1.0 POLICY:

To maintain complete and accurate Medical record for every patient of the hospital related to both IP & OP services, such that the medical record accurately reflects the continuity of care

2.0 PURPOSE:

To establish standardized Policies and procedures for use of Medical Records of the patient and smooth functioning of the department of Medical records without violating the basic patient's rights of confidentiality.

IDENTIFICATION OF MEDICAL RECORDS

A unique patient identification number (Outpatient / Inpatient No.) is allotted to each patient.

3.0 DEFINITION:

Continuity of care: A process of providing care and necessary documentation such that the care provided is defined by set standards and guidelines as defined by the hospital to provide comprehensive and continuous care to the patient concerned

4.0 ABBREVIATIONS (IF ANY):

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IP – Inpatient services

OP – Outpatient services

5.0 SCOPE:

Hospital wide

6.0 RESPONSIBILITY:

MRD in charge

7.0 DISTRIBUTION:

Medical Record Department

8.0 PROCESS DETAILS:

8.1 DESCRIPTION OF THE PROCESS

To maintain complete and accurate Medical records for every patient of the hospital receiving services (both IP & OP) such that it reflects continuity of care.

- An inpatient's medical record is complete when the following criteria are met:
  - It's contents reflect the patient's condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress and condition at discharge; and
  - It's contents, including any required discharge summary or final progress notes, are assembled and authenticated; and

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- Entry of Medical record: The medical records can be entered by
  - Treating consultant and Cross referred consultant
  - Resident Medical Officer, Duty Medical Officers, Coordinator - Clinical Services
  - Physiotherapist
  - Dietician
  - Nurse (only in nursing records)
  - The physical examination should reflect a comprehensive current physical assessment.
  - The recorded history and physical examination must be authenticated by a practitioner privileged to do so – preferably the primary consultant
  - When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record provided the original information is readily available.

CONTENTS OF THE MEDICAL RECORD FOR INPATIENTS

➢ **Charts and Forms**

- Patient Registration Form with his/her personal and Demographic Details
- General Consent for admission

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- Consent for Discharge against Medical advise
- Admission record – Initial assessment & care plan document – for all care providers
- IP record – that comprises of progress recording sheets for all care providers
    - Pain assessment and Functional Assessment
    - Physician's Order Sheet
    - Nursing Medical Record
    - Treatment Charts
    - Intake Output Chart
    - Investigations Chart
    - ICU charts
- Operating Room records
    - Surgery and Anesthesia consent
    - High Risk Consent
    - Checklist for prevention of Surgical Errors
    - Intra-operative nursing notes
    - Anesthesia Forms
    - Operation Notes
    - Recovery room notes
- Discharge Summary/Death Summary
- Consent forms

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➢ **Content of the Medical Record**

- The content of the medical record, which includes written, must be sufficiently detail, legible and organized to enable:
  - The practitioner responsible for the patient to identify the patient, provide continuing care, determine the patient's condition at a specific time, review the diagnosis and therapeutic procedures performed and the patient's response to treatment;
  - Another practitioner to assume patient care at any time;
  - And the retrieval of information required for utilization review, quality review, transfer recommendations, etc.
- Hospital inpatient medical records are required to contain at least the following:
  - The patient's name, address, date of birth, sex and name of any legally authorized representative (Provision to be made in admission / discharge form).
  - The patient's language and communication needs;
  - Documentation and findings of the patient's assessment;
  - Conclusions or impressions drawn from the medical history and physical examination;
  - The diagnosis, diagnostic impression or condition;
  - The reason for admission or care, treatment and services;

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- The goals of treatment and the treatment plan;
- Evidence of informed consent when required;
- Diagnostic and therapeutic orders;
- Diagnostic and therapeutic procedures and test results relevant to the management of the patient's condition;
- Operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
- Progress notes made by authorized individuals;
- Reassessments and plan of care revisions, when indicated;
- Relevant observations;
- Response to care, treatment and services provided;
- Consultation reports;
- Allergies to food is normally not recorded but for medicine it is recorded;
- Medications ordered or prescribed;
- Medications dispensed or prescribed on discharge;
- Every medication order documented as administered or not administered and any adverse drug reaction; (Details required to be documented)
- All relevant diagnoses/conditions established during the course of care, treatment and services;

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- Documentation of referrals and communications made to external or internal care providers and to community agencies;
- Conclusions at termination of hospitalization;
- Discharge instructions to the patient and family; and
- Discharge summaries or a final progress note or transfer summary;

CHART RULES AND REGULATIONS FOR INPATIENTS

- History and Physical Examination – initial assessment record
  - A complete history and physical examination shall be documented and filed on the patient's medical record within the first 24 hours of admission and prior to the performance of any surgery/procedure.
  - In the case of an emergency a preoperative note is recorded prior to the surgery/invasive procedure. In addition, the preoperative diagnosis & indicated diagnostic tests are completed and recorded in the patient's medical record before surgery/invasive procedure.
  - The history should include the following:
    - Chief complaint
    - Present illness
    - Relevant past, family, and social histories, appropriate for age
    - Inventory of body systems

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- Consideration of education needs and daily activities
- Family and/or guardian's expectation for and involvement in, the assessment, treatment, and continuous care of the patient

  - The physical examination should reflect a comprehensive current physical assessment.
  - The recorded history and physical examination must be authenticated by a practitioner privileged to do so preferably the primary consultant
  - When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record provided the original information is readily available. Normally Medical Officer Review the chart incase of re – admission. However the registered information pertaining to the patients is available in the Discharge Summary issued, which is taken into account.

