	Quality Management Systems Procedure	
	Title: Medical Record Policy	
	Document Number- 013/HP/TVVP/2017	
	Issue Number- 01	
	Effective Date- 01. Dec.2017	
Review and Approved by: Smt. Karuna Vakati, IAS (Signed)		

Policy:

This policy establishes the guidelines and standards for members of medical staff relating to the documentation of medical records.

Definition of "MEDICAL RECORD"

A **medical record** is the chronological documentation of health care and medical treatment given to a patient by professional members of the health care team. It is an accurate, prompt recording of their observations including relevant information about the patient, the patient's progress, and the results of the treatment.

The medical record is a means of communication among physicians, nurses, and allied health professionals who plan and conduct the care and treatment of the individual patient. Their quality tends to be seen as a reflection of the standard of medical care provided by the writer.

Its confidentiality shall be preserved by all who use it or become aware of its contents in the course of providing patient care.

Unit Medical Record System wherein all the IP and OP Records of a patient are maintained in a single folder. To the convenient of the treating doctor, consultant during the OP review the progress notes are separated with IP discharge summaries.

Admitting Doctor Responsibility:

- The admitting Doctor or his designee is responsible for documenting his/her own examination, opinion, and recommended treatment in each patient's medical record, and assuring that a complete and legible medical record is prepared for each patient and that it contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment and promote continuity of care with other healthcare providers.

- The Admitting Doctor is required to sign notes made by residents within 24 hours of initiation of the notes by the resident.

Content of Medical Records (Minimum Requirements):

1. Patient Identification Details on each page (e.g.: Name, UHID. No, etc)
2. Date and Time of examination
3. Presenting Complaints
4. Complete History
5. Assessment Findings
6. Provisional / Admitting Diagnosis
7. Reason For Admission
8. Investigation chart and Reports
9. Treatment Plan
10. Medication Orders
11. Progress notes and orders
12. Critical Care Notes as applicable
13. Handover Notes
14. Transfer Notes wherever applicable
15. Referral Notes where ever applicable
16. Operative reports (pl use Operation notes format)
17. Fitness for Discharge
18. Condition on discharge.
19. Discharge summary with all instructions:
    - Final diagnosis
    - Reason for admission, including a brief clinical statement of the chief complaint and history of the present illness
    - Pertinent physical, laboratory, x-ray and other diagnostic procedures and studies

- Medical and/or surgical treatment, including the patient's response, and complications
- Condition on discharge, including, for example ability to ambulate, degree of self-care, and ability to work
- Instructions for continuing care, including information on diet, medications, activities, and follow-up, including in emergency.
- Prescribed medications (to clearly mention drug, dose, route and duration)
- Follow up date, time and place
- Emergency Contact information after discharge.

Recording times and signatures

- Notes should be written during the patient encounter or immediately afterwards. Notes should be in a straightforward, purposeful and factual style. If on paper, write such that it cannot be erased. Use clear handwriting that is large enough to be readable on photocopying and ensure that you can be identified as the author.
- All notes MUST have a date, time and signature of Physician**.**

Content of Medical Records:

1. **Patient Identification Details on each page** (e.g.: Name, Age, Sex, Ward, etc).

   This is usually affixed as a label on each new sheet of paper used. Physicians must ensure that each sheet must have this identifier. In case the label is not there, then the details must be entered by hand and should include the Patients name, age, ID number and location.

2. **Date and Time of examination:** Must be written at each episode of record writing.

3. **Presenting Complaints:** Self Explanatory
4. **Complete History:** This should include history of present illness, past medical history, family history, medication history, allergies. Allergies Record, in a prominent place, any drug allergies or adverse reactions etc. In case of specific patients such as children and pregnant cases, their relevant immunization history or other that has been specified by the department shall be followed. If the patient's history is provided by a person other than the patient (e.g. a relative, police officer, translator or friends), record that person's name and status.
5. **Assessment Findings:**

   The physical examination must reflect a comprehensive review of systems. The history and physical exam must be concluded with conclusions or impressions and a planned course of action.

