IMS.4. POLICY ON MEDICAL RECORD REFLECTS THE CONTINUITY OF CARE RECORDS

1. Purpose

To ensure that patient medical records at Inodaya Hospital accurately and comprehensively reflect the continuity of care provided throughout the patient's journey—from admission to discharge and follow-up—supporting safe, high-quality, and coordinated care.

2. Scope

This policy applies to all departments and staff (clinical and non-clinical) who are involved in documenting or updating patient information in the medical record during the continuum of care.

3. Definitions

- Continuity of Care: The coordinated and uninterrupted provision of healthcare services across time, settings, and caregivers.
- Medical Record: The complete documentation of a patient's healthcare journey, including assessment, diagnosis, treatment, progress, and discharge.

4. Policy Statement

All patient medical records must reflect continuity of care through structured, sequential, and updated documentation of clinical and non-clinical information. Each entry must demonstrate linkage between:

- Initial assessment
- Investigations
- Diagnosis and treatment
- Clinical progress
- Interdisciplinary communication
- Discharge planning and follow-up

Responsibilities

Role	Responsibility
Medical Records Officer	Ensure records are complete and chronologically filed
Treating Physician	Ensure linkage between assessments, diagnosis, and treatment
Nursing Staff	Document continuous monitoring and care delivery
Allied Health Professionals	Document therapy provided and coordinate with clinical team
Quality Team	Conduct documentation audits and training
IT Department	Maintain EMR system for seamless continuity of care documentation

5. Key Principles

- Documentation must be chronological, comprehensive, and coordinated.
- All departments involved in care must document relevant entries (e.g., medicine, surgery, nursing, physiotherapy, dietary, etc.).
- Each transition in care (shift change, handover, referral, discharge) must be documented explicitly.

6. Procedure

6.1 On Admission

Emergency/OPD Notes: Must include presenting complaints, vital signs, brief assessment, and immediate care.

Admission Notes: Detailed history, physical examination, provisional diagnosis, initial care plan documented by admitting physician.

6.2 Assessment and Diagnosis

- Initial Assessment: Completed within 24 hours by a physician and nurse, including clinical, nutritional, and functional assessments.
- Investigations: Orders and results must be linked to the diagnosis and recorded in the relevant sections.
- Progress Notes: Must be updated daily by treating doctors and nurses to reflect ongoing treatment and patient response.

6.3 During Hospital Stay

- Doctor's Daily Progress Notes: Reflect medical decisions, condition updates, investigations, and changes in treatment.
- Nursing Notes: Document round-the-clock patient care, vitals, medication administration, and nursing interventions.
- Allied Health Notes: Physiotherapists, dieticians, counsellors, and others document their assessments, interventions, and outcomes.
- Handover Notes: At every shift change, notes must reflect the patient's current status and pending actions.

6.4 Multidisciplinary Communication

- Consultations from other specialties must be clearly documented with advice and follow-up.
- Interdepartmental referrals must be recorded with the reason, response, and subsequent action.

6.5 Discharge Process

- Discharge Summary: Includes final diagnosis, treatment provided, patient progress, condition at discharge, instructions, and follow-up plan.
- Patient Education & Counselling: Documented in the record, including understanding and consent by the patient/attendant.
- Medication Reconciliation: Documented to ensure safe continuation of medications post-discharge.

6.6 After Discharge

- Follow-up Documentation: Outpatient follow-up visits must be recorded and cross-referenced with inpatient data if applicable.
- Teleconsultation (if any): Must be recorded in the medical record along with advice given.

7.0 THE MEDICAL RECORD CONTAINES THE DETAILS OF ASESMENT AND RE ASSESSMENTS AND CONSULTATIONS IN ONE SINGLE PARAGRAPH OR BULLET POINTS

- The medical record includes **initial assessment** detailing history, physical examination, and provisional diagnosis by the attending physician.

