
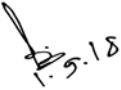
 <p>Govt. of Meghalaya</p>	<p><b>PRIMARY HEALTH CENTER NARTIANG WEST JAINTIA HILLS 793151 MEGHALAYA</b></p>	<p><b>Doc. No. NPHC/MRDP/13</b></p>
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<p><i>Approved by:</i> Dr.R.Pohsnem Sr.M&amp;HO I/C. Nartiang PHC</p>  <p>Signature &amp; Date</p>	<p><b>Maintenance of Patients Records, its Security, Sharing of Information and Safe Disposal</b></p>	<p>Revision No:00</p> <p>Page 1 of 4</p>

# Maintenance of Patients Records, its Security, Sharing of Information and Safe Disposal

## A. Purpose:

To provide guideline instructions & process of Management of Medical Records with the aims that

- Medical Records are readily retrievable, and
- Feedback loop is established for continuous improvements of Health Indicators.

## B. Scope:

It covers all patient medical records in the hospital.

## C. Responsibility:

Senior Medical Officer and Pharmacist, Lower Division Assistant(LDA)- (Record Section)- *Medical Records is responsible for maintaining medical records.*

## D. Objectives:

The Primary objective of the Medical Record Department is to develop good Medical Records containing sufficient data written in sequence of events to justify the diagnosis, treatment and end result of all patients treated in a hospital, keep them under safe custody and make the readily available as and when required for

- The Patient.
- The Doctor
- Hospital Administrators.
- Medico Legal Purposes.
- External Reporting.

### 1. For Patient, it

- Serves to document the clinical history and activities of patient treatment.
- Serves to avoid omission or repetition of diagnostic and therapeutic measures.
- Assists in continuity of care even in future illness whether it requires attention in or out of the hospital
- Serves as evidence in Medico-legal Cases.
- Give necessary certification for employment purposes.

### 2. For the Doctor, it

- Assures quality and adequacy of diagnostic and therapeutic measures undertaken.
- Serves as an assurance of continuity of medical care.
- Evaluates Medical Practices.
- Protection in litigation.

### 3. For Hospital Administrator

- To document the type and quantity of work undertaken and accomplished.
- To evaluate proficiency of Medical Staff for administrative and clinical purposes.
- To evaluate the services of the hospital in terms of accepted norms and standards.

- To serve as an Administrative record and Performance.
- To assist in futures Programmers for Planning and developments of hospital.

#### **4. For Medico Legal Purposes, it serves**

- As a documentary evidence
- To dispose claims of the Insurances.
- For Patient's WILL to indicate if the patient was of normal mental state or not.
- Malpractice Suits.
- Authorization for operation etc. signed document for consent for operation will prove that the Patient / Relative have allowed the performance of such Procedure.
- Criminal cases - as a Potential Document.

#### **5. Development Of Hospital Performance Statistics**

Statistical and epidemiological Data are needed to implement and manage medical care planning and to obtain Health Indicators to monitor and evaluate their effectiveness for Hospital Management as follows:

- Bed Occupancy Rate
- Average No. of Out Patients
- Average No. of Admissions
- Sex wise Admissions
- Average Length of Stay of Patients.
- Gross and Net Death Rate.
- Laboratory Tests.
- Information about Institution Deaths (Deaths occurring over 48 hrs.)
- Non Institution Deaths (Deaths occurring under 48 hrs.)
- Total Number of Babies born in a hospital.
- (Sex wise distribution / sex ratio/ Still Births.)
- Daily Census of the Hospital.

#### **6. Reporting to Health Authorities**

This is the responsibility of the department to submit the following Diagnostic Reports to District Medical & Health Officer (DMHO) West Jaintia Hills

- Daily / Weekly / Monthly Malaria and Dengue Fever cases to the DMHO
- All Communicable Diseases to the DMHO
- Notifiable diseases are reported immediately to control room to DMHO
- Monthly Leprosy Cases to the DMHO
- Morbidity / Mortality Statistics to the DMHO., on yearly basis or as and when required by the Directorate of Health and Family Welfare Department Government.

