Purpose:
To provide guideline instructions & process of Management of Medical Records with the aims that

- Medical Records are readily retrievable, and
- Feedback loop is established for continuous improvements of Health Indicators.

Scope:
It covers all patient medical records in the Hospital.

Responsibility:
Medical Records in Charge & Doctor is responsible for maintaining medical records.

Objectives:
The Primary objective of the Medical Record Department is to develop good Medical Records containing sufficient data written in sequence of events to justify the diagnosis, treatment and end result of all patients treated in a Hospital, keep them under safe custody and make the readily available as and when required for

- The Patient.
- The Doctor
- Hospital Administrators.
- Medico Legal Purposes.
- External Reporting.

1. For Patient, it

- Serves to document the Hospital history and activities of patient treatment.
- Serves to avoid omission or repetition of diagnostic and therapeutic measures.
- Assists in continuity of Care even in future illness whether it requires attention in or out of the Hospital.
- Serves as evidence in Medico-legal Cases.
- Give necessary certification for employment purposes.

2. For The Doctor, it

- Assures quality and adequacy of diagnostic and therapeutic measures undertaken.
- Serves as an assurance of continuity of medical care.
- Evaluates Medical Practices.
- Protection in litigation.

3. For Hospital Administration

- To document the type and quantity of work undertaken and accomplished.
- To evaluate proficiency of Medical Staff for administrative and Hospital purposes.
- To evaluate the services of the Hospital in terms of accepted norms and standards.
- To serve as an Administrative record and Performance.
- To assist in futures Programmers for Planning and developments of Hospital.

4. For Medico Legal Purposes, it serves

- As a documentary evidence
- To dispose claims of the Insurances.
- For Patient's WILL to indicate if the patient was of normal mental state or not.
- Malpractice Suits.
- Authorization for operation etc. signed document for consent for operation will prove that the Patient / Relative have allowed the performance of such Procedure.
- Criminal cases – as a Potential Document.

Development of Hospital Performance Statistics

Statistical and epidemiological Data are needed to implement and manage medical care planning and to obtain Health Indicators to monitor and evaluate their effectiveness for Hospital Management as follows:

- Average No. of Out Patients
- Average No. of Admissions

- Sex wise Admissions
- Average Length of Daycare of Patients.
- Number of Types of Therapies performed (Major & Minor)
- Number of diagnostic procedures done/ outsourced.
- Laboratory Tests.
- Daily Census of the Hospital.

Reporting to Health Authorities

This is the responsibility of the department to submit the necessary information's on Hospitalal statistics to Health Agencies like DMO, CMO and other departments under the ambit of Health & Family welfare department, Government of Delhi.

Process of Creating Medical Records

Medical Record contains different sections for recording the information as

- Identification Section
- Medical Section

1. Identification

This section fills up the Bio Data / Socio economic data / Patient Identification Data at the time of Registration and Admission. OPD file is generated at OPD registration counter; on the Admission Request of the Consultant In patient Admission record is prepared. Personal data for following particulars are provided at OPD registration and Admission counter by the Patient / Relatives.

- Name of Patient
- Father's / Husband's Name
- Age & Sex
- Occupation
- Permanent / Emergency Address.
- Telephone / Mobile Numbers
- Nationality
- Religion

- Patients/ bystanders consent for admission

These details are fed in the register manually and the patient is given a unique identification number which is entered in the designated area of the patient.

2. Medical Section

The Medical Section is filled up by the MS, and pertains to History, Physical examination, Treatment / progress of the patient, Ayurveda Therapy & Physiotherapy notes are also recorded, the information is recorded in the following Medical Record Forms, keeping in view two types of forms – Basic + Special

Basic:-

- Initial diagnosis Record Sheet
- History Record Form
- Reasons for Admission
- Physical Examination Record Form
- Progress And Treatment Record Form (Medical Record Form & Therapy Record form)
- Consultation Record Forms (special)
- Different Investigations Report Forms

In Special cases- Consent Forms, Therapy Record Form.