- **Re-assessments** during the hospital stay are documented regularly, reflecting:

  - Patient's clinical progress
  - Response to interventions
  - Modifications in treatment or care plan

- **Consultation notes** from specialists/subspecialists are clearly recorded and include:

  - Date and time of consultation
  - Reason for referral
  - Consultant's findings and clinical advice
  - Actions taken based on consultation recommendations

8.0. The medical record should reflect of all investigations

- All **investigations** (lab, radiology, diagnostic procedures) must be documented in the medical record.
- Each entry should include:

- **Date and time** of the order
- **Type of investigation** conducted
- **Clinical indication or rationale** for ordering the test
- **Results** of the investigation once received
- **Interpretation** by the treating physician
- **Clinical decisions or actions** taken based on the investigation findings

9. Operative Records Included in the Medical Record:

- Operative records are a **mandatory part** of the patient's medical record.
- Each operative record must include the following details:
  - **Date and time** of the surgery
  - **Name of the procedure** performed
  - **Pre-operative diagnosis**
  - **Post-operative diagnosis**
  - **Name of the operating surgeon**, assistant(s), and anesthetist
  - **Type of anesthesia** used
  - **Detailed description** of the surgical procedure
  - **Intra-operative findings**
  - **Complications (if any)** during the procedure

- **Estimated blood loss and transfusions** (if applicable)
- **Post-operative condition** of the patient
- **Instructions for post-operative care** and follow-up

10. Patient Transfer Record Included in the Medical Record:

- Patient transfer records are an **integral part** of the medical record.
- The transfer record must include:
  - **Date and time** of transfer
  - **Reason for transfer** (e.g., to higher care, diagnostic procedure, another facility)
  - **Condition of the patient** at the time of transfer
  - **Vital signs** prior to and during transfer (if applicable)
  - **Treatment given** prior to transfer
  - **Name and designation** of the person authorizing the transfer
  - **Mode of transfer** (e.g., wheelchair, stretcher, ambulance)
  - **Accompanying personnel** (e.g., nurse, doctor, technician)
  - **Receiving department/unit/facility** details
  - **Handover communication** between sending and receiving teams documented
  - **Signature of staff** involved in the transfer process

11. Discharge summary contains sign copy

Signed Discharge Summary Included in the Medical Record:

- A **signed copy** of the discharge summary is **mandatory** in the patient's medical record.
- The discharge summary must include:
    - **Patient identification details** (name, age, hospital ID, etc.)
    - **Date of admission and discharge**
    - **Final diagnosis** (including primary and secondary diagnoses)
    - **Summary of clinical course** during hospitalization
    - **Investigations and significant findings**
    - **Procedures or surgeries** performed (if any)
    - **Treatment given** (medical/surgical/interventions)
    - **Condition at discharge**
    - **Medications at discharge** with dosage and duration
    - **Dietary and activity instructions**
    - **Follow-up advice and appointments**
    - **Name, signature, and designation** of the treating doctor
    - **Date of documentation and signature** of the staff issuing the summary

12. Cause of death in case of death

In the event of a patient's death, the cause of death must be clearly documented in the medical record. This should include the date and time of death, the immediate cause (such as cardiac arrest or respiratory failure), and the underlying cause(s) that led to it (such as sepsis or myocardial infarction). Any contributory conditions like diabetes or hypertension should also be noted. A brief narrative summary of the events leading to death must be included. The name, designation, signature, and date of the certifying doctor are required. If applicable, the death certification number, details of post-mortem (if advised or performed), and a copy of the death certificate must be added. Communication with the family about the death should also be documented in the record.

13. Care providers have access to current and post medical record

Care providers have access to both current and past medical records of the patient to ensure continuity and quality of care. This access allows them to review previous diagnoses, treatments, investigations, and clinical outcomes, which supports informed decision-making during the patient's ongoing treatment. Records are made available in a secure and confidential manner, whether in physical or electronic format, as per hospital policy and regulatory guidelines

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		