Inodaya
Hospitals

MRD MANUAL

MRD MANUAL INODAYA HOSPITALS.

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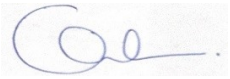
Prepared By :	**Designation: Medical Director** **Name : Dr.Gowtham Krihsna** **Signature:** 
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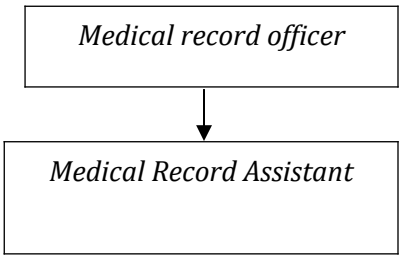
AMENDMENT SHEET

S.No	Section and Page	Date	Amendment	Signature

S.No	Abbreviation	Expansion
1	*IMS*	*Information Management System*
2	*IM*	*Information Matrix*
3	*ICD - 10*	*International Classification of Diseases and Related Health Problems (10^{th} Revision)*
4	*IP, OP*	*In Patient, Out Patient*
5	*MS*	*Medial Superintendent*
6	*MRD*	*Medical Records Department*
7	*MLC*	*Medico / Medical Legal Cases*
8	*NABH*	*National Accreditation Board for Hospitals and Healthcare providers*
9	*DEO*	*Data Entry Operator*
10	*TPA*	*Third Party Administrator*
11	*HOD*	*Head of the Department*
12	*MCI*	*Medical Council of India*
13	*NCI*	*Nursing Council of India*
14	*MRO*	*Medical Record Officer*
15	*MRRF*	*Medical Record Requisition Form*
16	*MRAL*	*Medical Record Auditors List*
17	*AP*	*Audit Plan*
18	*MRR*	*Medical Record Review*
19	*CCFC*	*Critical Care Flow Chart*
20	*DCL*	*Deficiency Checklist*
21	*MRT*	*Medical Records Tracker*
22	*PCR*	*Pest Control Register*
23	*MRR*	*Medical Record Register*
24	*HIDF*	*Health information Disclosure Form*

25	*MCS*	*Medical Case sheets*

ORGANOGRAM



1. INTRODUCTION

Medical/health records form an essential part of a patient's present and future health care. As a written collection of information about a patient's health and treatment, they are used essentially for the present and continuing care of the patient. In addition, medical records are used in the management and planning of health care facilities and services, for medical research and the production of health care statistics. Doctors, nurses and other health care professionals write up medical/health records so that previous medical information is available when the patient returns to the health care facility. The medical/health record must therefore be available. This is the job of the medical record worker. If a medical record cannot be located, the patient may suffer because information, which could be vital for their continuing care, is not available. If the medical/health record cannot be produced when needed for patient care, the medical record system is not working properly and confidence in the overall work of the medical/health record service is affected.

Aim of the work

Uses. The information contained in the **medical record** allows **health** care providers to determine the **patient's medical** history and provide informed care. ... An increasing **purpose** of the **medical record** is to ensure documentation of compliance with institutional, professional or governmental regulation.

Improve communication

OBJETCIVES:

- Between health professionals.
- Improve security and confidentiality of **patient** data and **records**
- Reduce duplication of data and procedures/examinations, prescription or referrals
- Ensure better quality of care, education and research

II.PURPOSE:

• To record the facts about a patient's health with emphasis on events affecting the patient during the current admission or attendance at the health care facility, and

• For the continuing care of the patient when they require health care in the future.

III. A patient's medical record should provide accurate information on:

: • who the patient is and who provided health care;

• what, when, why and how services were provided; and

• the outcome of care and treatment.

The medical record has four major sections:

• administrative, which includes demographic and socioeconomic data such as the name of the patient (identification), sex, date of birth, place of birth, patient's permanent address, and medical record number;

• legal data including a signed consent for treatment by appointed doctors and authorization for the release of information;

• Financial data relating to the payment of fees for medical services and hospital accommodation; and

• clinical data on the patient whether admitted to the hospital or treated as an outpatient or an emergency patient.

IV. MRD – IN CHARGE:

1.1. *Has the overall responsibility of all the day to day activities of MRD which includes Monitoring the preservation, control and movement of records*

1.2. *Handling Death LIC / insurance / claims/DAMA, etc*

1.3. *Responsible for any Patient Identification corrections / modification in any records*

1.4. *Approvals on information sharing with external agencies in consultation with the Medical Director.*

1.5. *Injury or Wound Certificates preparation*

1.6. *Coordinating with the Medical Auditors at the time of audits, minutes of meeting sent to concern departments, data analysis and presentation*

1.7. *Review of the case sheets.*

1.8. *Coordinating with the Medical Record Review at the time of audits, minutes of meeting sent to concern departments, review case sheets audit and data presentation*

1.9. *Manual ICD 10 Coding*

1.10. *Monthly / Annual Statistics*

1.11. *Monthly Quality Indicators sent by auditors*

1.12. *Monthly MRD KRA & KPI Submission & CA /PA analysis*

1.13. *To assign and supervise the departmental work to the staff*

1.14. *Supervision of the scanning case sheets*

1.15. *EMS collection of daily census and Legal cases review*

1.16. *Co-operate with the medical, nursing and other staff for rectification of the deficiency case sheets.*

1.17. *Communicable & infectious report submit to DMHO*

1.18. *Maintain Birth and Death registers, and to notify concerned authorities in duly Completing the required procedures*

1.19. *To maintain and protect medical records in accordance with the policies relating to presentation and destruction*

1.20. *Coordinating with internal & external audits at the time of audit and reply for the audit observations*

1.21. *Coordinating with advocates consumer court cases follow-up*

1.22. *Internal statistics requirements preparations*

1.23. *Monitoring of the destruction process*

1.24. *Train the staff for case sheets checking as per requirement.*

1.25. *Resolve the patient complaints*

1.26. *Perform any other work related to medical records as instructed by HOD*

1.27. Evaluate documentation for deficiencies in the Medical Case Sheets and to Arranging for completion of records with the co-operation of medical and nursing Staff

1.28. Daily Pending List Preparation & Follow up with concern wards

1.29. Sorting & Assembling of Medical records supervision of activity checking

1.30. Protect medical records, especially Medico legal cases from unauthorized Disclosure so as to maintain confidentiality

1.31. Filing of documents / case sheet contents in the respective Medical records

1.32. Receiving the Case Sheets of Discharged patients from the concerned wards

1.33. Pest control register maintenance

1.34. Attend the Consumer Court cases as when required

1.35. Court Summons received and document submit to court as when required

1.36. Daily Receiving case sheets on line updating

1.37. Birth/Death cases twice in a Month submit on line submit to KMC

1.38. Daily retrieval case sheets on line entry and pending cases monthly follow up

1.39. Weekly death Summaries pending list preparation & follow up Monthly Pending case follow up

1.40. Medical Audit/Medical Record Review data analysis once in a quarter

1.41. Perform any other work related to medical records as instructed by Medical Director.

1.42. Maintenance of Registers

1.43. Daily Discharge case sheets Received from the wards

1.44. Deficiency case sheets typing, and register Maintenance.

1.45. Mid Night census report preparation

1.46. Ward wise pending case sheets follow-up

5. MEDICAL RECORD ASSISTANT

5.1. *Daily open and close the department at proper timings*

5.2. *Cleaning the tables/Dusting the case sheets*

5.3. *Distribution of reports, circulars and communication documents to various departments*

5.4. *Based on the requisitions received, handover the files / Records to the requester &Follow up*

