AMALA INSTITUTE OF MEDICAL SCIENCES

AMALA NAGAR, THRISSUR

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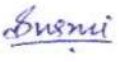
	Signature	
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ADDENDUM

Sl. No.	Section No. & Page No.	Details of the Addendum	Reasons	Signature of the preparatory authority	Signature of the approval authority
1.					
2.					
3.					
4.					
5.					

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AMENDMENT SHEET

Sl. No.	Section No. & Page No.	Details of the Amendment	Reasons	Signature of the preparatory authority	Signature of the approval authority

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CONTROL OF THE MANUAL

The authority over control of this manual is as follows:

Preparation	Approval	Issue
In charge MRD	Director	Accreditation coordinator

The procedure manual with original signatures of the above on the title page is considered as 'Master Copy', and the photocopies of the master copy for the distribution are considered as 'Controlled Copy'. The Master copy will be sealed as 'Master Copy' and Controlled copies will be sealed as 'Controlled copy'

Distribution List of the Manual:

Sl. No.	Designation
1.	Director
2.	Accreditation Coordinator
3.	In-charge - Medical Record Department

The holder of the copy of this manual is responsible for maintaining it in good and safe condition and in a readily identifiable and retrievable mode.

The holder of the copy of this Manual shall maintain it in current status by inserting latest amendments as and when the amended versions are received.

In charge- Medical Record Department is responsible for issuing the amended copies to the copyholders; the copyholder should `acknowledge the same and he /she should return the obsolete copies to the in charge.

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If amendment regarding any point is required, the person who prepared the manual should contact the Quality Coordinator, prepare the amendment and get approval from approval authority. It should be attached to the Master copy and details to be entered in its amendment sheet. Quality Coordinator is responsible for issuing copy of amendment(s) to the controlled copyholder and he/she should acknowledge the same. Quality Coordinator should also enter the amendment details in the amendment sheets provided in the controlled copy.

The manual is reviewed once a year and is updated as relevant to the hospital policies and procedures. Review and amendment can happen also as corrective actions to the non-conformities raised during the self-assessment or assessment audits by NABH.

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1.0 INTRODUCTION

The mission of the Medical Department is to develop, implement and continually improve the safe, confidential, systemic and effective method of receiving, filing storing, retrieving and discarding the medical record of the patients admitted for the treatment in accordance to the legal requirements. A medical record is the chronological documentation of health care and medical treatment given to a patient by professional members of the health care team. It is an accurate, prompt recording of their observations including relevant information about the patient, the patient's progress and the results of the treatment. The Department forms an integral part of the Amala Hospital, forming the base station for all the medical records. Medical record keeping is helps in analyzing the medical care, research base, a source of back reference in case the patient seeks the care in the same hospital or the need for review of the disease suffered or medication given is there in case the patient is taking services in some other health care set up thus forming a continuity of care.

2.0 DEFINITION

Medical Record: Medical record is a compilation of pertinent facts of a patient's life and health history, including past and present illness and treatment, written by healthcare professionals contributing to the patient care.

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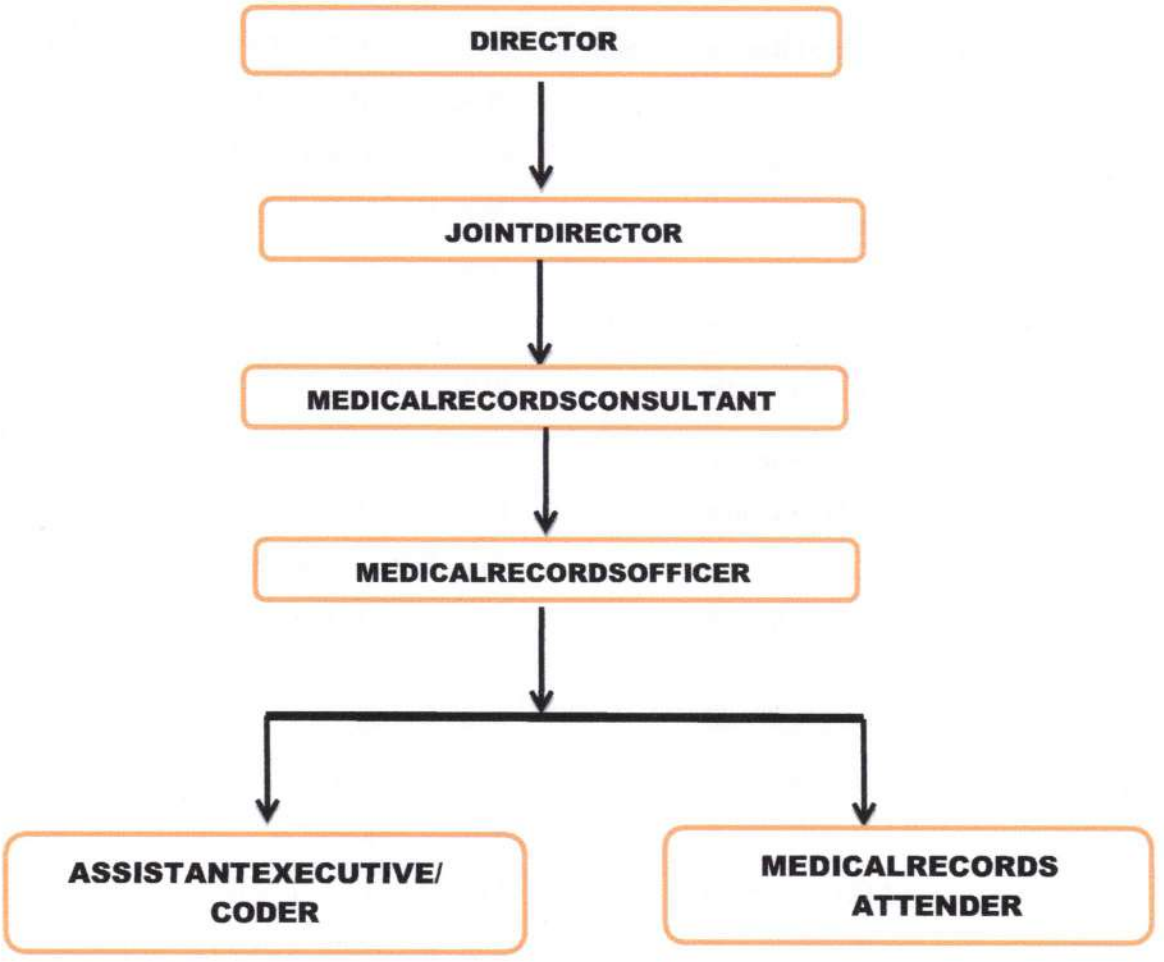
3.0 DEPARTMENTAL HIERARCHY



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4.0 COMPETENCY MATRIX

Sl. No.	Name of the Staff	Designation	Qualification	Experience (Years)
1	Dr. Joju V. Antony	Medical Records Consultant	B.Com, DMRM, PGDHA, PGHIM, MBA, PhD.	35 Years
2	Sruthi Prakash	Medical Record Officer	B Sc. Biotechnology, M. App. M Sc. Medical Documentation	4 years
3	Anu C K	MRD Assistant Executive	B.Com, Medical Coding	2 years
4	Sandhya C D	MRD Attender	PDC, Tally	21 years
5	Lincy K D	MRD Attender	Plus Two, ANM	19 years
6	Jessy C L	MRD Attender	Plus Two, BSS Hospital Doc. & Record Keeping	16 years
7	Ambily P H	MRD Attender	ANM,BSS Hospital Doc. & Record Keeping	17 years
8	Rajani T K	MRD Attender	PDC, Degree	17 years
9	Annie Paul	MRD Attender	B.Com, BSS Hospital Doc. & Record Keeping	16 years
10	Sujitha K S	MRD Attender	Plus Two, BSS Hospital Doc. & Record Keeping, ANM	16 years
11	Prabha Rajesh	MRD Attender	Plus Two	16 years
12	Beena C R	MRD Attender	PDC,B.Com	15 years
13	Greeshma K G	MRD Attender	Plus Two, BSS Hospital Doc. & Record Keeping	14 years

