ATHARV AYURVED MULTISPECIALITY HOSPITAL 112/29,Vasant Vihar,Sonepat Road,Rohtak Pin-124001	**Quality Operating Process**	**Document No :AAMH/03**
	Manual of Operations **Medical Audit**	**Date of Issue : 05/02 /2022** **Issue No. : AAMH/I//19** **Date of Revision: 04/02 /2023** **Revision No. : 01**

SERVICE NAME :	**Medical Audit**
DATE CREATED :	**05/02 /2022**
APPROVED BY :	**DR. PRINCE GIROTRA**
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AMENDMENT SHEET

No.	Section and Page	Date	Amendment	Signature

A. Purpose:

To provide guideline instruction for ensuring uniform Medical Audit.

B. Scope: Hospital Wide

C. Policy:

- All patients approaching the hospital for medical treatment will receive care appropriate to their healthcare need and scope of services provided by the hospital.
- Quality of medical care will be same in all care settings of the hospital and no discrepancy of any sort will be followed in the provision of medical care.
- All treatment orders would be signed, dated and timed by the concerned clinician.(Refer to Medical Record Policy).
- Any treatment order initiated by a hospital's clinician different from the primary treating consultant of the patient will be countersigned by the primary treating consultant within 24 hours.
- In case required the primary treating consultant of the patient may consult other care providers available within the hospital for patients care related issues.
- Patients response to treatment ,his /her health status further treatment plan etc. will be discussed among the clinical and nursing staff involved in provision of Medical Audit.
- The primary treating consultant can refer the patient to other clinical specialty either within the hospital or to the identified external healthcare institutions if the patients medical need demand the same (Refer Policy on Referral of Patients).
- The clinicians may resort to evidence based medicine which is the conscientious, explicit and judicious use of

current best evidence in making clinical decisions about the care of individual patients.

Clinicians are encouraged to consider the following points in using evidence based medicine for the provision of optimum care to the patients which are:

a. Convert information need into answerable questions.

b. Track down the best evidence to answer the question (with maximum efficiency).

c. Critically appraise the evidence for its validity and usefulness.

d. Integrate appraisal results with clinical expertise and patient values.

e. Evaluate outcomes.

WHAT IS MEDICAL RECORD ?

The medical record is a legal document providing a chronicle of a patient's medical history and care. Physicians,Paricharika, nurse practitioners and other members of the health care team may make entries in the medical record.

The medical record includes a variety of types of "notes" entered over time by health care professionals, recording observations and administration of drugs and therapies, orders for the administration of drugs and therapies, test results, x-rays, reports, etc.

Medication administration has been recorded and signed

The Medication form (if any) has been completed and signed . The main condition /principle diagnosis has been recorded on the front sheet Medication and/or procedures have been recorded on the front sheet Diagnostic reports have been attached Discharge/referral summary is duly filled and signed.

COMPONENTS OF MEDICAL RECORD

Frontsheet or identification summary sheet

OPD FILE :

- Priscription
- Initial Assessment Form
- Nutritional Assessment Form
- COVID-19 Mandatort Self Declaration
- Feedback Form

IF COME TO VULNERABLE PATIENT / CHILD

- VULNERABLE PATIENTCONSENT FORM
- PEDIATRIC NUTRITION ASSESSMENT FORM

IPD FILE:

- Charges Concern Form
- Test Request Form
- Admission Form
- General Consent
- Prakurti Chart Form
- Panchkarma Consent
- Procedure Care Plan
- Discharge Form
- Pain Scoring Chart
- Vital Chart
- Daily Medication Schedule
- Daily Vital Pain Scoring & Daily Feedback Form
- Daily Diet Assessment Form
- Progress Notes

Pt. Name :_____ **Age:**_____

Sex._____

UHID No._____ **OPD No.**_____ **IPD No.**_____

MRD FILE CHECK LIST

S No.	Documents Name	Yes	No
1	Prescription (Uhid Number)		
2	Initial Assessment Form		
3	Nutritional Assessment Form		
4	Covid-19 Mandatory Self Declaration		
5	Feedback Form		
6	Charge Concern Form		
7	Admission and Discharge Form		
8	Prakurti Chart		
9	General Consent		
10	Panchkarma Consent		
11	Procedure Care plan		
12	Discharge Summary		
13	Vital Chart		
14	Pain Score Chart		
15	Daily Medication Schedule		
16	Daily Vital Pain Scoring & Daily Feedback Form		
17	Daily Diet Assessment		
18	Progress Notes		
19	Payment Slip		
20	Final Bill		
21	Signature, Date, Time & Stamp		
22	Adhar Card		
23	Vulnerable Patient Consent Form		
24	Pediatric Nutrition Assessment Form		
25	Test Request Form		

Sign of MRD In charge

RETRIEVE OF PATIENT RECORD

Retrieve is form filled up concerned person.

After approval from MS, given to MRO.