5.5. *Placing the Medical Records in racks – Filing*

5.6. *Arrange case sheet copies (Indoor case sheet) for external authorities*

5.7. *Arrange case sheets for scanning department*

5.8. *Arrange case sheets for Medical Audit/Review*

5.9. *Involve in assembling of case sheets as and when required*

5.10. *Film Register Manual entry*

5.11. *Numbering of case sheets*

5.12. *Indexing of case sheets*

5.13. *Arrange the case sheets for Destruction*

5.14. *Maintain the pest control precautions'*

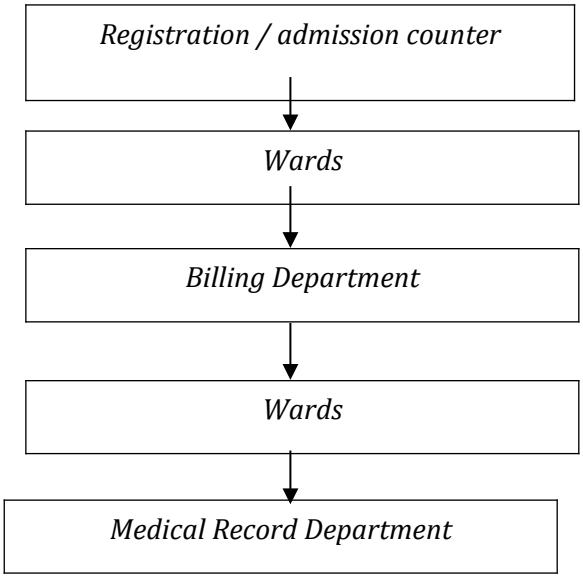
5.15. *Patient Personal details change EDP request ions written*

5.16. *Dusting of the inactive storage area*

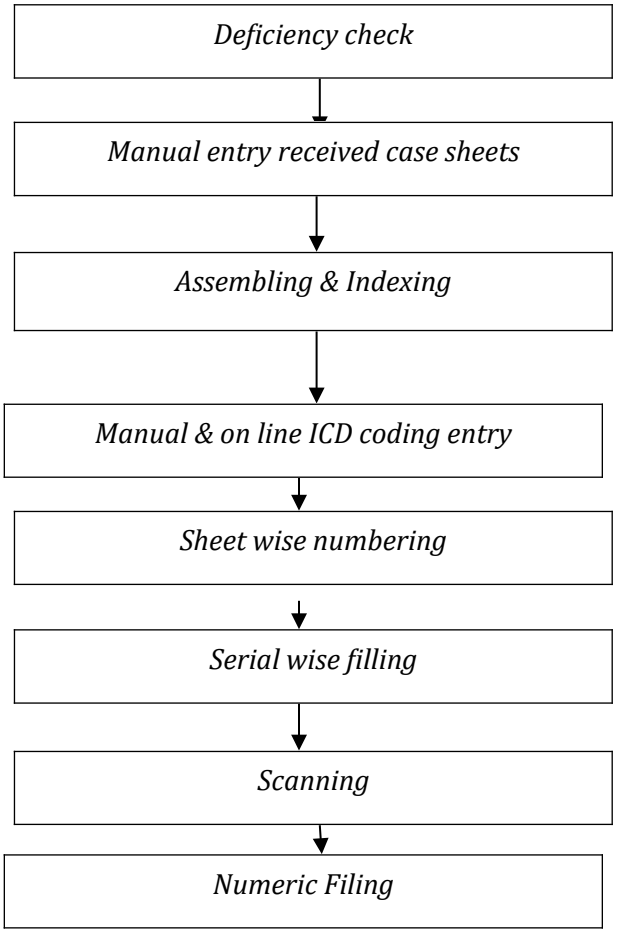
5.17. *Legal case sheets (Death/M.L.C) cases separation and filling*

5.18. *Perform any other work related to medical records as instructed by HOD*

INPATIENT CASE SHEET FLOW CHART



INPATIENT CASE SHEET FLOW CHART- MRD



RECORDS

PARTICULARS	IDENTIFICATION	LOCATION	RETENTION PERIOD
Admissions& Discharge register	*Soft Copy*	*MRD*	*Permanent*
Records Request Register	*INH/MRD/R/02*	*MRD*	*Permanent*
Death Register	*Soft copy*	*MRD*	*Permanent*
Birth Register	*Soft Copy*	*MRD*	*Permanent*
Film Register	*INH /MRD/R/05*	*MRD*	*Permanent*
Civil (Corporate) Register (Birth & Death)	*INH/MRD/R/06*	*MRD*	*Permanent*
MLC Register	*Soft Copy*	*MRD*	*Permanent*
Certificate Register	*INH/MRD/R/08*	*MRD*	*Permanent*
Deficiency Check Dispatch Register	*INH/MRD/R/09*	*MRD*	*Permanent*
Dusting & Pest Control Register	*INH/MRD/R/10*	*MRD*	*Permanent*
Scanning Details Register	*INH/MRD/R/11*	*MRD*	*Permanent*

Files

Daily Census file(Mid Night Census)	*Soft format*	*MRD*	*Permanent*
Monthly Statistics	*INH/ MRD/FL/02*	*MRD*	*1 year*
Circular	*INH / MRD /FL/03*	*MRD*	*1 year*
Interoffice Communication	*INH / MRD /FL/04*	*MRD*	*1 year*
Request letters	*INH / MRD /FL/05*	*MRD*	*1 year*
Policy File	*INH / MRD /FL/06*	*MRD*	*Permanent*
Infectious Disease Communication	*INH / MRD /FL/07*	*MRD*	*1 year*
O.P Police intimations	*INH / MRD /FL/08*	*MRD*	*1 year*
Op. Death details	*INH / MRD /FL/09*	*MRD*	*1 year*
Pending Case sheet follow-up	*VMSH / MRD /FL/10*	*MRD*	*1year*
Medical Audit File	*INH / MRD /FL/13*	*MRD*	*Permanent*
NABH Quality indicators	*Soft Format*	*MRD*	*Permanent*
Annual Statistics	*Soft Format*	*MRD*	*Permanent*

Bed Occupancy File	*INH / MRD /FL/16*	*MRD*	*1 year*
Manual Bed Occupancy File	*INH / MRD /FL/18*	*MRD*	*1 year*
Record request File	*INH / MRD /FL/19*	*MRD*	*1 year*
Medical Record Review file	*INH / MRD /FL/20*	*MRD*	*Permanent*

SL No	Organization	Data Shared	Periodicity	Approved By
	EXTERNAL DISSEMINATION OF DATA			
1	*State Govt (Municipal Authorities)*	*Birth / Death information*	*Twice in a Month*	*DM*
2	*State Govt (Municipal Authorities)*	*Communicable / Notifible diseases (eg: Dengue, Malaria, Viral Hepatitis, etc.)*	*Every Day*	*DM*
3	*Police & Legal Authrities*	*Injury /Wound Certificates*	*within 72hrs receiving the request*	*DM*
4	*Legal Jurisdiction*	*Case sheet copy, Reports and films other necessary documents (Bill copy ,OP documents etc)*	*as and when required*	*DM*
5	*Life insurance/Medi claim insurance authorities ,TPA's*	*Copy of indoor case sheet, reports, Claim forms & necessary certificates related to the pt. treatment*	*within 72hrs receiving the request*	*DM*
6	*Patient / Patient representative (Legal / Authorized attendant(Husband, Wife, Son, Daughter)*	*Indoor case papers* *Life insurance /Medi claim insurance certificates* *Cause of death* *Medico legal case registration forms* *Birth /Death forms* *GRBS Charts/ ER Forms* *Duplicate summaries/copies* *Correction letters, others as per request*	*within 72hrs receiving the request form concerned*	*DM*
	INTERNAL DISSEMINATION OF DATA			
1	*Medical professionals*	*Case sheets, treatment particulars*	*within 2hrs receiving the request*	*MRD-HOD*
2	*Medical & Paramedical staff*	*Case sheet*	*within 4hrs receiving the request*	*MRD-HOD*
3	*Administrative Staff(Billing, Insurance,*	*Case sheet, Reports*	*within 6hrs receiving the request between*	*MRD-HOD*

	Corporate billing)			
4	*Research professionals*	*Case sheet*	*within 6hrs receiving the request*	*MRD-HOD*
5	*Medical and Paramedical Students*	*Case sheet, patient details*	*within 6hrs receiving the request*	*MRD-HOD*
6	*Medical Audit team*	*Case sheet*	*within 2hrs receiving the request*	*MRD-HOD*
7	*Other Hospital Administrative authorities*	*Case sheet*	*with in 2hrs receiving the request*	*MRD-HOD*
8	*Level 1 Administration*	*Hospital Statistics*	*once in a month, and as when required*	*MRD-HOD*