14	Jonsy Joseph	MRD Attender	SSLC, ANM,BSS Hospital Doc. & Record Keeping	16 years
15	Julee O F	MRD Attender	Plus Two, BSS Hospital Doc. & Record Keeping	16 years
16	Saraswathy T K	MRD Attender	PDC, Comp Info ware Course	16 years
17	Shiji C J	MRD Attender	Plus Two	14 years
18	Soumya M S	MRD Attender	Plus Two, BSS Hospital Doc. & Record Keeping	15 years
19	Gincy P L	MRD Attender	SSLC	15 years
20	Rosily E V	MRD Attender	BA Hindi, BSS Hospital Doc. & Record Keeping	15 years
21	Sarika N N	MRD Attender	Plus Two	15 years
22	Sinitha C O	MRD Attender	SSLC	13 years
23	Siji K G	MRD Attender	Plus Two	14 years
24	Liji C V	MRD Attender	SSLC	12 years
25	Neethu M S	MRD Attender	SSLC	12 years
26	Smitha Joseph	MRD Attender	Plus Two	13 years
27	Sanchana C S	MRD Attender	PDC	12 years
28	Annie C K	MRD Attender	SSLC	10 years
29	Aji Mathew	MRD Attender	Plus Two	10 years
30	Manila P R	MRD Attender	SSLC	2 years
31	Jiljy Jose	MRD Attender	Plus Two	1 year
32	Saumia K V	MRD Attender	Plus Two	year

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5.0 STAFF PATTERN:

There are 3 Medical Record Department Rooms

1. Chavara Block MRD
2. Devamatha Annex Block MRD
3. Sacred Heart Block MRD

Total no. of staff is 32 including MRO.

Chavara Block MRD Staffing Pattern	-	13
Medical Record Officer	-	1
Medical Record Consultant	-	1
MRD Assistant Executive/Coder	-	1
MRD Attender for Indexing Purpose	-	1
Others	-	9
Devamatha Annex Block MRD Staffing Pattern	-	7
Sacred Heart Block Oncology MRD Staffing Pattern	-	3
Night only at Chavara Block MRD	-	3

6.0 LIST OF SERVICES PROVIDED:

1. Storing of Patient files
2. Processing of Patient's file
3. Checking of Deficiency in Patient's file
4. Preparation of Statistics
5. Retrieval of Records

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6. Release of Information
7. Support of Legal Proceedings and Medical Legal Protection

7.0 DUTIES AND RESPONSIBILITIES:

MEDICAL RECORD CONSULTANT

- To establish, organize and manage medical record department with appropriate systems to provide an effective service in the hospital.
- To develop policies and procedures relating to the MRD in accordance with the Health Directorate.
- To review the medical records of the patients to ensure that they include all important documents and patient information.
- To cooperate with the medical, nursing and other staff in completing patient medical records.
- To prepare monthly statistical reports concerning the hospital activities carried out, and to submit to concerned authorities any suggestions for improvements.
- To observe professional ethics and to protect the confidentiality of information from authorized person; to keep medico legal records under safe custody.
- To select appropriate personnel for the MRD and train them for performing their jobs efficiently.
- To implement information technology (Computer application) for the effective functioning of the registration systems to collect clinical and administrative statistics.
- To supply patient files in accordance with the established procedures for medical care, medical education, medical training, medical care evaluation management, and legal purposes.
- To cooperate with the medical, nursing, head of departments, patients, health agencies, other hospitals, and legal authorities for smooth and efficient functioning of the hospital in general and the medical record department in particular.
- To supervise the work of MRD staff.
- To carry out other duties and functions related to Medical Record Services as instructed by the immediate chief.

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MEDICAL RECORD INCHARGE

- Plans, Organize, direct, coordinates and supervises the operation of medical record unit and other administrative and medical office support activities.
- Development and implements policies and procedures relating to the management, retention and storage of medical records.
- Supervises, directs, trains and assigns the work of clinical, medical records and other assigned staff, either directly or through subordinates and supervisors and lead staff.
- Evaluate employee performance and recommends employee selection, initiate disciplinary action and other personnel activities.
- To establish, organize, manage a MRD with appropriate system to provide an effective service in the hospital.
- To develop policies and procedures relating to MRD in accordance with the legal or Government policies.
- To review the medical records of OP and IP to ensure that they include all important documents and pertinent information.
- To cooperate with the medical, nursing and other staffs in completing patient medical records.
- To assist in quality assurance utilization review, infection control and other committee and programs.
- To prepare monthly statistical report concerning the hospital activities carried out and to submit to concerned authorities and suggestion for improvement.
- To ensure confidentiality of information.
- To effectively control the movement of the patient files to achieve a unit record system and protect medical records in accordance with the policies relating to preservation and destruction.
- Interdepartmental relations relating to the patient flow, maintenance of medical records and other documents like nursing, laboratory, radiology, administrative, public relations, medical social service and doctors.
- Plan, develops and administers health information system for health care facility consistent

with standards of accrediting and regulatory agencies and requirements of health care systems.

- Develops and implements policies and procedures for documenting, storing and retrieving information and for processing medical legal documents, insurance data and correspondence requests in conformance with federal, state and local statutes.
- Coordinates medical care evaluation with medical staff and develops criteria and methods for such evaluation.
- Prepare and conducts training sessions in medical records maintenance, processing, retention and release of the departmental staffs.
- Conducting Monthly Medical Record Audit Review Committee.
- Practice policies and procedures relating to confidentiality and the protection of personal and sensitive data of patients, colleagues and others.

ASSISTANT EXECUTIVE

- Responsible for record maintenance: Ensuring all medical records are complete and updated. Checking for missing documents or reports and notifying concerned department
- Medical Coding and Indexing: Review patient medical records to extract relevant information and code with appropriate ICD-10 diagnosis codes and procedure codes according to the proper coding guidelines and regulations and is indexed for easy retrieval.
- Release of Information: Verify request for legitimacy, check consent and authorization, coordinate with MRD staff, and ensure timely release.
- Maintaining confidentiality: To safe guard the medical records with strict confidentiality and ensuring no unauthorized access. Ensure that all records maintained are based on hospital policy and legal standards.
- Assisting Medical Records Officer: Assist for Audits, documentation reviews and inspections. Regularly check records for errors or omission and follow up for corrections. Monthly collection of statistical data and assisting for monthly statistics preparation.
- Basic Administrative Works: To do basic administrative works; attending phone calls responding to official mails, photocopying and handles queries and clarifications.

- Any other duties assigned by the Directors/HOD/In charge: Classifies and verifies coding of diseases and operations in accordance with the coding of standard nomenclature and classification systems.