MRO gives the person the record in duplicate & notes down the number of pages in the form & takes signature

The treating consultants and the other clinical doctors are authorized to have access to the discharged in patient health record charts. The non-clinical doctors and other administrative staff can access the charts with the written approval of the Medical Superintendent In all MLC and death cases the Medical Superintendent's written permission is a must to access them Concerned person from outside should get written approval from Patient in order to get the patient record In Insurance cases, the release of such information without the prior consent of the patient is permissible because the patient had waived his claim of this privilege at the time of taking out a policy with the corporation

After giving the record back, the person signs on that form.

USE OF MEDICAL RECORDS

To document the course of patient's illness & treatment. Communicate between attending doctors and other health care professional providing care to the patient Collection of health Statistics.

- Legal Matters & Court Cases
- Insurances Cases

SEQUENCE OF MEDICAL RECORD

• Information & identification sheet

• Clinical Notes

Diagnostic reports

Blood Transfusion notes

• Nurse Notes

• Informed Consent X-ray Films are stored Separately

RETENTION OF MEDICAL RECORDS

Usually records are retention policy of the records depending upon the space availability within the Hospital, but every hospital more or less maintain

OPD records - 3 years IPD records- 5 years

MLC cases - 10 year s As per Forensic Department of India

Where there is chance of litigation arising for medical purpose of negligence, record should be preserved for at least 10 years, especially because there are rules where the minors have the rights to sue the doctor within three years from the date of majority, for the injuries sustained due to negligence of the doctor during the period of his minority. Other medico legally important records should be preserved upto 10 years after which they can be destroyed after making index and recording summary of the case. Routine cases records may be preserved upto 5years after completion of treatment and upto 10 years after death of the patient. There are certain records in hospital, which are of public interest and are transferred to public records library after 10 years for release to public and those involve confidentiality of the individuals are released only after 10 years

FUNCTIONS OF MEDICAL RECORD DEPARTMENT

Filing of Medical records. Retrieval of medical records for patient care and other authorized use. Completion of medical records after an inpatient has been discharged or died. Coding diseases and operations of patients discharged or having died Evaluation of the Medical Record Service. Completion of monthly and annual statistics. Medico-legal issues relating to the release of patient information and other legal matters.

PREPARING A MEDICAL RECORD FOR COURT

On receipt of a subpoena, the MRO records the date and time the subpoena was received and records in a diary the date and time the medical record is due in court. The MRO should notify the attending doctor and hospital administration that a subpoena has been received for the release of the medical record to court The MRO should locate the medical record. If the medical record is not on file, the MRO should find it and keep it in a safe place awaiting preparation for court. A tracer is made out showing that the medical record is with the MRO for medico-legal purposes The MRO should check that all necessary information, as specified in the subpoena, is in the medical record and that it is complete. Medical record is given in Duplicate and page numbers are written on the case sheets. When the original medical record is returned to file, the copy is removed from file and destroyed. To protect the privacy of the patient, it is important that if a medical record is copied, the copy MUST be treated with the same respect as the original and MUST be destroyed on return from court. These steps apply to original and photocopied medical records

Monitoring & Audit of Medical Records

Medical Record Committee is established which is responsible for all matters relating to the content of Medical records and the provision of medical record services in the hospital. Members of the Committee should consist of

Doctors from surgery & Medicine Nursing Administration Management Staff

Medical Record officer Responsibilities - Review of medical records to ensure that they are accurate, clinically pertinent, Complete and readily

available for continuing patient care, medico-legal requirements, and medical research; Ensure that medical staff complete all the medical records of patients under their care by recording a discharge diagnosis and writing a discharge summary (where required) for each discharged patient within a specified period of time; Determine the standards and policies for the medical record and the medical record services of the health care facility; Recommend action when problems arise in relation to medical records and the medical record service; Determine the format of the medical record and approve and control the introduction of new medical record forms used in the health care facility (all forms should be cleared by the Medical Record Committee before being put into use) Assist and support the MRO in liaising with other staff/departments in the health care facility.

RESPONSIBILITY OF MEDICAL RECORD OFFICER

Management of Medical Record Department (including Central Admitting and Enquiry Office) Development, analysis and technical evaluation of clinical records

Development of secondary records (ie indexes of various types) • Preservation of medical records

Development of statistics • Assistance to the Medical Staff

Co-operation with all other departments in the matter of records Pest Control measures at equal Intervals

COMPLETION OF MEDICAL RECORDS

The consent form for treatment has been signed by the patient; Patient identification details (name and medical record number) are correct and entered on all forms

Doctors have recorded all essential information Doctors have signed and dated all clinical entries

The front sheet has been completed and signed by the attending doctor

Nurses have recorded and signed all daily notes regarding the condition and Medical Audit. All the orders for treatment have been recorded in the medication form and signed;

QUALITY INDICATORS OF MEDICAL RECORD DEPARTMENT

Are medical records filed promptly? Is the file room clean and tidy? Are Master Patient Index cards filed promptly? An MRO checks the information on records with a doctor. Are all discharges returned to the Medical Record Department the day after discharge? Are the Medical Records Complete Are medical record forms filed in the correct order?

Are all medical records completed within a specified time after discharge? • Are medical records coded correctly? • Are all discharges for last month coded by the middle of the next month? • Are the monthly and yearly statistics collected within a specified time?

Medication administration has been recorded and signed

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