Format No: INH/C.S/F/04

CHECK LIST FOR ASSEMBLING & DEFICIENCY

Patient Name: *Age / Sex:*
Consultant: *Department:*
I.P No: *Ward / Bed No:*
Date of Admission: *Date of Discharge:*

Case Sheet Forms	*No. of Pages*	*Clinical*	*Non Clinical*
Explanation Letters/Patient details change documents			
Legal Forms (MLC / DEATH/certificates)			
ER assessment form			
Check list for assembling & deficiency			
Request letter – choice of primary doctor			
Discharge Summary (Original / Fair Copy/ Hand Written)			
ECHMO Datasheet			
Investigation Record			
Investigation Result Chart			
Diabetic Chart			
IP Billing Record			
Pan card undertaking letter			
Ward Transfer Record			
All Physiotherapy Records			
Patient Information Record			
Registration Slip			
Admission Slip			
General Consent			

Patient Initial Assessment Record			
Doctor Progress Notes			
Dialysis charts			
Clinical Record			
Treatment Record			
Antimicrobial Stewardship Programme Form			
Drug Prescription Record			
Observation Intake & Output Record			
Nursing Care Plan			
Nurses Progress Record			
Pain Assessment Sheet			
Risk Assessment for pressure ulcer			
Patients who are identified for risk of falls			
Peripheral Venous Access Documentation			
Liquid Diet chart			
Aarogyasri Consent certificate			
All patient counseling, meeting, Comfort care & condition of patient related consent forms			
All High Risk Consent Forms/Consent forms / Blood Consent/ OT Booklet/ Delivery sheet/CT surgery operation notes soft/hard copy/procedure consent/DNR/MTP consent			
Blood Compatibility Certificate			
Neurological Observation Chart			
Surgical Safety check list			
Surgical Site Infection Bundle Checklist			
Position Changing Chart			
Daily Patient Goal Chart			
Initial Assessment by Staff Nurse			
Nutritional Assessment Record			
Hospital Infection Control Related Checklist			
Protocol For Radial Band Removal			
Physical Restraint Informed Consent			
Post Operative Cardiothoracic Chart			
EVD / Lumbar drain chart			
Critical Care Chart			
Lab Reports			
X Ray Films			

Radiotherapy Treatment Chart			
Insurance /Arogya sri /Credit related documents			
Other reports			
TOTAL NO. OF PAGES			
Ward Incharge Signature	**Medical Record Executive Signature**		

Record Requisition form:

S.NO	*IP NO*	*PATIENTS NAME*	*AGE/SEX*	*CONSULTANTS NAME*	*DURATION*

TRACER CARD:

Issued Date	I.P. No	Issued to Dept./ Ward/ Consultant	Issued By sign

1. **PURPOSE:** *The purpose of this procedure is to providethehospitalwithauthorizedstafftomakeentriesinthemedicalrecord*

2. **SCOPE**

The procedure is applicable to the clinical nursing and medical records staff.

3. RESPONSIBILITY

Assistant Medical Superintendent is responsible.

4. PROCEDURE

The following criteria shall be observed:

4.1 *There is a unique identifier (Name and Employee Number) for each staff member.*

4.2 *Physicians shall be expected to have a stamp bearing both (Name and Employee Number).*

4.3 *Dated and signed (include day, month and year)*

4.4 *Timing of entries is required on Medication Administration, Pre-Operative and Nursing documentation*

4.5 *Legible and include clear, concise and pertinent patient information*

4.6 *Authenticated. Signature and professional title*

4.7 *Chronological*

4.8 **All disciplines** *document according to discipline specific documentation standards*

4.9 **Entries** *written in error shall have a single line drawn through and* **"ERROR"** *written above.* **Never** *erase, obliterate or use liquid paper correction fluid on a patient's record*

4.10 *No part of the medical record is* **ever** *to be removed after entry*

4.11 **The Patient's** *name and IP number must appear on every record page/document in the medical record*

4.12 **Written Signatures** *validate written orders and written notes*

4.13 **Inpatient care** *is documented in the Medical Record and includes:*

- *Reason for admission, diagnosis, and plan of care*
- *Evidence of the initial patient assessment and all subsequent re-assessments*
- *Documentation of interventions based on physician orders and/or on unit standards of care or approved protocols*
- *Documentation of nursing care provided*
- *Any operation /Procedure performed in details. Name, signature, and date, time on every entry made in the record*
- *The records should be legible*
- *The records should be in a chronological order demonstrating the continuity of case*
- *Transfer notes should be in accordance to the policy of transfer and should include-Date, reason for discharge and name of the receiving hospital*
- *Medication administration is recorded on the Medical Administration Record or area specific*

forms

- *Specific CARE during operative or other invasive procedures, in the emergency department, the dialysis unit, obstetrics, the clinical research centre, and the sub-acute unit is documented on forms specific to each specialized are*
- *Patient discharge instructions*
- *Discharge summary should be prepared and signed or countersigned by the Clinician In-charge*
- *Death summary should include – cause of death, date, time and should bear the signature of the clinician In-charge*

4.14 *Timeentriesaremadeusing12hoursclocksystem.*

4.15 Authorized Staff Members to make Entries:

4.16 *ThefollowingMedicalandHealthCareProfessionalsareauthorizedtomakeentriesinthe MedicalRecordsof VMSH Hospital with the coordination of Medical Records Staff Members:*

- *All physicians.*
- *Nurses.*
- *Physiotherapists.*
- *Dietician.*
- *Medical Records Staff.*
- *Other HealthCare Providers sharing in patient's care.*

4.17 Procedures in Making Entries:

- *ResponsibleMedicalorHealthCareProvidersarerequiredtocompletethes paces provided for the date, patient's name, age and sex.*
- *Detailed clinical assessments shall been done in legible manner.*
- *Aftertheentryofeachclinicalassessmentttheresponsiblemedicalorhealthc areproviders must place their name or number, signature, date and time.*

5. INTERFACE

This procedure is with reference to Chapter 10- Information Management System, IMS 3(b) (c) (d) NABH Standards requirements-4th Edition

1. **SCOPE**

The procedure is applicable to the Clinical and non clinical data to be shared with the Stake holders / external authorities in INH

2. **RESPONSIBILITY**

Assistant Medical Superintendent is responsible for identification of information needs as well as approval of DGM& M.S to sharing information to the stake holders.

3. **PROCEDURE**

Identifying stake holders

4.1. *The Management determines the list of persons to whom hospital information need to be made available.*

4.2. *An Information Matrix [INH/MRD/IM] that lists out the details to be available to different stake holders of the hospital is prepared by the Assistant Medical Superintendent and maintained by the Medical records officer under the instructions of the management.*

4.3. *The Information Matrix [INH/MRD/IM] is reviewed every Yearly to update the contents of information to be made available for different stake holders. This includes information availability to any new stake holder, disabling full or part of information availability to any existing stake holder and revision of contents of information made available to stake holders.*

4.4. *Whenever there is any change in the contents of information required by external stake holders [statutory authorities, Medical Council of India and others], the Assistant Medical Superintendent discusses the details with the M.S & DGM and then suitably amends the information contents.*

4. **INTERFACE**

This procedure is with reference to Chapter 10- Information Management System, IMS- 1(a), NABH Standards requirements-4th Edition

INFORMATION:

2. **PURPOSE**

The purpose of this procedure is to explain the activities relating to release of information to external authorities in INH

3. **SCOPE**

The procedure is applicable to the (clinical / non clinical) Information from the MRD to the external agencies.

All the procedures explained below are in consonance with the prevailing laws and regulations.

4. **RESPONSIBILITY**

Chief Operating Officer / Assistant Medical Superintendent are responsible for date dissemination of Medical Case sheets.

5. **PROCEDURE**

5.41. Customers of Information

5.41.1. The customers of information is listed in the Information Matrix [INH/MRD/ANX/01] with whom information is shared. This list is reviewed and modified once a year. This list includes all the stake holders and also the statutory bodies.