MRD ATTENDERS

- Responsible for filing and retrieval of medical records: Arranging & filing patients' records systematically. Responsible for dispatch & return of medical records to and from the concerned OPD, wards, ED, ICU.
- Responsible for record maintenance: Ensuring all medical records are complete and updated. Checking for missing documents or reports and notifying concerned department. To cross-check and ensure all issued case sheets are returned to MRD, includes tracking and clearing missing files.
- Transporting files: Deliver files to OPDs, wards, OP to OP cross consultations, departments and MRD. Keep track of medical records taken out and returned.
- Indexing: Review patient medical records to extract diagnostic codes and index using proper guidelines and regulations.
- Maintaining Confidentiality: To safe guard the medical records with strict confidentiality and ensuring no unauthorized access.
- Assisting Medical Records Officer: Supporting senior staff in organizing and archiving records and day to day activities in medical records department. Assist in preparing records for audits or inspections.
- Basic Administrative works: To do basic administrative works: Attending phone calls, photocopying, sorting, arranging, filing, handling queries and clarifications and other clerical tasks. Maintain cleanliness and order in the records area. Report any missing or damaged files to the MRO. Any other duties assigned by the Directors/HOD/In charge. To strictly follow hospitals Rules & regulations and policies.

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8.0 POLICIES AND PROCEDURES (APPLICABLE):

PURPOSE

- To document patient history, assessment and treatment provided emphasizing on the events affecting the patient during the current episode of care.
- To ensure identification and control of outpatient and in-patient medical records through various stages of patient care.
- Compilation, classification and indexing of patient records to ensure continuity of care, aiding administrative process and for legal purposes.
- Compilation and reporting of various hospital statistics relating to various hospital services and outcomes.

SCOPE

- To define the overall policy of the hospital with regard to the process of managing patient medical records
- Identification, issue and ensuring traceability of the medical records through various stages of patient care in the hospital.
- Defining various processes of medical records management at the hospital.
- Filing and retrieving of both OP and IP records at both active and in-active record storage areas.
- Compilation, reporting and filing of hospital statistics including daily census reports, service utilization statistics, disease patterns and outcome analysis.

IDENTIFICATION OF RECORDS

A medical record has a unique identification number and for easy identification of records different color codes are given for medical records.

- MLC records are identifies in red color folder
- IP records are in green color
- OP records are in blue

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- Oncology records are maintained separately in rose color.

PATIENT REGISTRATION

A central computerized registration system with 24 hours service is maintained for all outpatients and inpatients.

- Seven digit hospital numbers are used for outpatients and inpatients. OP and IP charts are kept together according to Hospital number. Every sheet in the medical record shall have this unique identifier.
- The important identification information for each new patient is registered in computer.
- Registration card is given to each new patient. The organization has a complete and accurate medical record for every patient.

ENTRIES IN MEDICAL RECORDS

- Organization has a written policy that authorizing who can make entries and the content of entries.
- Only authorized staff shall enter the details in the respective areas in the case sheet.
- The medical records are assembled in chronological order (from admission to discharge) in the medical record.
- All entries in the patient medical records are signed, dated, timed and named.
- All entries should be documented immediately but no later than one hour of completion of the assessment/procedure.
- All the entries are identified by the full name and signature of the author along with date and time. Persons authorized to make entries in the medical records of the patients are: Doctors (Consultants, Resident Doctors; Staff nurses; Physiotherapist; Dietician; Medical records professionals)

The details of format filling authority			
FORMS NAME	DOCTOR	NURSE	OTHERS
Medical ER / OP Form	*		
Medical and Pediatric H&P	*		
Medical (Progress Record, Reference Form, Pre-Op. Assessment, OT Record, Anesthesia form, Consent forms, Medication Order etc.,	*	*	
Nursing (Nurses Daily Assessment, plan of care, Monitoring Flow Sheet, Pre-op checklist, Daily treatment/Activity chart, Vital Chart, Medication Administration, functional Screening form etc.,		*	
Deficiency Check list	*	*	MRD Staff
Functional Physiotherapy Assessment			Physiotherapist
End of life Care form	*	*	
Nutritional Assessment	*		Dietician

- In case abbreviations are used, a standardized list of approved abbreviations shall be used throughout the organization .For medications, error prone abbreviations are used.
- Only controlled forms and formats, which are approved by the management, shall be used by the service providers for the medical records.
- Medical Records are arranged in process oriented method. All medical records are checked for the deficiency after the medical records reach MRD.

Legibility Standards when writing into the Medical Records

- There are a number of factors that contribute to effective medical record maintenance. At Amala Hospital, the staff involved in the patient care process are expected to adhere to the standards outlined below.

- All records when being written must:
  - Be factual, concise and accurate
  - Be written as soon as possible after the event occurred, providing current information on the care and condition of the patient.
  - Be accurately dated (day/month/year) and timed (using 24hour clock or clearly denoting AM / PM when 12 hour clock is used)
  - Identify the author of the entry by full name or by mentioning employee code number or with the help of stamp or printing their name and signature on the first entry. All signatures must be legible.
  - In case of electronic based records, authorized e- signature as per statutory requirements is kept.
  - Be written in blue indelible ink – do not write in pencil at any time.
  - Be written as neatly as possible so that others can read and understand the text.
  - Clear communication between those caring for the patient is essential.
  - Be written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read.
  - Never erase or use correcting fluid. If an error occurs in recording the information, the following should be used: Strike through the entry with a single line, date and record the time the error was corrected, and then make the correct entry and counter sign the entry.
  - Never alter entries retrospectively. If later discovered that something has been written as inaccurate, misleading or incomplete, insert an additional note in the next available space as a correction. Make it clear that the new note is a later amendment and that there is no attempt to tamper with the original records. Remember to date and sign the later entry.
  - Do not leave spaces between each entry.
  - Do not use derogatory remarks, insulting comments or value judgments. Use objective rather than subjective comments whenever possible.
  - Record accurately the information given to patients in respect of their treatment choices and associated risks.

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- Be written in chronological order and each entry should provide evidence to determine each healthcare professional who has been in contact with the patient or who is responsible for decision making about the patient's treatment.
- Provide clear evidence of the care planned and any decisions made to and ensure the information is written so it can be shared with the other appropriate Healthcare Professionals.
- Identify problems that arise with a patient's treatment and the action that was taken to rectify them.
- Provide evidence of any discussions / conversations with the patient or family regarding the patient.
- If a patient's history has been provided by a person other than the patient (e.g. a relative, caretaker, translator or police officer), record that person's name, status and if required their contact number.
- Investigation results must always be signed and dated by clinical staff within 24 hours of receipt. They must not be filed into the notes unless they have been authorized.

ISSUE OF INPATIENT RECORDS AND OUTPATIENT RECORDS

- If the patient is visiting the hospital for the first time a new outpatient record is created and issued to the relevant department.
- On any subsequent visit the same Outpatient record of the patient is issued.
- All issued Outpatient records are returned to the Medical Record Department on the same evening.
- If any records are not returned, the Medical Record Department shall follow up the next day.
- Inpatient records are created for each admission.
- After a patient is discharged, the Inpatient records and Outpatient records are returned to the Medical Record Department.

PROCESSING OF PATIENTS RECORDS

Control of Medical Record Formats

- The Medical Records Officer is responsible for ensuring the control of the various formats used by various patient care units for documentation of patient care activities, which forms the medical record of the patient.

- The Medical Record Officer shall maintain and update a List of Medical Records (Refer to annexure) with the details of the various records used by the hospital including record numbers, titles and revision status.
- The Medical Record officer shall maintain a catalogue of the master formats of all the medical records used by the hospital. The master formats shall have the approval of the appropriate authority for approval of the format.

Deficiency Check

- The medical record attender shall perform a deficiency check for each medical record received. The deficiency check shall verify;
- Sorting order of the folder
- Completeness of the reports
- Signature of the consultants / clinicians with date and Time
- Completeness of Diagnosis and discharge status
- Completeness of the consent forms
- Completeness of operation reports
- Missing diagnostic reports
- In case of any deficiencies the same shall be noted in the checklist and the concerned department requested to ensure the completeness of the records.
- In case of abbreviations a standardized list of approved abbreviations are used in the medical records.

