IMS.3d. POLICY ON Authorized Staff Entries in Medical Records

1. Purpose

The purpose of this policy is to:

- Define the **staff roles** that are authorized to make entries into **patient medical records.**
- Establish **guidelines** for making accurate and secure entries in medical records.
- Ensure compliance with **data privacy regulations**, such as **HIPAA** (Health Insurance Portability and Accountability Act) in the United States or other local regulations.
- Protect patient confidentiality and ensure the **integrity** of medical records.
- **Prevent unauthorized access** or alterations to patient records.

2. Scope

This policy applies to:

- All **staff members** of Inodaya Hospitals, including clinical, administrative, and support staff, who interact with patient medical records.
- **Medical records** in all formats, including **paper records**, **electronic health records (EHR)**, and **hybrid systems.**

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3. Definitions

- **Medical Record:** A comprehensive document containing all clinical and administrative data relating to a patient's care.
- **Authorized Staff:** Personnel identified and approved by the hospital to document in medical records based on their role and responsibilities.

- **Entry:** Any handwritten or electronic note, order, report, or communication documented in the medical record.

4. Policy Statement

Inodaya Hospitals is committed to ensuring that all **medical records** are accurately maintained and protected. **Medical records** are a critical source of information for patient care and must be kept secure, accurate, and up-to-date. This policy outlines the **authorized personnel** who are permitted to make entries in medical records, the processes they must follow, and the responsibilities of staff regarding the integrity and security of these records.

All entries in **patient medical records** must be made by authorized staff members in accordance with **hospital protocols** and **regulatory standards**. Unauthorized or inaccurate entries will not be tolerated, and staff must adhere to strict **documentation practices**.

5. Authorized Personnel

The following personnel are **authorized** to make entries in patient medical records, based on their roles and responsibilities:

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1. **Physicians and Surgeons:**
   - **Primary Care Physicians, Specialists,** and **Surgeons** may make entries related to **diagnosis, treatment plans, medications,** and **progress notes.**
   - They may also add or update **medical histories** and **treatment outcomes.**
2. **Registered Nurses (RNs):**
   - **Registered Nurses** may document **vital signs, nursing assessments, medication administration, patient care observations,** and **progress notes** during shifts.
   - Nurses can also record **patient concerns** and updates on **care plans.**
3. **Other Licensed Healthcare Professionals:**
   - **Physician Assistants (PAs), Nurse Practitioners (NPs),** and **Clinical Psychologists** may document their respective assessments, **diagnosis,** and **treatment plans.**
   - They must follow the same **documentation standards** as physicians.
4. **Pharmacists:**
   - **Pharmacists** may document **medication orders, drug interactions, prescriptions,** and any changes to **medication therapy.**
5. **Medical Records Department:**
   - Staff in the **medical records** or **health information management** department are responsible for maintaining the integrity of the records, assisting with **data entry,** and ensuring that records are **properly stored.**
6. **Clinical Assistants and Technicians:**

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- **Medical Assistants**, **Lab Technicians**, **Radiology Technicians**, and other relevant staff may make entries related to **lab results**, **imaging studies**, **procedures performed**, or **testing outcomes**.

The following individuals are authorized to make entries:

Role	Permissible Entries
Consultants / Attending Physicians	History, physical examination, diagnosis, progress notes, orders, discharge summaries
Residents / Junior Doctors	Daily progress notes, medication orders (as per delegation), investigation orders
Nurses	Nursing assessments, care plans, medication administration, shift reports
Allied Health Professionals (Physiotherapists, Dietitians, etc.)	Discipline-specific assessments and care
Medical Records Officers	Administrative data, coding, record completion

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Role	Permissible Entries
	tracking
IT/Admin Personnel (limited)	Data entry under supervision for non-clinical information (e.g., demographics)

6. Guidelines for Making Entries

1. **Accuracy and Completeness:**
   - All entries must be **accurate, complete,** and **legible.** The entry should reflect the **true state** of the patient's condition and care.
   - **Document in real-time** or as close to the event as possible to avoid inaccuracies.
2. **Legible Entries:**
   - If using **paper records,** entries should be **clear and legible** to prevent errors. For **electronic records,** text should be typed clearly using the system's interface.
   - **Abbreviations** should be used carefully and only if they are part of standard medical terminology.
3. **Timeliness of Entries:**

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- **Entries should be made immediately** after patient care activities or as soon as practical. This ensures that patient data is up-to-date and reflects the current state of care.

4. **Date and Time Stamps**:

   - Every entry must include the **date and time** it was made, especially for **critical updates** such as changes in patient status, medication adjustments, or test results.

   - **Electronic records** should automatically date and time-stamp entries. If entering on paper, the person making the entry must write the date and time manually.

5. **Authorized User Identification**:

   - Each entry must clearly identify the **author** of the entry, either through a **digital signature**, **username**, or **employee ID** (for paper records, initials and credentials should be included).

   - This ensures accountability and traceability of any changes made to the medical record.

6. **Corrections**:

   - **Corrections** to medical records should be made by **crossing out the incorrect information** with a single line, **writing the correction clearly**, and including the **date**, **time**, and **initials** of the person making the correction.

   - **Do not use white-out** or erase any entries. In electronic records, use the **corrective features** of the system, such as a change log or audit trail.

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7. **No Unauthorized Entries**:
    - Only **authorized personnel** may make entries in medical records. Staff should not make entries on behalf of others unless explicitly allowed by protocol (e.g., documenting a physician's orders).
    - **Unauthorized entries**, including entering information that is **not related to patient care** or **discrepant data**, will result in disciplinary action.

7. Confidentiality and Security

- **Confidentiality**:
    - All patient information documented in medical records is **confidential**. Staff must adhere to hospital confidentiality agreements and **data privacy regulations** (e.g., **HIPAA** in the U.S.).
    - Access to medical records should only be granted to those **directly involved in patient care** or those with a **legitimate need to know**.
- **Electronic Health Records (EHR)**:
    - In the case of **EHR systems**, **user accounts** and **passwords** must be **kept confidential**.
    - **Audit trails** should be in place to track all changes made to electronic records, including the identity of the person making the change and the time and date of the change.
- **Paper Records**:

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- For paper-based records, ensure that records are stored in **locked** areas and are accessible only to **authorized personnel**.
- **Patient files** should not be left unattended, and **confidential information** should be protected at all times.

8. Monitoring and Enforcement

- The **Medical Records Department**, **Compliance Officers**, and **IT Department** will regularly monitor the integrity of medical records through **audit trails**, **spot checks**, and **quality assurance reviews**.
- Any violation of this policy, including unauthorized entries, incorrect documentation, or failure to follow guidelines, will be subject to disciplinary action, including possible **termination** of employment.

9. Responsibilities

Designation	Responsibility
Medical Superintendent	Oversight and approval of authorized personnel
HODs / Clinical Leads	Ensuring compliance within departments
Medical Records Department	Policy implementation, audits, and training

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Designation	Responsibility
IT Department	EMR access control and cyber security
Quality Team	Monitoring documentation quality and reporting non-compliance

DOCUMENT REVISION HISTORY		
Version	**Date of issue**	**Reason for Revision**
Original version - 1		
Revised version - 2		
Revised version - 3		
Revised version - 4		
Revised version - 5		

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