Discharge summary is given in case of Discharged – Cured, Relieved, LAMA, and Discharge on Request or Death. A copy of the same is preserved in the patient's medical record.

i. In case of death, Medical certification of cause of death forms is to be filled up by the Medical Superintendent. A copy of the death certificate is preserved in the patient's medical records file.

Discharge summary is given in case of discharge cured, LAMA, DOR or death

Flow of Medical Record from Admission to Post Discharge

- The Medical Record Department ensures a smooth flow of Medical Record of the patient from the day of his admission to the day of his discharge and onward maintenance till the retention period.

- Admission request form is filled by the treating doctor of the patient. Formalities for admission of the patient are carried in the registration counter (during working hours).The general inpatient case sheet for patients is prepared at the time of admission in the respective inpatient admission counters.

- After getting the orders of discharge of the patients from the treating Consultant, the Staff, on duty get the discharge summary prepared from the Consultant, the slip is sent to the Billing Department for necessary payment

- Necessary payment done at Billing Department and receipt is given to patient relative. Nursing staff discharges the after getting clearance slip from billing department. Patient file is sent to medical record room.

- In case the patient is transferred or referred to another Hospital the medical record contains information regarding reasons for transfer, name of the Hospital where the patient is being transferred

Confidentiality and Integrity of Record:

The Hospital identifies its responsibility as custodian of medical records and observes the following procedure to maintain its confidentiality, security and integrity:

1. Patient is the owner of his medical record and no form of it would be made available to any third party without written authorization from the patient. The Hospital observes the following guideline instruction for the purpose:

- Maintain records in proper accessibility manner.

- Hand over the records as & when required by Directors /Medical Superintendent/ Managers for administrative purposes by getting slip signed by the person receiving the record.
- Physicians for follow up purposes by getting permission from Medical Superintendent and get the records.
- Records required for Medico Legal Cases in the Court of Law by the Consultant / M.O.'s.
- For Follow up of In-patients by the Consultants as well as by the Patients.
- As & when they require Discharge Summary, Investigation Reports etc.
- Patient's relatives will require a written authorization from the patient for obtaining information from the medical records. However such information would not be given in original, a xerox of the same would be handed over to the patient and signature taken in specific format.

2. In case loss or tampering of patient's medical record data is reported, the medical records in charge would immediately inform the same to the Medical Superintendent who would be responsible for taking appropriate action. He will inform the external agencies as applicable and would hold an internal enquiry for investigating the cause for such event. He would form an internal committee under the Medical Officers. THE medical officer who would hold the enquiry in reality and would submit the report to the Medical Superintendent as per the committee's finding for further action. In case the internal committee confirms any sort of negligence or discrepancy on part of any Hospital employee, Medical Superintendent would inform the same to higher authorities.

3. The Medical Record Department is responsible for proper storage, retrieval and maintenance of confidentiality and security of the record. During normal working hours it is the policy of the Hospital to have at least one staff available in the department. At the end of the day medical record clerk is responsible to lock the department in the presence of a security staff.The key is handed over to the concerned security staff. There after the security department is made responsible for the protection of the medical record room.

Retention Policy:

Prepared By	Verified By	Approved By
Doctor Name	Doctor Name	Doctor Name

Policy: The Department is responsible for consolidation of all Forms belonging with patient is sent for storage in a manner with the help of Admission Number, which is assign at the time of Admission. These records are stored in the Medical Record Departments for the following Retention Period as per the Govt. Orders.

Daycare	Five (5) years
Out-patient	Five (5) years
Medico Legal record	Life time

Security:

- Access to Medical Records Department is limited to only person authorized department staff.
- In case any record is issued to any designate individual as per the retrieval policy; the same is recorded in the outgoing patient record entry register for accountability.
- No form of record is issued to any person without proper authorization from the designated authorities.
- During non-working hours the security staff in responsible for safety of the department.

At the end of the designated retention period the medical record clerk will seek written approval from the director for destruction of the medical records who have crossed the retention period.
Only after obtaining written from the designated Hospital authority, the medical records will be destructed by the department staff.