Compilation and Maintenance of Patient Record Folder (Entry Protocol)

- The medical record contains information regarding reasons for admission, diagnosis and plan of care
- Operative and other procedures performed are incorporated in the medical record
- When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital
- The medical record contains a copy of the discharge note duly signed by appropriate and qualified personnel

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- In case of death, the medical record contains a copy of the death certificate indicating the cause, date and time of death.
- Care providers have access to current and past medical record
- The patient record folder is compiled by addition of the required record sheet by the nursing staff of the patient care unit or the concerned department technicians in cases of diagnostic and therapeutic units.
- Proper identification shall be made on each record by noting down details like patient name, Hospital number, age & sex etc.
- The clinicians, nursing staff & other health care members are responsible for documenting the patient care activities as required, signed by the staff with date and time.
- The various medical records shall be arranged with the patient record folder as per the pre-determined Sorting Order of Medical Records (Refer to annexure).
- The various investigations report and consent forms shall be properly mounted by the nursing staff as specified.

CONFIDENTIALITY AND SECURITY OF THE MEDICAL RECORDS

- It is the duty of each and every staff member to safe guard the medical records and ensures the confidentiality of information they come across while performing their duty.
- No staff member shall approach the medical records department directly for obtaining their or their families medical records. They shall follow the guidelines for issue of medical records and approach the reception for the same.
- In case a staff member finds a medical record misplaced anywhere in the hospital, they shall immediately hand it over to the custody of the medical records department.
- In no case shall a medical record or the medical record folder as a whole be given in the hands of the patients or their family.

Entry Protocol in Medical Record Department

- Only Doctors and Nursing staff are allowed to enter MRD. Other departmental staff and patient entry is strictly prohibited.

- Nurses are allowed for replacing the files after 11.00pm. Police Officers for enquiring the files and Insurance staff for taking the files and from insurance company staff for investigate files are allowed to enter inside the MRD.

Pest Control Activity

- Pest and rodent control have to be done in all MRD by warehousing corporation in every month.
- Data kept under the maintenance Department and Medical Records Department.

Security and Fire

- CCTV Surveillance in all MRD and the Fire-Fighting Equipment has installed one at the entrance and one inside the room and once in 6 months internal audit has been done.

FILING AND RETREIVAL OF MEDICAL RECORD

International Classification of Diseases (ICD) coding

The medical records officer and MRD record Coder shall code the patient records as per International Classification of Diseases - Tenth Revision (ICD 10CM) published by the World Health Organization. The coding shall cover primary, secondary and final diagnosis. All the data are stored in the server.

Medical Record Indexing

Indexing done by the MRD attender on the hospital software iApps Backup stored in the server.

Filing of Medical Records

- The medical record attender shall receive records intended for filing after processing and place them in specifically designated areas.
- The OP and IP files shall be kept according to hospital number.
- The filing order for the various files shall be mapped in the medical records file-tracking feature of the hospital management system. The filing of the records shall be done in sequential order according to their hospital numbers.
- All the shelves and racks used for filing of the records shall be appropriately labeled / numbered to facilitate easy filing and retrieval of records.

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Custody of Medico Legal and Death Cases

- Medico legal case sheets and Death case sheets are kept under the custody of the Medical Records Officer in the Medical Record Department.
- In case any clinician wants to review the death files, they shall approach the Medical Records Department. If these files are to be moved from the premises of the medical records department for purposes of research works, they shall obtain written permission from Medical Superintendent.
- For the purposes of insurance and issue of certificates, the medical records of death cases shall be issued to the concerned department after approval from the Medical Superintendent.

Retrieval of Medical Records

- The medical records shall be retrieved based on requests generated through the hospital information systems.
- All medical records are entered in a register.
- The retrieval and issue of the patient records shall be updated in the hospital information system to keep a track of issued records.
- Special request for records from any other departments are entered in a special register called File issuing register for staff and for Doctors are entered in a File Issuing Register for Doctors (Study and Thesis Purposes).
- And for legal purposes it entered in a special register.

PROCEDURE FOR TIMELY AND ACCURATE DISSEMINATION OF DATA: MEETING INFORMATION NEEDS OF SOCIETY

Timely and accurate information is given to relevant stakeholders after analysis of data. The top management and policy makers are obviously important users of information. Depending on the specific department of the organization information needs could be different. At the individual level needs information to their interest.

PURPOSE/OBJECTIVE:

- To ensure the customer satisfaction for the request for copies of medical records
- To issue the patient medical records copy to patient/physician/insurance companies
- To issue the MLC records for the for the MLC cases to court and police
- To issue the copy of modifiable disease case records and maternal death case records to government authorities like DHS,PHC,DMOH & CHC
- to issue the case records of patients to the staff inside the hospital for audit, research and administrative purposes
- To issue the electronic data include the OP, IP and Occupancy statistics to various purposes.

Patients

- Details about departments and doctors - available in the website.
- Telephone booking – Check the system for Doctor's availability.
- Registration, admission done through the system. Tariff is communicated with patients.
- Different reports are generated through HMS.
- Hospital bill is generated through HMS.
- IP patient's bed details are available online to the staff.

Visitors

- Visitor's policy and age restriction in ICUs is displayed in front of ICUs.

Staff

- Facility for bedside medicine delivery
- Employee suggestions
- Employee satisfaction survey
- Incident reporting
- Service Requests
- Intranet mail

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- Leave application
- Training Schedule
- Staff Relative SMS
- Intranet website for communication through circulars, memos (OneAmala)
- Department manuals are provided through intranet website

Management

- Daily census – HMS, Night Supervisors report
- OT utilization rate – From OT
- ICU utilization rate –From HMS
- Bed occupancy rate, Average Length of stay - From HMS

External agencies

- Vital statistics – DMO office
- Notifiable diseases – IDSP

Community

- Information regarding new technology, new medical staff – Newspaper, Radio, Television, YouTube channel, Website.

MECHANISM TO ENSURE THE ACCURACY OF INFORMATION INTRODUCTION:

Accurately and adequately document a patient's life and health history including past and present illness and treatments with emphasis on the events affecting the patient during the current episode of care.

Complete and accurate medical record keeping that help to ensure that the patient get the right care at the right time. In effect they can help to provide patient with better care after malpractices claims, accurate record might even help settled the claim. The data integrity essentially means is that the data is accurate and has not been wrongfully altered in any way. Data accuracy is one of the components of data quality. It refers to whether the data values stored for an object are the correct values.

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Information resources include information on the website, brochures, newsletters, education material etc. Accuracy of information resources could be ensured by forwarded it to concerned department HODs, then prepare and review the material by Quality department.

PURPOSE

- To disseminate accurate information to the stakeholders.
- To maintain the integrity of the data.
- To maintain the quality of data.

SCOPE:

- Hospital management
- Health care providers
- Patients
- Government agencies

RESPONSIBILITY:

- Doctors
- Nursing staff
- IT staff
- Medical records department
- Quality department
- Purchase & Store department

FLOWCHART FOR FORMS/ PALMPHETS/ LEAFLETS PRINTING

Existing form

Store:

New form

User department

If there is a need of new form, **user department** should submit it to **Quality Department** with all details (format of form, Quantity needed, Break needed for 1 year, In charge/ HOD's Name & signature).

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Store staff submits existing forms with **Store** In charge's Name & Signature with Date to **User Dept**. In charge, when stock is not enough for the next 1 or 2 months. Mention present stock in store.