#### **E. Process of Creating Medical Records**

Medical Record contains different sections for recording the information as

- Identification Section
- Medical Section

- Nurses Section.

All entries made in the medical and nursing section of the patient record are entered by authorized care providers who authenticate the entries made so as to facilitate identification of the particular author of patient's medical records.

### **1. Identification**

This section fills up the Bio Data / Socio economic data / Patient Identification Data at the time of Registration and Admission.

OPD file is generated at OPD registration counter; on the Admission Request of the doctor. Indoor patient Admission record is prepared. Personal data for following particulars are provided at OPD registration and Admission counter by the Patient / Relatives.

- Name of Patient
- Father's / Husband's Name
- Age & Sex
- Occupation
- Permanent / Emergency Address.
- Telephone / Mobile Numbers
- Nationality
- Religion
- Medico Legal Case if any.

These details are fed in the register manually and the patient is given a unique identification number which is entered in the designated area of the patient.

### **2. Medical Section**

The Medical Section is filled up by the Attending doctor, and pertains to History, Physical examination, Treatment / progress of the patient, , the information is recorded in the following Medical Record Forms, keeping in view two types of forms - Basic + Special

#### **Basic:-**

- Initial diagnosis Record Sheet
- History Record Form
- Physical Examination Record Form
- Progress And Treatment Record Form
- Investigations Report Forms

#### **In Special cases - Consent Form..**

Discharge summary is given in case of Discharged - cured, LAMA , Discharge on request or Death. A copy of the same is preserved in the patient's medical record.

i. In case of death ,Medical certification of cause of death forms is to be filled up by the attending consultant or emergency medical officer according to Registration of Birth and Death Act 1969. A copy of the death certificate is preserved in the patient's medical records file.

### **3. Nurses Section**

The Nurses Section is responsible for filling up the following

- Medication Record Forms

- T.P.R. Chart.
- INTAKE and OUTPUT Record Form.
- Diet sheet

Discharge summary is given in case of discharge cured, LAMA, DOR or death

#### **F. Flow of Medical Record from Admission to Post Discharge**

1. The Medical Record Department ensures a smooth flow of Medical Record of the patient from the day of his admission to the day of his discharge and onward maintenance till the retention period.
2. Admission request form is filled by the treating doctor of the patient. Formalities for admission of the patient is carried in the registration counter (during working hours ) or in the emergency department of the hospital (during non peak hours) .The general inpatient case sheet for patients is prepared at the time of admission in the respective inpatient admission counters.
3. All datas pertaining to the patients stay in the hospital and care provided are preserved in the patients bed head ticket which is maintained by the nursing staff of the concerned ward where the patient is admitted, all entries made in the Bed Head Ticket is recorded in a chronological manner and authenticated by the designated author of the particular entry clearly mentioning the time and date of the entry.
4. After getting the orders of discharge of the patients from the treating doctor, the Nursing Staff, on duty get the discharge summary prepared from the Medical officer, staff nurse on duty hand over the DC summary to the patient and discharge him/her
5. Patient file is sent to medical record room.
6. In case the patient is transferred or referred to another hospital the medical record contains information regarding reasons for transfer, name of the hospital were the patient is being transferred

#### **G. Midnight Census :**

Ward Census Reports from each ward is generated by nursing staff at night duty and entry made in the midnight census register

The midnight census register is to be checked and verified from time to time by the MO IC

#### **H. Confidentiality and Integrity of Record:**

The hospital identifies its responsibility as custodian of medical records and observes the following procedure to maintain its confidentiality, security and integrity:

Patient is the owner of his medical record and no form of it would be made available to any third party without written authorization from the patient. The hospital observes the following guideline instruction for the purpose:

##### **1. Retrieval / Accessibility of Medical Record:**

- Maintain records in proper accessibility manner.
- Hand over the records as & when required by MO IC for administrative purpose by getting slip signed by the person receiving the record.
- Physician for follow up purposes by getting permission from MO IC and get the records.
- Records required for Medico Legal Cases in the Court of Law by the M.O.'s.
- For Follow up of In-patients by the MOs as well as by the Patients.