5.41.2. The MRD determines the customers to whom voluntary reporting is done. This includes

5. *Hospitals with whom INH has information sharing agreement*
6. *Research institutions or researchers in medical field*
7. *Government authorities (including Police department / Legal Department)*
8. *Any other social organizations which is in need of information.*
9. *Stake Holders within INH*

5.41.3. VMSH also shares information under regulatory reporting commitment to agencies, institutions or government. The type of data varies from time to time as per the changes in the regulatory requirements.

5.41.4. In all the above cases, INH provides information, after studying the request from the recipients / customers and after the approval from the MS

5.41.5. Whenever information is shared under voluntary reporting or regulatory reporting, care is taken to ensure that only the relevant and needed information is provided.

5.41.6. All information provided is done only after approval is obtained from MS

5.41.7. The details of the information shared with the various stake holders / associations are registered by the Medical Records Department staff in the Medical Records Issue Register (INH/MRD/R/08)

5.42. Statutory sharing of information

5.42.1. The Medical Records Department of ABCCH submits periodical reports – daily, monthly, and annual, to the management. These reports give details on Inpatients/Outpatients/Births/Deaths/Surgeries conducted/Investigations done/Infectious diseases etc.,

5.42.2. The details of Birth and death are sent to the State Government authorities twice in a month and the evidence of the same is maintained in the Civil / Corporation Register (INH/MRD/R/06)

5.42.3. The details of Notifiable diseases every day reporting to DM &HO as and when confirmed and evidence of the same is maintained in the Notifiable Disease file(INH/MRD/FL/07)

5.42.4. As and hen required the patient information is also shared to the court to aid in the legal proceedings.

5.42.5. A part from the statutory sharing of information as per the Information Matrix, the information is also released to the external agencies over and above what is to be given based on the requests received in the Caw sheet copies request Form [INH/MRD/F-04] .The approval of the MS is also obtained before sharing information in such cases..

6. INTERACE

This procedure is with reference to Chapter 10- Information Management System, IMS-1(a, b, c, and e), 2(c) NABH Standards requirements-4th Edition.

Medical Record Management:

10. PURPOSE

The purpose of this procedure is to explain the activities relating to management of medical records by the Medical Records Department of the Hospital

11. SCOPE

The procedure is applicable to Medical Records department in the hospital and includes activities related to

a. Receipt of Medical Records from the wards

b. Issue of medical records to requestors

c. Identification, storage and protection of Medical Records.

All the policies and procedures explained below are in consonance with the prevailing Laws and regulations.

12. RESPONSIBILITY

3.1 *MS is responsible for approvals with regards to sharing of information to external bodies*

3.2 *The HOD of MRD is responsible for monitoring the issue of medical records / follow up / periodical review of pending records / storage / protection etc.*

3.3 *Delay in obtaining issued case sheets*

3.4 *Regular Pest control activities*

3.5 *Periodical Medical record audits*

3.6 *Corrective & preventive actions*

13. PROCEDURE

a. Medical Record Generation

i. The table below gives details on the data / information that are generated in each section of the Hospital and the template in which they are updated which is finally collected in the Medical Record File and on discharge of the patient sent to the MRD. Change according to the deficiency Check list patient flow :

b. Receipt of Case Sheets

i. The updated Medical Case Sheets are received from the wards on discharge of a patient on a daily basis.

ii. On receiving the Case Sheet / Medical Record file the staff of the MRD carry out the deficiency check on each case sheet.

iii. The deficiency check is done based on the Deficiency Checklist [INH/C.S/F/04]. As a part of the Deficiency check the staff check for the following

7. *Missing date & time of entry*
8. *Signature of the person who made the medical record entry*
9. *Accuracy of the operative and other medical procedures undertaken*
10. *Details of the patient care in chronological order*
11. *Plan of care, Provisional & final diagnosis etc.*
12. *Copy of the death certificate in the case of death*
13. *Copy of discharge / death summary*
14. *Completion of document form wise*

iv. If any missing details are noticed the Case Sheets are immediately returned back to the concerned ward / staff nurse / doctor and the necessary details are updated.

v. The MRD ensures that the author of the entry in the medical record can be identified. In case of any doubts in identifying the author the staff of the MRD verifies the signature and stump and Employee number.

vi. Perform assembling /sorting /indexing/numbering activities

vii. MRD ensures that all the case sheets are coded as per the International Classification of Disease (ICD-10) 10th revision.

c. Preparation of duplicate Case Sheets

i. In the case of missing / lost case sheets the duplicate case sheet will be maintained in the MRD with approval of A M.S /Chief Operating Officer.

ii. If any case sheet missing / lost in the ward, the concerned ward in-charge nurse should write an explanation and get it approved by the Nursing Superintendent and Assistant Medical Superintendent .then preparation of duplicate case sheet.

d. Identification , Storage , Protection of Records

i. The Medical Case Sheets are identified by the Inpatient Number (I.P No.). The Medical files are stored in open racks in strict numerical filing order with appropriate identification numbers

ii. *For easier retrieval each rack contains a list of the range of the numbers and the rack name which helps to identify the rack in which a particular record is placed*

iii. *Records are protected from pests by spraying pesticides at regular intervals .This activity is carried out periodically by the vendor as agreed in the contract. Details of the visits made and the work done are maintained in the Pest Control Register [INH/MRD/R/10].*

iv. *The Head of the MRD also ensures that adequate fire protection measures are in place inside the Medical Records room so that there is minimum or no damage to the records in the event of fire. The staff of the MRD is also trained in the usage of fire extinguishers.*

v. *The Medical Case Sheets are placed in racks and also issued to the requesters only by the Medical Record Department staff.*

vi. *The MRD team ensures that no one else apart from the MRD has access to the Medical records placed in the MRD.*

vii. *The MRD ensures that Medical Case Sheets are not handed over to the external parties / Agencies. In case such requirements arise the Case Sheets are handed over within the MRD premises and reviewed only in the presence of the Medical record officer. After the review is done the MRD personnel ensures that the records are placed in the racks.*

viii. *Medical record officer carries out regular audits to check compliance with the laid down policy on confidentiality and security of information.*

e. FILE ASSEMBLING

Completed Inpatient files assembled as per the Inpatient file as per standard checklist

4.6 ICD 10 CODING

Coding is done based on final diagnosis with all complications given in the discharge summary. ICD codes are entered on the discharge summary, file labeling and coding, details of the patient (Name / UMR No / IP No etc) entered on the file, and same enter in the on line. For easily find out particular disease ICD -10 Code no wise.

4.7 STORAGE AND PRECAUTIONS

Completed files are kept in the storage area as per the IP No of the patient. Pest control (spray, rat pads) daily in active area, twice in a month in inactive area. Acknowledgment taken in pest control register (INH/MRD/R/10)

4.8 MLC / DEATH FILES MANAGEMENT

Death / MLC case sheets received from the concern wards with MLC stamp and MLC number. MRD staff checks the deficiency in the case sheet. MLC and Death cases are entered in Admission register or online entry. Assembling the case sheet as per MRD standard checklist wise & chronological order

wise. Medico Legal Case sheets kept the separate Room for storage area. Files are issued only on the signed approval of Assistant Medical Superintendent / Chief Operating Officer on the Medical Records.

4.9 ISSUE OF INPATIENT FILES

Requisition slips received from Doctors / concern departments, Check done for information accuracy, completeness & proper authorization on the requisition slips. Inpatient files are retrieved; Tracer Cards with relevant details of the Inpatient file(s) are put in place of the retrieved files. Details entered in file issue register, and requisition slips are filed in the Access to medical record Request file. Inpatient files issued to the requesting Departments, weekly/monthly check for files due for Return/ Delay reminders issued for due files. Extension (if required) for inpatient files entered in the loan slip. Inpatient file comes back to MRD, Tracer Cards are removed & the files are kept at its respective place.

4.10 PREPARATION OF PENDING FILES LIST

Daily discharge Reports are taken from HIMS. Cut of the Received case sheets.