User department

Corrections, Quantity needed, Break needed for 1 year has to be written in form by **user department** in charge/ HOD with Name & signature and submit it to **Quality** on **Mondays**

Quality department

Quality department staff should cross check the format, numbering and check for any corrections needed. Quality department staff submits to purchase dept. on **Wednesdays** and take signature from **Purchase dept**.

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Quality department

Cross check with **Store** In charge whether any similar form is present or not in Store

↓

User department

User department check the corrections that is made in the form by them and by Quality. Inform printing company for any other further corrections.

After all corrections, Approval has to be done in Hard Copy (form with all requirements like font, paper quality) by Department In charge/ HOD with Name & Signature. (Mention Approved) with Date and send it to Quality department for Final approval.

↓

Quality department

Carefully check for any further corrections (spelling mistakes, grammatical errors, additions or deletions) and cross check with old form in which corrections made while receiving the final draft and give approval.

↓

Printing company

Printing company gives ordered forms to Medical College Library.

Medical College Library

Library staff checks for paper quality & other requirements and compare it with old form and approved form.(final approval).Inform store staff also once it reaches the store.

Keep a copy in the "Forms" folder, if there is any revision in the form or new forms.

Printing company

Printing company informs store staff once the Printing material reaches the Medical College Library.

Store

Store staff checks for paper quality & other requirements and compare it with old form and approved form.

Store

Store staff checks with the bill regarding the quantity ordered and break details. Enter break details and other details in an excel sheet.

Store

One copy to Quality, if there is any revision in the form or new forms.

If it's a new form, inform Quality and user department once it reaches the store.

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RESPONSIBILITIES

Store staff

- Send forms for printing 1 or 2 month prior according to the usage of the form.
- Should keep Break details of each form and send it to user department in each break for any changes needed and Inform Quality department also.
- Store staff should collect all printing details from purchase department regarding Printing company who got the printing order, quantity ordered, Break details etc. and save it an excel sheet.
- Keep forms in department wise and numbering wise order in rack.
- Keep all forms in separate folder (department wise and numbering wise). If there is any revision, replace it with new on
- Finish the old stock first, if there is any revision.
- If user department is not able to use the old stock without revision, store staff must inform Quality department and take approval from Fr. Deljo for discarding the same.

1. Quarterly checking of non moving items and send a list to Quality department.
2. Compare the quality and other requirements with the approved form once receiving the stock. Do not receive the material, if our all requirements are not met.
3. If store staff is giving complete stock of forms to the user department, keep a track on it or else keep one month stock in store.
4. If it's a new form or a revised form, inform Quality and user department once it reaches the store and give a copy of the same to them.

Library staff

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1. Staff checks for paper quality & other requirements and compare it with old form and approved form.
2. Do not receive the material, if all requirements are not met and inform Purchase department.
3. Keep all forms in separate folder (department wise and numbering wise).
4. Inform store staff also once ordered forms reaches the store.

Purchase department

Keep all forms in separate folder (department wise and numbering wise). Take quotations from all printing company.

Give order to printing company with the lowest quotation. Keep the Break details of each form.

Should keep details of the all printing orders

Printing company

1. Take quotation from purchase.
2. Contact user department and Quality for the corrections needed in the form.
3. Prepare the first proof and send it via Email to user department within 1 week after receiving the quotation and copy to purchase & quality.
4. Bring hard copy or can send Email for checking the corrections.
5. Give prior information to user department for collecting final proof (in hard copy). User department representative/ HOD has to come and collect from Quality department and give approval.
6. Take approval from user department & quality dept. before printing.
7. Approval has to be taken in hard copy (form with all requirements like font, paper quality).
8. Bring the approved form to the store along with the printing material.
9. Maintain the quality of the form and meet all the requirements.
10. Inform Store staff once the ordered forms is ready and available at library.

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User department

1. Printing order is only through store. User department should contact the Store in charge directly for printing order not with the printing company.

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2. If user department is taking complete stock from Store, they should intimate Store In charge before 1 or 2 months according to the usage.
3. Corrections should be done without any delay and send it to Quality department. Check carefully for any corrections (spelling mistakes, grammatical errors, additions or deletions).
4. Revision of forms should be planned accordingly.
5. If user department is taking complete stock of forms from the store, intimate store 1 or 2 month before it finishes.
6. While receiving the final draft, check carefully for any further corrections (spelling mistakes, grammatical errors, additions or deletions) and cross check with old form in which corrections made and give approval. User department representative/ HOD have to come and collect from Quality department and give approval.
7. Give it to Quality department for final approval.

Quality department

1. Corrections should be done without any delay and send it to Quality department. Check carefully for any corrections (Numbering, spelling mistakes, grammatical errors, additions or deletions).
2. Corrected forms have to submit to Purchase dept. for printing and take signature.
3. While receiving the final draft, check carefully for any further corrections (spelling mistakes, grammatical errors, additions or deletions) and cross check with old form in which corrections made and give final approval.
4. Keep all forms in separate folder (department wise and numbering wise). If there is any revision, replace it with new one.
5. Collect and keep all revised form and new forms from store.

IMPORTANCE OF ACCURATE MEDICAL RECORDS:

The detailed information, most records can help pinpoint where mistakes occurred. To correct, they can help provide patients with better care. After malpractice claims, accurate records might even help settle

the claim.

All records when being written must:

- Be factual, concise and accurate
- Be written as soon as possible after the event occurred, providing current information on the care and condition of the patient.
- Be accurately dated (day/month/year) and timed (using 24hour clock or clearly denoting AM / PM when 12 hour clock is used)
- Identify the author of the entry by full name or by mentioning employee code number or with the help of stamp or printing their name and signature on the first entry. All signatures must be legible.
- In case of electronic based records, authorized e-signature as per statutory requirements is kept.
- Be written in blue indelible ink – do not write in pencil at any time.
- Be written as neatly as possible so that others can read and understand the text.
- Clear communication between those caring for the patient is essential.
- Be written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read.
- Never erase or use correcting fluid. If an error occurs in recording the information, the following should be used: Strike through the entry with a single line, date and record the time the error was corrected, and then make the correct entry and counter sign the entry.
- Never alter entries retrospectively. If later discovered that something has been written as inaccurate, misleading or incomplete, insert an additional note in the next available space as a correction. Make it clear that the new note is a later amendment and that there is no attempt to tamper with the original records. Remember to date and sign the later entry.
- Do not leave spaces between each entry.
- Do not use derogatory remarks, insulting comments or value judgments.
- Use objective rather than subjective comments whenever possible.

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- Record accurately the information given to patients in respect of their treatment choices and associated risks.
- Be written in chronological order and each entry should provide evidence to determine each healthcare professional who has been in contact with the patient or who is responsible for decision making about the patient's treatment.
- Provide clear evidence of the care planned and any decisions made to and ensure the information is written so it can be shared with the other appropriate Healthcare Professionals.
- Identify problems that arise with a patient's treatment and the action that was taken to rectify them.
- Provide evidence of any discussions / conversations with the patient or family regarding the patient.
- If a patient's history has been provided by a person other than the patient (e.g. a relative, caretaker, translator or police officer), record that person's name, status and if required their contact number.
- Investigation results must always be signed and dated by clinical staff within 24 hours of receipt. They must not be filed into the notes unless they have been authorized.

PROCEDURE FOR RELEASE OF INFORMATION:

a. Request from patient/ authorized attendants

- The patient or authorized attendant shall submit a written request to medical superintendent or deputy medical superintendent
- Upon approval of the medical superintended or deputy medical superintendent the MRD staff is informed to take a photocopy , the patient shall bear the cost of photocopy
- The receiver acknowledge the receipt on the same requisition letter and it shall be filed for reference

b. Request from medical/ Administrative staff of the hospital

- The staff shall fill a requisition slip indicating which medical records are needed, reason for retrieval and expected date of return.