- Documentation of consideration of educational needs and daily activities.
- Documentation of periodic review of the planned course of action, as appropriate. The treatment-planning process is completely individualized, based on current patient needs and clinical status. The treatment plan is updated when the patient's needs and response to treatment change. Documentation of daily progress notes with appropriate annotation of the patient's response to changes in the patient's progress.

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- Post Operative Documentation includes:
  - Vital signs;
  - Level of consciousness;
  - Medications (including intravenous fluids);
  - Blood and blood components;
  - Any unusual events or post operative complications and management of such events;
  - Patient's discharge from the Post sedation or post anesthesia care area by the responsible licensed independent practitioner or according to discharge criteria;
  - If discharge criteria are used, they are approved by the medical staff. Compliance with discharge criteria is documented, and If the patient is discharged by a licensed independent practitioner, the practitioner's name is recorded in the post operative documentation.
- Progress Notes
  - The admission progress note should summarize the present illness, pertinent past history, the pertinent physical and laboratory findings, the initial impressions of the physician and the initial diagnostic and therapeutic plan.
  - Progress notes (reassessments) should give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition, the result of treatment and plans for future care. Whenever possible, each of

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the clinical problems shall be clearly identified and correlated with specific orders as well as results of tests and treatment.

- An authenticated legible progress note is required daily to document medical necessity and acute level of care.
- Progress notes must reflect the involvement of the attending physician in the patient's care.
- All progress notes must be signed and dated with time

- Consultations
  - Consultation reports shall be a part of the patient's medical record and shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, the consultant's recommendations and the signature of the consultant.
  - A request for a review by another consultant shall be noted in the physician's orders.
  - Emergency or 'stat' consultations should be requested only when there is an emergency or urgent need for the consultation. The consultation form will remain on the chart.
- Informed Consent: a physician prior to any invasive and/or operative procedure must obtain Informed consent from each patient or the patient's legally authorized representative. Informed consent implies that the patient has been informed of

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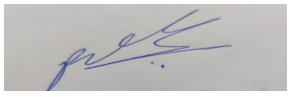			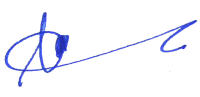
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the procedure to be performed, the risks involved, any alternative procedures and the intended outcome. Informed consent is documented by making 1) appropriate progress notes in the patient's medical record and 2) by obtaining the signature of the patient or his/her legal representative on the approved consent form. The progress notes should reflect the content of the discussion with the patient and the physician's evaluation of the patient's understanding and response to the information provided. All notes should show the date and time of the discussion.

- Operative Reports
  - Any practitioner who is required to attend the patient shall enter a brief legible comprehensive operative progress note into the medical record immediately after surgery to provide pertinent information for use. A complete operative report should also be dictated immediately after surgery and should include the following:
    - Name of the surgeon and any assistants
    - Procedure(s) performed
    - Description of the procedure
    - Findings
    - Estimated blood loss
    - Specimens removed
    - Postoperative diagnosis

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- The surgeon must authenticate the completed operative report as soon as possible following surgery.

- Pre and Post Anesthesia Evaluation
  - There must be a pre-anesthesia note in the patient's medical record prior to administering anesthesia that is reasonably expected to result in loss of protective reflexes. The note shall specifically include:
    - Provisional diagnoses,
    - A history and physical exam,
    - Any abnormal lab,
    - Brief description of the planned procedure(s),
    - Planned anesthesia type, including risks, benefits and alternatives,
    - Patient's previous drug history,
    - Other anesthetic experiences,
    - Any potential anesthetic problems
  - A documented post anesthesia visit shall note any intra- operative or post-operative anesthesia complications.

- Discharge Summary
  - The discharge summary should be completed before or shortly after the time of inpatient discharge from the facility and should follow the following approved format:

- Patient Name:
- IP Number:
- Hospital Service:
- Attending Physician:
- Referring Physician
- Admission Date:
- Discharge Date:
- Date of Surgery (if any)
- Discharge Diagnosis (documented without the use of abbreviations or symbols):
- Reason for Hospitalization:
- Significant Findings (physical and laboratory):
- Procedures performed and care, treatment and services provided:
- Condition on discharge (measurable comparison with condition on admission - able to swallow with minimum difficulty; a febrile and ambulating with crutch, no signs of infection, etc.):
- Information provided to the patient and family (i.e., diet, medication, activity and follow-up, other discharge instructions):

o In the case of death, the discharge summary is replaced by a death summary stating essentially the same information, plus a summary of events

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immediately prior to death, including the cause of death as well as the date and time of death.

- In the case of a patient leaving "Against Medical Advise" (DAMA), the summary or progress note should include the same information,
- The responsible practitioner shall authenticate all discharge summaries.

8.2 ACTIVITY AND RESPONSIBILITY

S. No	Activity	Responsibility
1	Complete and accurate Medical record for every patient hospital is catering services (both IP & OP patients) must be maintained.	Medical record department
2	Standardized Policies and procedures for use of Medical Records of the patient must be established & followed as well.	Medical record department
3	All the detailed forms & charts of the medical record must be maintained & checked properly.	Concerned staff and Medical record department.

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9.0 REFERENCES:

Code of Medical Ethics

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