Files not received from wards within 4 days of discharge prepare the pending list. Weekly reminders issue the concern wards & information sent to Assistant Medical Superintendent and inform to Nursing Superintendent.

4.11 Reports Issue to External Authorities

- *Birth/Death information*
- *Notifiable Diseases information*
- *Wound/Injury Certificates*
- *Indoor Case Papers*
- *Cause of Death Certificates*
- *Discharge Summaries*
- *MLC Copies*
- *Life insurance Certificates*
- *Medi claim Insurance forms*
- *ER forms*
- *Reports*
- *Films*
- *Correction letters*
- *Diabetic charts*

4.12 **Reports Issue to Internal Authorities**

- *Case sheets*
- *Monthly/annual statistics*
- *ICD Disease wise Count/Data*
- *Dept wise type of surgeries*

4.13 VERIFICATION OF LIC / MEDICAL INSURANCE CASES

Surveyors submit an authorization letter from the Insurance Company / TPA along with employee ID proof for verification. After getting the approval from the treating consultant & Assistant medical superintendent or Chief Operating Officer, files are shown and copy of case sheet given to the consent surveyors with payment of service and acknowledgement taken from issue register.

4.14 COMMUNICABLE / NOTIFIABLE DISEASES

Receipt of serology report from Lab, ward inform to MRD, MRD Staff submit to on line registration through DMHO website followed by daily/weekly report of Communicable / Notifiable diseases.

A copy of the daily report is kept in Communicable / Notifiable diseases file.

4.15 PREPARATION OF MID NIGHT CENUS (12am TO 12pm)

Print out of admission, discharge and current Inpatient list is taken from HIS. The list of patients remaining in the hospital at the previous day census plus the admission for the following day, minus the Discharge (including deaths) for the day is taken. Details of Patients are taken ward wise and specialty wise.

4.16 MONTHLY Report Preparation: *Monthly Data collection from the concern Dept's and on line Reports, collection of data and analysis and preparation and submit to Management. Same file the Monthly Statistics file.*

- *Department wise admissions*
- *Department wise surgeries*
- *Department wise registrations*
- *Consultant wise consultations*
- *Department wise Mortality*

4.17 Hospital information*:*

- *Total admissions*
- *Total discharges*
- *Total inpatient days*

- *Bed occupancy rate*
- *Bed turnover rate*
- *Bed interval*
- *Gross death rate*
- *Net death rate*
- *Post operative death rate*
- *Total no of lama cases*
- *Total no of cancel admissions*
- *Total no of Transplant*
- *Total no of Liver Transplant*

The above details of the information shared with the various stake holders are listed in the information matrix.

4.18 POLICY FOR MAKING CHANGES IN MEDICAL RECORD

- **Purpose:** *To standardize the process of making changes in the medical record according to requirement of the law.*
- **Policy:** *The changes made in the demographics of the patient only submission of requisition form*
- **Specific Information:**

1.27. *Any change in demographics of the patient admitted or seen in the IPD requires an application along with proof of change and sent to EDP after counter signature of the Assistant Medical Superintendent or Chief Operating Officer. If proof of change is not available then a stamp paper of Rs. 10/- is duly signed by district magistrate and given to administration.*

1.28. *The request for change in demographics will not be entertained once submission of the legal document.*

1.29. *The change in the medical documents should be made by the people already mentioned. The original script should be return to consent department, reprint the medical document. The person making a change should sign on the correction made*.

14. INTERFACE

This procedure is with reference to Chapter 10- Information Management System, IMS-2(a,b,d,e), 3(a,b,c,d,e,f,g), 4(a,b,c,d,e,f,h), 5(a,b,c,d,e,f,g,), 6(a,b,c,d) - NABH Standards requirements-4th Edition.

Medical Records Review:

15. PURPOSE

The purpose of this procedure is to explain the activities involving the review of medical records in the Medical Records Department of the Hospital.

16. SCOPE

The Scope of the procedure includes Periodical reviews of Medical Records in the MRD by the Medical Record auditors in the hospital

17. RESPONSIBILITY

3.1*The Medial Record Audit chairman are responsible for the periodical review of the Medical records, Audit report generation and follow-up of the status of the review.*

3.2 *The Chairman of the medical audit is responsible for planning, scheduling and conducting the audits .The MRD – In-Charge is also responsible for coordinating with the Medical Record Auditors as well as the staff of the MRD for the closure of the audit findings.*

18. PROCEDURE

a. Review Plan / Schedule

i. *The Hospital has identified qualified personnel to conducted review of medical records and the details of the same are maintained in the Medical Record Auditors List [VMSH/MRD/ANX/02]*

ii. *The review of medical records is done at least once in 3 months by the auditors.*

iii. *The details such as the date / time are discussed and finalized with the auditors by the Chairman of Medical Audit.*

iv. *The frequency of the audits may be increased based on the outcome of the previous audits, number of records added to the MRD every week / month, trend analysis and the nature of deficiencies identified and corrective and preventive action is taken.*

v. *The decision to do Medical Record reviews more frequently is taken up jointly by the Chairman of Medical Audit in consultation with the Medical Auditors as well as the Medical Superintendent.*

b. Medical Record review

i. *The review is carried out as per the plan and the outcome of the review is documented in the Review File [VMSH/MRD/FL/20]*

ii. *During the review the reviewers/auditors check the medical records to check for safe and rational prescription of medications as per criteria.*

iii. *The review includes an adequate mix of both active as well as discharged patient's case sheets depending on the availability of the case sheets of both active as well as discharged patients.*

iv. *The review team ensures that at least 5 % of the records added to the MRD after the previous audit is reviewed.*

v. *On receiving the Review Report from the reviewers the Audit team members study the observation / deficiency mentioned in the report and take appropriate corrective / preventive action based on the root cause identified.*

vi. *The deficiencies are closed as per the target date agreed with the Medical Record Auditors*

vii. *The details of the corrective / preventive action taken are also updated in the Review File.*

19. INTERFACE

This procedure is with reference to Chapter 10- Information Management System, IMS- 7(a, b, c, d, e, f, and g) NABH Standards requirements-4th Edition-Dec 2015.

ISSUE CERTIFICATES:

1. PURPOSE:

To describe the process for issuing the Certificates and Medical reports

2. SCOPE:

This policy is applicable to MRD and Clinical Departments.

3. RESPONSIBILITY:

Medical Superintendent is responsible for Issue of certificates to needs.

4. PROCEDURE:

Demanding certificates are

c. *Wound / Injury certificate – MRD by Doctors*
d. *Discharge summary copies - MRD*
e. *Claim documents & Reimbursement form – MRD*
f. *Cause of Death certificate*
g. *Medico legal cases register forms*
h. *Birth / Death Information forms*
i. *Indoor case sheets copies*
j. *ER Forms*
k. *Patient details change summaries*
l. *Life insurance claim forms*
m. *Correction letters*
n. *Medi claim forms*
o. *Diabetic charts*
p. *Hemo dialysis charts*
q. *Insurance related activities – MRD*

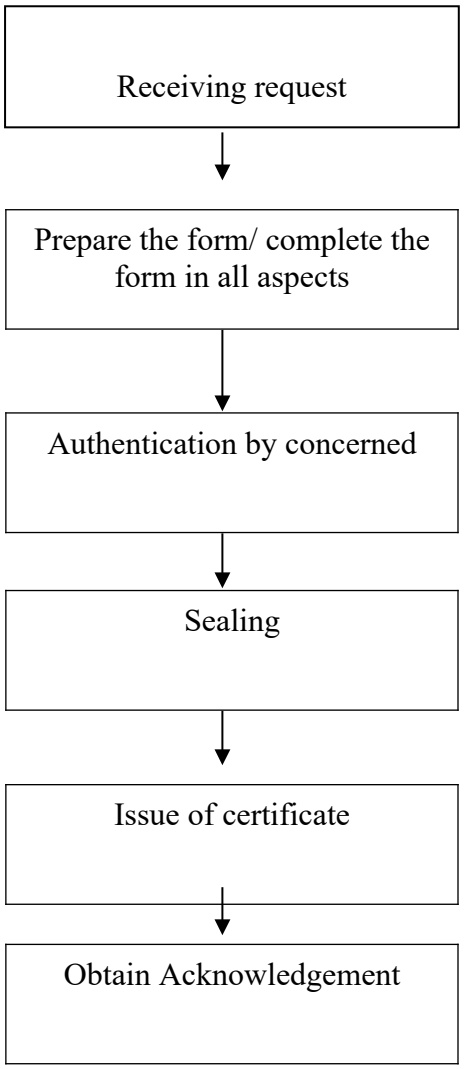
r. *Birth information forms*

s. *Death information forms*

t. *Medical reports & Investigation reports, films and others.- MRD*

All certificate requests shall come to MRD/Doctors Secretary based on type of certificates as mentioned above and these certificates are to be issued by the admitting consultants. The hospital has the right to deny release of the above record/ certificates if it is requested by the person other than patient, unless he/she produces evidence to provide his relation/legal guardian or permission from patient to obtain such documents.