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- The medical record executive shall sign the slip and hand over the medical records to the staff.

c. Request from TPA and other third party payer

- TPA personnel (with consent of the patient) shall write an application to administrator on duty with authority letter from patient for access to medical records.
- Administrator on duty shall verify the identity of attendant with the patient and forward the application to MRD.
- The attendants/ TPA concerned shall deposit specified amount at billing counter (MRD charges) for the same.
- The application along with the receipt shall then be submitted to MRD officer.
- Concerned consultant shall be informed and verified by him/ her about the same.
- The copy of the record shall be handed over to the respective person within 5 working days as per NMC rules from the MRD office.

d. Request from Government organization

- They shall be allowed to access only for specified purpose as stated by state authorities.
- Access shall be provided in presence of MRD staff.
- Check a written evidence of permission from state authorities regarding access, which should specify the purpose for access.
- Note for this access shall be kept in the MRD.
- Do not provide access if,
    - Identification of the person cannot be established satisfactorily.
    - Any person or organization, other than those mentioned above asks for access.
    - In case of any confusion contact Medical Superintendent.

e. Process of Retrieval of case file for submission to court

- Take out the photocopy of the case file before issuing the original Case file.
- A board with a tag line of "Safe in Custody" shall be replaced when the case file is removed for photocopy. This board should contained the Name & Hospital No of the patient, Court case No., &

Issuance No:

- Remove the board after replacing the photocopy of the case file
- A common register is maintained

f. Billing Section and Consultants

- Case files issued to Medical Superintendent, Billing department and Consultants should be entered in separate internal issue Log book
- A common register is maintained.
- Duplicate of Investigation Reports should be issued to patients/relatives based on following requests:
  - Outpatient shall produce a copy of Cash Bill
  - Discharged inpatients shall produce a copy of discharge summary
  - No formal documentation is required

g. Release of Information & Copies Medical Records

- In case of a written request of the patient appearing in person, on obtaining approval of the Deputy Medical Superintendent, Relevant copies of the Medical Record can be issued with the authorization of Medical Records Officer.
- The medical record shall be issued within 5 working days (as per NMC) after getting the approval from the concerned clinician.
- Investigation reports like X-rays, Scan reports, ECG, Echo and TMT reports can be given to patient after ensuring a copy of the same is filed in the patient record folder.
- The reports shall be issued only after obtaining the signature in the Register.

h. Issue of copies of records in cases of death

- The Medical Records Officer can issue the copies of relevant records after obtaining the signature of the receiver in the concerned register.
- The copies of other medical records in cases of death shall be issued after getting written authorization from the concerned clinician.

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i. Issue of Medical Records for Academic and Research Purposes

- Out Patient records and In Patient records, for the purpose of research or patient care, are issued to doctors and other research team only after a written request is received to the medical records department from them.
- Medical Students are allowed to see the records in the Medical Record Department only with the written approval from their Head of the department.

j. Issue of Electronic Data

- The electronic data is only accessible to authorized staff by using User name & password. It will be different for each staff.
- Electronic data include the OP, IP and Occupancy statistics are issued to doctors and other research team only after a written request is received to the medical records department from them.
- Issue OP, IP and Occupancy statistics for various inspection purposes like ISO, NABH, NMC, NAAC, and KUHS to concerned higher authority.
- Monthly OP, IP and communicable disease statistics for HMIS portal to DMO office.
- Monthly death statistics to Quality department for mortality committee meeting.

RETENTION AND DESTRUCTION PROCEDURE TO ADDRESS THE PATIENT'S RECORD

All Medical Records including IP, OP and registers relating directly to patient care have to be maintained by MRD. The records are to be maintained until retention period as per order GO (MS) No. 06/2014/H&FWD Thiruvananthapuram, Dated 03.01.2014. When the preservation period of the document is over, it shall be treated as inactive and disposed. With the authorization of the head of the institution those documents are removed from the register. The Director must issue proceedings to this effect and communicated to all officials concerned. The disposed items are to be destroyed by burning through incinerator. These file details must be kept for future reference.

The destruction of medical records, data and information are in accordance with the written guidance. The record which is to be destroyed as per the policy shall be identified every year in the month of November.

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- Outpatient records are discarded if the patient has not to visit the hospital for a period of **5 years** after his/her last visit.
- Inpatient records are discarded after **5 years** from the date of admission.
- Medico legal case sheets and Death case sheets are maintained indefinite.
- The medical record department should ensure that the medical records for the pediatric patient's files as per retention policy of the hospital for pediatric, the child reaches an age of 18 years, the records (hardcopy / softcopy) shall be stored and for three more years from the date such a patient attaining 18 years (18 years + 3 Years) 21 years of the child.

The details of all the records that are destroyed shall be noted in the Record Discarding file.
It should be displayed in the notice board of the hospital and also published in the newspaper.

HOSPITAL STATISTICS AND COMMITTEES

Collection and preparation of statistics

The data necessary for preparations of statistical summaries and reports shall be obtained from the hospital information systems, various units and by the analysis of the patient records.

The medical records department shall act as the coordination point for generation and reporting of various types of hospital statistics as required by management and clinicians for purpose of operational effectiveness and medical research.

a. Death and Birth

A separate Kiosk is work for Birth and Death Registration and issuing of certificate inside the hospital near the chavara registration counter.

b. Communicable Disease Statistics

This statistics is available from Community Medicine Department. If a communicable disease is reported from a ward they are informed to community Medicine department.

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PEADIATRIC POLICY ON MEDICAL RECORDS:

Purpose:

The medical record department should ensure the medical records for the pediatric patient's files as per retention policy of the hospital for pediatric, the child reaches an age of 18 years, the records (hardcopy / softcopy) shall be stored and for three more years from the date such a patient attaining 18 years (18 years + 3 Years) 21 years of the child.

Scope

This procedure applies to all the pediatric patients of medical records.

Responsibility

Attenders, Assistants and Medical Records Technician

Definition & Abbreviation: Nil

Procedure:-

Any Medical Record classified as those records belonging to pediatrics age group, till such time the patient attains an age of 18 years. Once such patient reaches an age of 18 years, the records shall be stored (soft or hard copy) for 3 more years from the date such a patient attaining 18 years (18 years + 3 years) All the files of Pediatric will be preserved accordingly.

POLICY ON MISSING RECORDS:

Purpose: To handle the situation of missing records when the files are missing

Scope: This policy aims for tracing the missing records.

Responsibility: Attenders, Assistants and Medical Records Technician

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Procedure

- When the file/files are missing check the possible areas to trace
- Contact the doctor/doctors related to the concerned section
- Check the files issue registers
- If not found, raise the incident
- Do the route cause analysis
- If not found, file the F.I.R. nearby police station
- Prepare a duplicate file for patient's treatment with possible documents like copy of discharge summary, investigations reports, and collect the patient's present and past details, etc., to continue the treatment.

AUDITING AND REVIEWS

Conducting meetings of the Medical Record Committee:

A medical Record Committee has been constituted, Chaired by Medical Superintendent and medical records are audited by members of the concerned department doctors for strengthening and improve the quality of documentation of medical record and systemic functioning of medical record department. Medical record committee should be conducted in every 3 months. Minutes of the meeting along with action taken on the various decisions must be intimated to the concerned department HODs through department meeting and circulars.

Appropriate corrective and preventive actions of deficiencies in file audit.

The deficiencies according to the last audit will be analyzed to find the root causes of their occurrence and suitable corrective and preventive action will be identified for each type of deficiency, and the actions that have been identified and communicate to all the doctors through the circulars and departmental trainings and meetings for their reference and necessary action.