- As & when they require Discharge Summary, Investigation Reports etc.
  - Patient's relatives will require a written authorization from the patient for obtaining information from the medical records. However such information would not be given in original, a Photostat copy of the same would be handed over to the patient and signature taken in specific format.
2. In case loss or tampering of patient's medical record data is reported, the medical record clerk would immediately inform the same to the MO IC who would be responsible for taking appropriate action. He will inform the external agencies as applicable and would hold an internal enquiry for investigating the cause for such event. He would form an internal committee under the MO who would hold the enquiry in reality and would submit the report to the MO IC as per the committee's finding for further action. In case the internal committee confirms any sort of negligence or discrepancy on part of any hospital employee, MO IC would inform the same to higher authorities of the Health and Family Welfare Department for further action. .
  3. The Medical Record Department is responsible for proper storage, retrieval and maintenance of confidentiality and security of the record. During normal working hours it is the policy of the hospital to have at least one staff available in the department.
  4. At the end of the day medical record clerk is responsible to lock the department in the presence of a chowkider .The key is handed over to the concerned security staff. There after the security department is made responsible for the protection of the medical record room.

#### **I. Retention Policy :**

i. Policy : The PHC is responsible for consolidation of all Forms belonging with patient is sent for storage in a manner with the help of Medical Record Number(MRN), which is assign at the time of Admission. These records are stored in the Medical Record Departments for the following Retention Period as per the Govt. Orders

In - Patient Record	:	
Out- Patient Record	:	
Medico Legal Record	:	Life time

ii. Security :

- a. Access to Medical Records Department is limited to only person authorized department staff.
- b. In case any record is issued to any designate individual as per the retrieval policy; the same is recorded in the outgoing patient record entry register for accountability.
- c. No form of record is issued to any person without proper authorization from the designated authorities.
- d. During non working hours the chowkider is responsible for safety of the department.

iii. At the end of the designated retention period the medical record clerk will seek written approval from the director for destruction of the medical records who have crossed the retention period. Only after obtaining written approval from the designated authority, the medical records will be destructed by the MO IC

#### **J. Medical Audit :**

1. Medical Audit Committee:

Scope of Work: Evaluate medical record keeping, quality, content, format, accuracy, pertinence, staff compliance with documentation policies .Review and evaluate fatal cases/ Deaths in hospital.

Frequency of meeting: Quarterly/ as required

## **2. Members of the Committee:**

1. Medical Officer In charge
3. MO
4. Pharmacist
5. Staff nurse
6. Senior Most Nursing Supervisor
7. Medical Record Clerk

## **3.Process:**

The Medical Audit Committee meets at periodic interval to evaluate the patients medical records. The Committees reviews both active and discharged patients inorder to have an objective review of the completeness of patients record.

## **4. Purpose and Objective of the Committee:**

The committee periodically evaluates the medical record

1. To review the completeness of the patient's records in the Medical Record.
2. To see that all records are dated, timed and legibly signed by the persons authorized to make entries in patient's records.
3. To review that the patients record contains all the necessary documents ( as applicable)
4. To identify any discrepancy in the records such as absence of date, time or signature, lack of proper documentation or incomplete record etc
5. To instruct the medical record department to rectify the deficiency on an immediate basis.
6. To provide guideline instruction for better management of patient's medical records

The minutes of the meeting are recorded in the minutes in order to trace the points discussed in the meeting , decisions taken , discrepancy if any in patient's record noted , remedial measures suggested , actions taken etc. In case the committee issues any sort of instruction relating to the patients record, the progress on the same is reviewed at the next meeting.

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