u. Process of issuing certificate



The patient/relative/legal representative shall give the written application to the MRD Office. An acknowledgement is issued to the patient/legal representative on request. Medical records officer prepares the requested certificate and sends the same to the concerned Doctor for correction and final issue. The certificate is completed in all respect and after putting Doctor's signature and seal the certificate is issued to the patient/relative/legal representative. An acknowledgement is obtained from the patient which is recorded in the Certificate Register (VMSH/MRD/ R/ 08)

v. Disability certificate

The Patient/relative/Legal Representative will be directed to get the certificates from the Govt. Authorities. Since private practitioners are not authorized to issue the same.

Note: Disability certificate will be issued to the Patient/relative/Legal Representative for the personal purpose.

4.14 Copies of case sheets

Requests are received from Patient/relative/Legal Representative to MRD for the Case sheet. The patient/relative/legal representative shall give the written application to the MRD Office. An acknowledgement is issued to the patient/legal representative on request. The request will be sent for approval of Hospital Administrator/Medical Superintendent. Medical records department prepares the Xerox copies of case sheet. A payment of Rs.150 is collected as a Medical Record Service charge. An acknowledgement is obtained from the patient who is recorded in the Certificate Register (VMSH/MRD/ R/ 08)

4.15 *Issuing of birth and death certificate*

Birth certificate

- *Birth report form (Form1) shall be filled by patient/relatives with relevant details and submit to the PRO's office. After verification data shall be sending to the local bodies. The birth certificate shall be send by the local bodies to GHMC within one week and issue to the concerned beneficiaries/patients. The registration of the birth shall be entered in the Civil/Corporation register*
- *Inclusion of name of babies or any updating later on shall be done by the local bodies against the certification of VMSH authorities.*

Death certificate

- *Death report form (Form 2) shall be filled by the MRD staff and Form 4(Medical certificate of cause of death) shall be filled by the concerned doctor and submit to the GHMC office. After verification data shall be sent to the local bodies. The death certificate shall be send by the local bodies to GHMC*

within one week and issue to the concern beneficiaries. The registration of death shall be entered in the Civil/Corporation register.

- *Form no 1,2 and 4 are issued from the local bodies and the original certificates are reissued from there. GHMC is coordinating these activities.*

TRACEBULITY MEDICAL RECORDS:

15. PURPOSE

The purpose of this procedure is to explain the activities relating to easy and fast case sheet retrieval by the Medical Records Department of the VMSH

16. SCOPE

The procedure is applicable to Medical Records department in the hospital and includes activities related to

a. *Receipt of Medical Records from the IPD and OPD*
b. *Issue of medical records to requestors/ stake holders*
c. *Identification, storage and protection of Medical Records.*

All the policies and procedures explained below are in consonance with the prevailing Laws and regulations.

17. RESPONSIBILITY

3.7 The HOD of MRD is responsible for monitoring the issue of medical records / follow up / periodical review of pending records / storage / protection etc.

3.8 Delay in obtaining issued case sheets

5. PROCEDURE

5.1 OP Case sheet retrieval

20. Every visit of a patient will be registered / entered in the Health Information Management System (HIMS) by front office or respective secretaries in the OPD areas.
21. After registration a follow up sheet will be generated automatically by HIMS for documentation of current events i.e. findings, advised and prescription.
22. Case sheet request will be generated and displayed in the MRD automatically after completion of registration of a review patient.
23. MRD will accept/ approve the request
24. Quality check will be done for existing case sheet images
25. Send the digitalized case sheet to the concerned consultant's desktop through online
26. Consultant can view the patient record in his desktop but he cont perform any activity on the patient

record.

27. Doctor will document the patient information on follow up sheet for that particular visit
28. Hand over the investigation reports and prescription to the patient
29. All the follow up sheets will be submitted to MRD by the OPD secretaries at the end of the OPD time.
30. MRD will perform the scanning, indexing and uploading to the respective UMR nos
31. The online digital document will be disappear within one day in out patient

***Note:** If any patient come for further review the process starts from 5.1.1 to 5.1.12

5.2. In Patient Case sheet retrieval

In patient case sheet retrieval will be two types' Physical case sheet and online case sheet

5.2.1 Physical (Hard copy) Case sheet

1.30. The requests for Case Sheets are received from the stake holders / Doctors through the Medical Case sheets Request Form [VMSH/MRD/F-02]

1.31. The MRD HOD analyses the request and based on the Information Matrix [VMSH/MRD/IM], the required Case Sheets are issued to the requester.

1.32. The details of the requested case sheets are updated in the Record Request Register [VMSH/MRD/R/02] with details such as the name of the requestor / date of request / the Medical Record I.P Number and the person who issued etc.

1.33. The details of the issue are also updated in the Medial Records, record request file in the system to follow-up in case there is a delay in receiving the Medical Records.

1.34. Whenever any internal stakeholders need additional information, over and above that is accessible to them, the request is sent to MRD through the [VMSH/MRD/F-02], who receives such requests and then in consultation with the AMS / Chief operating officer provides the additional information to the requester.

1.35. Such requests are treated as one time request and incase of permanent need for such information, the Information Matrix [VMSH/MRD/IM] is amended after the approval of the AMS to update the information availability to the stakeholders.

1.36. When MRD is closed, the Manager on duty with the help of security guard opens the MRD and retrieves the Medical records and the same is documented in MOD report and MRD for information.

18. INTERFACE

This procedure is with reference to Chapter 10- Information Management System, IMS-2(d), IMS-3(a,b,c,d,f,g), 4(h), 5(a,b,c,d,e,f,g,), 6(a,b,c,d) - NABH Standards requirements-4th Edition-Dec 2015.

CONFIDENCIAL RECORDS:

PURPOSE: To maintain confidentiality of all types of information. This includes medical records diseases, operation index.

SCOPE: This is applicable for Medical record dept.

RESPONSIBILITY

Assistant Medical Superintendent and Medical record officer is responsible

6. PROCEDURE:

6.1 Persons working in the Medical Records, persons directly involved in patient care and other authorizedpersonswhohaveaccesstopatientmedicalrecordsmustnotunderany circumstancesdiscloseanytypeofpatientinformationtounauthorizedpersons.

6.2 Disclosures of anyinformationcontainedinthemedicalrecordsareabreachofconfidentiality.

6.3 Anyone found tohavedisclosedanyinformationtounauthorizedpersonswouldbesubjecttodisciplinary action and possible termination.

6.4 Authorized persons, who need to obtain any kind of patient information, should adhere to guidelines in policy and procedures for the "Release of Information".

6.5 MedicalRecordsinthedepartmentarekeptsecuredandinstrictconfidentiality

6.6 No unauthorizedpersonsareallowedtohaveaccesstopatientmedicalrecordsoranytypeof patient data information.

7. INTERFACE

This procedure is with reference to Chapter 10- Information Management System, IMS 5 (a) (b) (e) (f) (g) IMS-1(b), (c), (e), and NABH Standards requirements-4th Edition.