- The medical records are reviewed periodically. (Every 3 Month)
- If there is any deficiency noted during the deficiency check by the MRD department, the files will be kept separately and the intimation will send to the concerned department or doctor to get

complete the records.

- The medical record review focuses on the timeliness, legibility and completeness of the medical records with medical record audit checklist which has to be done by the concern department doctors.
- The review process includes records of both active and discharged patients; live chart audit done by the Quality department and the death file audit done by the department doctors.
- The deficiency that is noted during live chart audit has been communicated to the concerned authorized staff by Quality dept. for the completion of the records.
- The review points out and documents any deficiencies in records and the statistics presented to the meeting.
- Appropriate corrective and preventive measures undertaken are documented.
- The deficiencies points out and discussed with the concerned department HODs meetings and MRD meeting.

STATISTICAL REPORTS

The medical record department shall compile and publish statistical reports on the following areas.

- Hospital Census – the hospital census report shall cover total number of admissions and discharges, total number of outpatients and inpatients, Bed occupancy rate, Admission, Discharge doctor wise and unit wise etc. It's all available from the software.
- Disease and demographic statistics – The report on disease and demographic patterns shall include consolidated classification of diseases and various operations performed, major and minor surgeries, daycare procedures, number of interventional procedures done unit wise, number of modifiable diseases (From community Medicine) high light or new or rare diseases / conditions treated etc.
- Every month total no of discharges including death reported to Quality department for mortality review presentation.
- Monthly auditing of medical records includes the statistics about the medical record. A checklist is

prepared for auditing files. Every month it will be presented.

- **Quality Indicators**- Every month quality indicators given to Quality Department, which include

1. Percentage of medical records having incomplete and / or improper consent

ANNEXURE

1. List of Patient Records
2. Sorting Order for Medical records

Structure and Filing of Medical Records – Chronological Order of arranging the case sheets is as listed below.

The case sheet shall be arranged in the following order.

PART – 1

- Discharge Summary/ Death summary/Transfer summary
- All Investigation Reports
- Investigation Status Sheet

PART - 2

- Inpatient Details Checklist
- OP/IP Initial Assessment Form
- Intern's Case Sheet
- Head Injury Sheet (Neuro Surgery)
- History & Physical Examination Record (Neuro Surgery)
- IAP Body Mass Index Chart (Paediatric Growth Chart)
- MEWS Form(Paediatrics/ Obstetrics /Adult)
- Diabetic Management
- Intake – Output Chart

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- Intensive Monitoring Chart
- Ventilator Chart
- Investigation Flow sheet
- CVSICU Receiving Form
- ED Case Record
- Doctors Notes
- Venous Thromboembolism Form (VTE)
- Medication Reconciliation Form
- Antimicrobial drug kardex
- Drug Kardex I
- Drug Kardex II
- Acitrom Chart/ Heparin Chart
- Cross Consultation Form/Referral Form
- Physiotherapy Patient Record
- Doctor's Handover Record
- Pre- Cath Evaluation
- Cathlab Nurses Note
- Perfusion Data Sheet
- Cardiac OT Consumption
- CVSICU Progress Note

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- Pre- Operative Checklist
- Surgical site infection (SSI) Bundle (Surgery Safety Checklist)
- Pre- Anesthetic Record
- Operation Record
- Post-Operative Checklist
- OT Nurses Record
- Chest pain Chart
- Neuro Assessment Chart
- Nutrition Screening Form
- ED Initial Nursing Assessment Form
- Inpatient Initial Nursing Assessment Form(Adult / Paediatric)
- Nursing Endorsement Record
- Nursing care plan
- Nurses Record
- Patient & Family Counselling/Education Record
- Direction to patients Account sections

PART - 3

- All Checklists including admission/ discharge, Bundle checklist etc.
- All Consents
- Narcotic Drug Sheet

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9.0 LIST OF REGISTERS

9.1.1 Daily OP Outgoing Register - AIMS/MRD -02

9.1.2 OP Register - AIMS/MRD -03

9.1.3 IP Register - AIMS/MRD -04

9.1.4 File Issuing Register for Doctors - AIMS/MRD -05

9.1.5 File Issuing Register for Legal Purposes and for patients - AIMS/MRD -06

10.0 LIST OF FILES

1. Staff Training
2. Induction training (new staff)
3. Letters /Circulars
4. Master Forms
5. Duty list
6. Department Meeting
7. MRD Committee Meeting
8. Housekeeping Records
9. Death Statistics
10. Department Manual
11. File Request- Doctors/staffs
12. File Request- Court/ police
13. Statistics
14. Quality indicator
15. Miscellaneous
16. Audit checklist

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17. NMC
18. Wound Certificate Request
19. NABH
20. Discharge list
21. IMS- NABH Guidebook
22. HIC –manual
23. Hospital safety & disaster manual

11.0 LIST OF FORMS

1. Request form for Medical Records – AIMS/IMS02/MRD -01
2. Request For Medical Information And Reports(Patients) - AIMS/MRD/RMIRP-02
3. Medical Records Audit Checklist - AIMS/QC/MRAC-05
4. Deficiency Checklist for discharge files - AIMS/MRD/ DCDF-7

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8.0 POLICIES AND PROCEDURES (APPLICABLE):

PURPOSE

- To document patient history, assessment and treatment provided emphasizing on the events affecting the patient during the current episode of care.
- To ensure identification and control of outpatient and in-patient medical records through various stages of patient care.
- Compilation, classification and indexing of patient records to ensure continuity of care, aiding administrative process and for legal purposes.
- Compilation and reporting of various hospital statistics relating to various hospital services and outcomes.

SCOPE

- To define the overall policy of the hospital with regard to the process of managing patient medical records
- Identification, issue and ensuring traceability of the medical records through various stages of patient care in the hospital.
- Defining various processes of medical records management at the hospital.
- Filing and retrieving of both OP and IP records at both active and in-active record storage areas.
- Compilation, reporting and filing of hospital statistics including daily census reports, service utilization statistics, disease patterns and outcome analysis.

IDENTIFICATION OF RECORDS

A medical record has a unique identification number and for easy identification of records different color codes are given for medical records.

- MLC records are identifies in red color folder
- IP records are in green color
- OP records are in blue

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- Oncology records are maintained separately in rose color.

PATIENT REGISTRATION

A central computerized registration system with 24 hours service is maintained for all outpatients and inpatients.

- Seven digit hospital numbers are used for outpatients and inpatients. OP and IP charts are kept together according to Hospital number. Every sheet in the medical record shall have this unique identifier.
- The important identification information for each new patient is registered in computer.
- Registration card is given to each new patient. The organization has a complete and accurate medical record for every patient.

ENTRIES IN MEDICAL RECORDS

- Organization has a written policy that authorizing who can make entries and the content of entries.
- Only authorized staff shall enter the details in the respective areas in the case sheet.
- The medical records are assembled in chronological order (from admission to discharge) in the medical record.
- All entries in the patient medical records are signed, dated, timed and named.
- All entries should be documented immediately but no later than one hour of completion of the assessment/procedure.
- All the entries are identified by the full name and signature of the author along with date and time. Persons authorized to make entries in the medical records of the patients are: Doctors (Consultants, Resident Doctors; Staff nurses; Physiotherapist; Dieticians; Medical records professionals)

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The details of format filling authority			
FORMS NAME	DOCTOR	NURSE	OTHERS
Medical ER / OP Form	*		
Medical and Pediatric H&P	*		
Medical (Progress Record, Reference Form, Pre-Op. Assessment, OT Record, Anesthesia form, Consent forms, Medication Order etc.,	*	*	
Nursing (Nurses Daily Assessment, plan of care, Monitoring Flow Sheet, Pre-op checklist, Daily treatment/Activity chart, Vital Chart, Medication Administration, functional Screening form etc.,		*	
Deficiency Check list	*	*	MRD Staff
Functional Physiotherapy Assessment			Physiotherapist
End of life Care form	*	*	
Nutritional Assessment	*		Dietician

- In case abbreviations are used, a standardized list of approved abbreviations shall be used throughout the organization .For medications, error prone abbreviations are used.
- Only controlled forms and formats, which are approved by the management, shall be used by the service providers for the medical records.
- Medical Records are arranged in process oriented method. All medical records are checked for the deficiency after the medical records reach MRD.

