. adults, minor, lack mental capacity) or outpatient records	Diagnostics images, which form part of the patient's Medical Records in the relevant care setting, should be retained as per the retention period for the guidelines for that setting.

FOOTNOTE FOR ANNEX

[1] 15 years starts from the date of the occurrence of the act / omission that is alleged (a) to constitute the negligence or breach of duty, and (b) to be attributable to the injury in question (in whole or part).