COADING AND DATA ABSTRACT:

1. **PURPOSE:** To correctly and accurately assign Standards Disease, Operationand /orProcedure Codes to alldischargedInpatientsMedicalRecordsandtoenterthedatainthecomputerforfuturereference.
2. **SCOPE:** The procedure is applicable to research medical and paramedical team.
3. **RESPONSIBILITY**

Assistant Medical Superintendent is responsible

4. PROCEDURE:

4.1. Receive medical records from the Medical Record staff who have analysed the file for completeness.

4.2. Discharged inpatient medical records will be coded daily against the discharge census. The medical record staff will refer to their list of discharges for all files that are not yet coded.

4.3. Review the medical record Inpatient Admission Sheet, Discharge Summary ,History and Physical, Physician Progress Notes ,Consultation Notes ,Operation and Procedure Note sand all Investigations(if present).

4.4. Compare the final diagnosis of the Inpatient Admission sheet to the one recorded on the Discharge Summary, History and Physical and progress report.

4.5. Determine that the primary(final)diagnosis has been listed first and any secondary codes are listed incorrect coding sequence.

4.6. Code the identified Diagnosis, Operations and Procedures, listed them inpencilontheInpatient.Admissionsheetincorrectsequence,inthecolumnmarked"ICD-10"

4.7. Placeyourinitialnexttothoseoftheanalystintheblankboxnexttothecolumnmarked ICD Code Numbers on the Inpatient Admission sheet.

4.8. CODINGGUIDELINES:

The following basic steps in coding should be followed:

- Locate them a intermonth Alphabetic Index.
- Refer to any notes under the main term.
- Refer to any modifier soft the main term.
- Refer to any sub terms indented under the main term.
- Follow any cross–reference instructions.
- Read and be guided by any instruction, terms, symbolised which may further qualify the code.
- Assign the Code Number thus obtained.

4.9. Each individual diagnosis or procedure must be assigned a correct and complete code. If the physician had not given specific information, search the history and physical, doctors progress notes, operative reports and pathology reports for more information. If not clearly defined, as the concerned physician for clarification.

4.10. The principle diagnosis and the principle procedure must be coded first, because the categories in

which patients are grouped for the purpose of evaluating the utilization of Health Record facilities are based on principle diagnosis and principle procedure. Secondary codes must be sequencedintheorderofimportanceandtheireffectintheprincipleдiagnosis.

4.11 AftereachcodingprocedurehasbeencompletedforadischargedInpatientMedicalRecord, put a high light in each appropriate medical record number from the correct discharge census list. The code should be entered in the software. Then the file be put in the filing area.

NOTE: CODING IS AN IMPORTANT ASPECT OF THE MEDICAL RECORDS DEPARTMENTANDITMUSTBEDONEACCURATELY.

5. INTERFACE

This procedure is with reference to Chapter 10- Information Management System, IMS 4 (a) - NABH Standards requirements-5th Edition.

SECURITY IF MECIAL RECORDS:

6. PURPOSE: To ensure that all Medical Records (Data Information) are kept safe andsecuredintheMedicalRecordsDepartmentandprotectionofMedicalRecordsfrom loss, theft or deliberate alteration/tampering.

7. SCOPE: This is applicable for the Medical records department.

8. RESPONSIBILITY

Assistant Medical Superintendent is responsible

9. PROCEDURE:

4.1. Medical Records originated in the hospital are the property of INODAYA HOSPITAL and are maintained for the benefit of patients and hospital staff.

4.2. In accordance with INODAYA HOSPITAL policies, medical records shall not be removed from the hospital except by court of Ministry of Health. (Only copy).

4.3. Medical Records can be taken out of Medical Records Department only by authorized persons.

4.4. If the file are required for a purpose, other than patient appointment, the persons requesting the file/should fill up a file request form within the organization“, available from Medical Records

Department.

4.5. For emergency patient the medical records staff will promptly deliver the file to nurse orthestaffcancollectthefilefromMedicalRecordsDepartmentwithproperidentification.

4.6. To ensure maximum security against loss, defacement, tampering and from use by any unauthorized individual:

4.7. NounauthorizedpersonsareallowedtoenterMedicalRecordsDepartmentortohave access to patient Medical records out of the department.

4.8. AllmedicalrecordstakenfromtheMedicalRecordsdepartmentduringworkinghours by any outpatient department/ER or by any authorized persons/ units should be returned on the same day. No records are to be kept overnight in any unit other than inpatients.

4.9. Patients or their relatives will not be allowed to carrythepatientfilesortokeepthemintheirpossessionsauthorizedallowed

4.10. ThemaindooroftheMedicalRecordsDepartmentshouldbekeptlockedafterworkinghours.

4.11. AllpersonswhoneedtoenterMedicalRecordsDepartmentafter5:30pmshouldcontactMedicalRecordstaffondutythroughreceptioncounterorbyphoneExt. ****.

4.12. No records/files should be left unattended.

4.13. Medicalrecordstaffshouldalwaysbeavailable.Nostaffshouldleavethedepartment without handing over.

4.14. Any misconduct made by any of the authorized and responsible staff members against this policyrequiresimmediatenoticefromtheheadofmedicalrecordswiththeapprovaloftheMedical Superintendent for prompt initiation of penalty depending on the signification of offenses candelas follows:

4.15. First offense requires a warning letter signed by the medical superintendent stating the consequence if the same misconduct is repeated and he is trained further motto repeat him is take again.

4.16. Secondoffensenecessitatesathreetoseven–dayssalarydeductiondepending upon the type off assault along with a written memorandum duly signed by the Medical Superintendent and the HR.

4.17. Third offenses subject to termination of contract.

10. INTERFACE

This procedure is with reference to Chapter 10- Information Management System, IMS 5(a) (c) (d) (e) NABH Standards requirements-5 th Edition.

STORAGE OF MEDICAL RECORDS:

PURPOSE: To store old medical records (which are inactive and less likely to be needed) in such a manner that they could be retrieved if required.

SCOPE: This is applicable for the Medical records Dept.

RESPONSIBILITY

Assistant Medical Superintendent and medical record officer is responsible

PROCEDURE:

4.1 Patient records(In-patient):

- These files shall be stored in a place in close proximity to the Medical Records Department so that they could be retrieved quickly.
- Theserecordswillbearrangedproperlyinshelvesinserialordertofacilitateeasyretrieval when required.

4.2 Legal File

- Legal shall be kept in special shelves in serial order to enable easy retrieval.

4.3 GeneralInstructionforStoringOldRecords:

- Old records should be stored in a safe and secured place.
- All the old and inactive records have to be retained until they are disposed off, as per the rules laid down by Govt for "Record Retention",

ANALYSIS:

11. **PURPOSE:** To Complete all Medical Records of in-patient discharges in compliance with the hospital's standards.

12. **SCOPE:** This is applicable for medical records department.

13. RESPONSIBILITY

Assistant Medical Superintendent and medical record officer is responsible

14. PROCEDURE:

5.1 Allnewlydischargedandexpiredrecordswillbeanalysedwithin1 week after discharge.

5.2 Verify that all discharged records for the day are collected or present.

5.3 UseaPhysicianIncompleteChecklistfromforeachphysicianhavingmedicalrecords deficiencies in any record.

5.4 UseNursingDeficiencyChecklistformforeachNursingUnithavingdeficiencies.

5.5 NursingDeficiencyChecklistformusedwillthenbedistributedasfollows:

- Top copy will be given to each nursing unit in the ward with backed copy signed by any of the nursing staff from the ward.
- Alldeficienciesrequiringsignatureswillbetaggedwithcoloredlocatortags.
- The appropriate colored tags will be placed on each deficiency checklist.
- The following information will be recorded on the Physician Deficiency checklist:
  - Patient Name.
  - Patient Medical Record Number.
  - Ward/Department
  - Date of Deficiency.
  - Type of Deficiency.
- For each Medical Record having discharge summary and/or operation report that needs to be typed.
- Mortality Records:

- If the patient has expired, record all the information in Death Register (patient name, date of death, medical record number, ward/unit, sex and treating physician).
- Ensure mortality records are completed such as death summary, diagnosis or cause of death.
- Write to each top face side of folder "EXPIRED" with date and time of death.
- Keep the expired files in separate filing shelves filed in serial order.
- Analysed files will be passed onto the person(s)responsible for Coding.