Legibility Standards when writing into the Medical Records

- There are a number of factors that contribute to effective medical record maintenance. At Amala Hospital, the staff involved in the patient care process are expected to adhere to the standards outlined below.

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- All records when being written must:

  - Be factual, concise and accurate
  - Be written as soon as possible after the event occurred, providing current information on the care and condition of the patient.
  - Be accurately dated (day/month/year) and timed (using 24hour clock or clearly denoting AM / PM when 12 hour clock is used)
  - Identify the author of the entry by full name or by mentioning employee code number or with the help of stamp or printing their name and signature on the first entry. All signatures must be legible.
  - In case of electronic based records, authorized e- signature as per statutory requirements is kept.
  - Be written in blue indelible ink – do not write in pencil at any time.
  - Be written as neatly as possible so that others can read and understand the text.
  - Clear communication between those caring for the patient is essential.
  - Be written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read.
  - Never erase or use correcting fluid. If an error occurs in recording the information, the following should be used: Strike through the entry with a single line, date and record the time the error was corrected, and then make the correct entry and counter sign the entry.
  - Never alter entries retrospectively. If later discovered that something has been written as inaccurate, misleading or incomplete, insert an additional note in the next available space as a correction. Make it clear that the new note is a later amendment and that there is no attempt to tamper with the original records. Remember to date and sign the later entry.
  - Do not leave spaces between each entry.
  - Do not use derogatory remarks, insulting comments or value judgments. Use objective rather than subjective comments whenever possible.
  - Record accurately the information given to patients in respect of their treatment choices and associated risks.

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- Be written in chronological order and each entry should provide evidence to determine each healthcare professional who has been in contact with the patient or who is responsible for decision making about the patient's treatment.
- Provide clear evidence of the care planned and any decisions made to and ensure the information is written so it can be shared with the other appropriate Healthcare Professionals.
- Identify problems that arise with a patient's treatment and the action that was taken to rectify them.
- Provide evidence of any discussions / conversations with the patient or family regarding the patient.
- If a patient's history has been provided by a person other than the patient (e.g. a relative, caretaker, translator or police officer), record that person's name, status and if required their contact number.
- Investigation results must always be signed and dated by clinical staff within 24 hours of receipt. They must not be filed into the notes unless they have been authorized.

ISSUE OF INPATIENT RECORDS AND OUTPATIENT RECORDS

- If the patient is visiting the hospital for the first time a new outpatient record is created and issued to the relevant department.
- On any subsequent visit the same Outpatient record of the patient is issued.
- All issued Outpatient records are returned to the Medical Record Department on the same evening.
- If any records are not returned, the Medical Record Department shall follow up the next day.
- Inpatient records are created for each admission.
- After a patient is discharged, the Inpatient records and Outpatient records are returned to the Medical Record Department.

PROCESSING OF PATIENTS RECORDS

Control of Medical Record Formats

- The Medical Records Officer is responsible for ensuring the control of the various formats used by various patient care units for documentation of patient care activities, which forms the medical record of the patient.

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- The Medical Record Officer shall maintain and update a List of Medical Records (Refer to annexure) with the details of the various records used by the hospital including record numbers, titles and revision status.
- The Medical Record officer shall maintain a catalogue of the master formats of all the medical records used by the hospital. The master formats shall have the approval of the appropriate authority for approval of the format.

Deficiency Check

- The medical record attender shall perform a deficiency check for each medical record received. The deficiency check shall verify;
- Sorting order of the folder
- Completeness of the reports
- Signature of the consultants / clinicians with date and Time
- Completeness of Diagnosis and discharge status
- Completeness of the consent forms
- Completeness of operation reports
- Missing diagnostic reports
- In case of any deficiencies the same shall be noted in the checklist and the concerned department requested to ensure the completeness of the records.
- In case of abbreviations a standardized list of approved abbreviations are used in the medical records.

Compilation and Maintenance of Patient Record Folder (Entry Protocol)

- The medical record contains information regarding reasons for admission, diagnosis and plan of care
- *Operative and other procedures performed are incorporated in the medical record*
- When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital
- The medical record contains a copy of the discharge note duly signed by appropriate and qualified personnel

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- In case of death, the medical record contains a copy of the death certificate indicating the cause, date and time of death.
- Care providers have access to current and past medical record
- The patient record folder is compiled by addition of the required record sheet by the nursing staff of the patient care unit or the concerned department technicians in cases of diagnostic and therapeutic units.
- Proper identification shall be made on each record by noting down details like patient name, Hospital number, age & sex etc.
- The clinicians, nursing staff & other health care members are responsible for documenting the patient care activities as required, signed by the staff with date and time.
- The various medical records shall be arranged with the patient record folder as per the pre-determined Sorting Order of Medical Records (Refer to annexure).
- The various investigations report and consent forms shall be properly mounted by the nursing staff as specified.

CONFIDENTIALITY AND SECURITY OF THE MEDICAL RECORDS

- It is the duty of each and every staff member to safe guard the medical records and ensures the confidentiality of information they come across while performing their duty.
- No staff member shall approach the medical records department directly for obtaining their or their families medical records. They shall follow the guidelines for issue of medical records and approach the reception for the same.
- In case a staff member finds a medical record misplaced anywhere in the hospital, they shall immediately hand it over to the custody of the medical records department.
- In no case shall a medical record or the medical record folder as a whole be given in the hands of the patients or their family.

Entry Protocol in Medical Record Department

- Only Doctors and Nursing staff are allowed to enter MRD. Other departmental staff and patient entry is strictly prohibited.

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- Nurses are allowed for replacing the files after 11.00pm. Police Officers for enquiring the files and Insurance staff for taking the files and from insurance company staff for investigate files are allowed to enter inside the MRD.

Pest Control Activity

- Pest and rodent control have to be done in all MRD by warehousing corporation in every month.
- Data kept under the maintenance Department and Medical Records Department.

Security and Fire

- CCTV Surveillance in all MRD and the Fire-Fighting Equipment has installed one at the entrance and one inside the room and once in 6 months internal audit has been done.

FILING AND RETREIVAL OF MEDICAL RECORD

International Classification of Diseases (ICD) coding

The medical records officer and MRD record Coder shall code the patient records as per International Classification of Diseases - Tenth Revision (ICD 10CM) published by the World Health Organization. The coding shall cover primary, secondary and final diagnosis. All the data are stored in the server.

Medical Record Indexing

Indexing done by the MRD attender on the hospital software iApps Backup stored in the server.

Filing of Medical Records

- The medical record attender shall receive records intended for filing after processing and place them in specifically designated areas.
- The OP and IP files shall be kept according to hospital number.
- The filing order for the various files shall be mapped in the medical records file-tracking feature of the hospital management system. The filing of the records shall be done in sequential order according to their hospital numbers.
- All the shelves and racks used for filing of the records shall be appropriately labeled / numbered to facilitate easy filing and retrieval of records.

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