15. INTERFACE

This procedure is with reference to Chapter 10- Information Management System, IMS 4 NABH

RETENSITION PERIOD OF MEDICLA RECORDS

1. **PURPOSE:** *The purpose of this policy is to preserve the medical records for a given period of time for legal, medical cases. Records that are no longer needed by the medical records can be discarded/ destroyed*
2. **SCOPE:** *This policy is applicable to MRD department.*
3. **RESPONSIBILITY:** *Medical Records Officer.*
4. **PROCEDURE:**

4.1. *A Medical Records retention schedule is attached to the case sheets. A Retention/ Disposal schedule is created for the case sheets and they are destroyed or retained accordingly*

4.2. *The Assistant Medical Superintendent is the overall administrative in charge who is responsible for the Medical records Destruction/ Retention. He will also be responsible to implement this policy and to supervise its implementation and retention/destruction schedule*

4.3. *The Medical Superintendent are the authorized personnel's to make any modifications time to time to ensure that these in consonance .*

4.4. *Only after obtaining written approval from the designated hospital authorities, the medical records will be destructed by the department staff.*

4.5. *The data will be preserved for a period of 5 years in CDs / Electronic Data process after destruction of case sheets*

4.6 APPLICABILITY:

- *This policy applies to all physical records generated in the course of patient treatment of VMSH, including both original and duplicate documents. It also applies to the electronic documents.*

4.7 *The policy was approved by the management of ABC Hospitals*

4.8 Preservation of Records:

- *All medical records including patient's files, registers etc., related directly to patient care have to be maintained by the medical records department.*
- *The old files, registers are to be preserved in a secure place for a prescribed period. Later the records have to be disposed off as per the Record Retention Schedule.*

4.9 *Special care has to taken to reserve the safety of records. Records have to be protected from insects, termites and prevent them from being exposed to heat, fire, dampness and dust. Adequate fire extinguishers should be available in the filing areas.*

4.10 RECORD RETENTION SCHEDULE

Retention period for MRD are as follows:

Record type	**Retention period**
In-patient case records	*5 years*
MLC case records	*Life Long*
Death case records	*Life Long*
Electronic data / records	*5 years after destruction of physical record*
X-ray / CT films	*5 years*
In patient Neonatal and Pediatric case record	*Until patent reaches at the age of 18 years' old*

4.11 Destruction

Records that have satisfied their legal, fiscal, administrative and archival requirements may be destroyed in accordance with the Record Retention Schedule. However electronic / CDs will be created & preserved for a period of 5 years.

4.12 Procedure

- *Obtain a written approval from the designated internal hospital authorities or*
- *Before destruction written information should be given to local police station*
- *Publish in the local newspaper and specify the period of records destroying .If anyone wants to collect the records, the Hospital would hand them over*
- *Maintain a destruction register with minimum details like Pt Name, Admission number, Date of admission, date of discharge, Name of the consultant etc.*

4.13 Method of Destruction:

The following will be used to destruct the medical records according to its nature (Paper, film etc)

- *Shredding*

4.13 Destruction committee members:

1. *Medical Superintendent/Assistant Medical Superintendent*
2. *Patient care Manager*
3. *Security Manager*
4. *Nursing Superintendent*
5. *Medical Record Officer*

Approval /Certificate of Records Destruction

Department Name:					
Description, including type and quantity of record series to be disposed of					
Series Code	**Series Title**	**From date**	**To date**	**Media**	**Remarks**

Signatures indicate approval for destruction of the above records

Department HOD *Authorized Facility approval*

Signature: _____ *Signature: _____*

Name: _____ *Name: _____*

The records described above were destroyed in the normal course of business pursuant to a proper retention schedule and destruction policy and procedure.

Date of destruction: _____ *Method of destruction- Shredding* ☐

Records Destroyed By: **Witness:**

1) *Signature: _____* **2)** *Signature:_____*

Date:_____ *Date:_____*

Name:_____ *Name:_____*

Designation / EMP Code:____ *Designation / EMP Code:____*

PENDING LIST FOLLOW UP

32. PURPOSE

The purpose of the pending case sheets follow up in MRD, without missing case sheets in our hospital.

2. **Scope:**

The scope of medical record staff daily Follow up the pending list.

33. RESPONSIBILITY

1) *Nursing Superintendent is responsible to deposit all the discharge case sheets on time.*
2) *MRD officer is responsible to receive the same.*

34. FOLLOW UP THE PENDING CASE SHEETS:

34.41.1. When the patient is discharged from the ward, the case sheet should reach MRD within 1 week in charge sister of the ward is responsible to ensure that these case sheets are submitted to MRD.

34.41.2. Sister i charge should check correctness of documents as per checklist.

34.41.3. MRD Executives will thoroughly check the case sheets. In case of any deficiencies the case sheets will be returned to concern wards the MRD staff will take acknowledgement in deficiency register.

34.41.4. Deficiency case sheets should be returned to MRD within 4 days

34.41.5. If it is ot submitted within 1week , the MRD staff should communicate the same to the Nursing Superintendent and the ward in charge

34.41.6. Follow up will be done by the MRD staff after 10days. He will visit the ward and liaise with Nursing Superintendent. If still action is incomplete then it is escalated to the Assistant Medical Superintendent.

APPROVED ABBRIVATIONS

19. PURPOSE

The purpose of this policy is to establish ABC Hospitals requirements regarding the use of Abbreviations in clinical documentation.

20. PRINCIPLES

2.1. Abbreviations cause a significant risk of misinterpretation by other healthcare providers.

2.2. If there is any question of correct interpretation of an abbreviation or symbol, the word(s) must be written or displayed in full text.

2.3. The Institute of Safe Medication Practices (ISMP) has established abbreviations that shall never be used in medication documentation (see Appendix A).

2.4. Do Not Use abbreviations (Appendix A) shall not be used in handwritten clinical documentation; VMSH approved clinical forms, or any medication documentation.

21. ROLES AND RESPONSIBILITIES

All Staff and Physicians: The author of the document containing an abbreviation, symbol and/or acronym assumes responsibility for usage. The onus is on the author to ensure the meaning is clear and understandable to the health care provider who must take action or use the information to provide care. A reader who is unsure of the meaning must clarify it with the writer.

22. POLICY & PROCEDURE

4.1. Abbreviations and Symbols used within INODAYA Hospitals shall be used and accepted as referenced in Jablonski's Dictionary of Medical Acronyms & Abbreviations – 6th Ed. (2009) and Appendix B (Approves abbreviations as per JCI and approved abbreviations in INDAYA Hospitals) except as noted in the Do Not Use List (Anx-08).

4.2. The ISMP (Institute of Safe Medication Practices) list of Do Not Use Dangerous Abbreviations, Symbols and Dose Designations is to be strictly adhered to in all handwritten clinical documentation, all medication documentation and all INODAYA Hospitals approved clinical forms. Abbreviations on the attached Do Not Use list are never to be used, as they are frequently misinterpreted and have resulted in harmful medication errors

4.3. Pre-printed physician orders, treatment orders, or other paper or electronic forms related to medication use shall not include any abbreviations, symbols, and/or dose designations identified on the Do Not Use List.

4.4. The dangerous abbreviations, symbols and dose designations as listed in the Do Not Use List will not be used on any pharmacy-generated labels and forms.

4.5. Abbreviations shall not be used on consent forms, for medication names, to describe procedures or as a final diagnosis.

4.6. Auditing of continued usage of prohibited abbreviations in medication related documentation will be undertaken by the Medical records review Committee on a regular basis.

Annexure- 08: ISMP List of error prone Abbreviations, Symbols, and Dose Designations

Annexure-09: Common Medical Abbreviations in usage

23. INTERFACE: This procedure is with reference to Chapter 10-Informaiton Management System, IMS 3 (f), NABH standard requirements- 5th Edition (January 2020)