   Record all the systems examined, note all positive findings, important negative finding and objective measurements such as blood pressure, pulse, temperature and respiratory rate. In case a pre printed format is available, then all entries shall be completed. Summarize the information given to the patient about his or her condition, including, where appropriate, warnings about the risk/benefits of proposed treatments.

6. **Provisional / Admitting Diagnosis:** This must be written in each case, and this should be on the basis of ICD accepted nomenclature**.**
7. **Reason For Admission**
8. **Treatment Plan**
   a. Surgery etc
   b. Investigations Ordered
9. **Medication Orders:** These should be written in a uniform place in the Physician order sheets. The orders should be in capital letters, using Formulary drugs only. The

correct dose, route, frequency MUST be mentioned. Only authorized abbreviations should be used. Generic names are preferred.

10. **Progress notes and orders:** All patients need to be reassessed regularly and the records should have notes appropriately reflecting the findings, progress of patients and treatment modifications. In case of change in patient condition or treatment, the notes need to be added on.

All telephonic and verbal orders need to be signed by the ordering person within twelve hours of such orders.

All clinical entries in the patient's medical record shall be accurately dated, timed and signed and have name written under signature/stamped.

Critical Care Notes as applicable: All formats and parts of forms should be completed.

11. **Transfer Notes** wherever applicable: These should mention reason for transfer, Added Clinical condition of the patient, accompanying equipment/staff, category whether urgent or routine, and time of transfer request and actual transfer
12. **Referral Notes** where ever applicable.
13. **Consent Forms:** There are ***Procedure Specific Informed Consent Forms*** for various departments available on the nursing stations/ user departments. For the procedures that have these consent forms, these should be used. In case of others a generic consent form should be filled, however this should specify all aspects of that particular procedure such as complications, risks etc. Informed consent is supposed to be taken by the physician from the patient before any procedure and be placed in the medical record file. The form is supposed to be **duly signed** by the physician & the patient/ relative/ witness/ parent/ guardian etc.

    Note: All consent forms written by resident doctors/Nurse to be counter signed by the consultant in charge.

14. Operative Notes:

For surgical cases, the detailed operation notes must include date of operation, name of surgical team, planned procedure and procedure done. Pre- operative diagnosis, post operative diagnosis, intra operative findings and steps of procedure, biopsy sent, diagrams (as applicable), any other significant findings, duration of surgery etc. As a mandate the Surgical Notes are to be documented **by the Operating Surgeon** immediately on completion of the Surgery or before the patient leaves the OT/ by Designee in case of which the Surgical notes are to be counter-signed by the Operating Surgeon before the Patient leaves the OT.

15. Procedure Notes:

Any bedside procedures carried out shall also be recorded in the medical record.

16. Fitness for Discharge:

Discharge planning should begin early during the stay of the patient and discharge plan should be documented at least 24 hrs before the actual discharge process is initiated.

Clinical criteria for discharge must be documented and note of patients functional, medical and other systems status should be made.

The treating doctor must record that the patient is 'fit for discharge' and record the condition on discharge.

17. Discharge summary: The summary should reflect the treatment given with all instructions:

a. Final diagnosis
b. Reason for admission, including a brief clinical statement of the chief complaint, history of the present illness, significant findings and diagnosis on discharge.
c. Pertinent physical, laboratory, x-ray report findings and other diagnostic procedures and studies.
d. Medical and/or surgical treatment, medication and other treatment given including the patient's response, and complications.
e. Condition on discharge, including, for example ability to ambulate, degree of self-care, and ability to work.
f. Instructions for continuing care, including information on diet, medications, activities, and follow-up, including in emergency.
g. Prescribed medications.
h. Follow up date.
i. Emergency Contact information after Discharge.

18. Admission & Discharge Criteria to Intensive Care:

These should be completed in all cases including transfer and when patients come in through emergency, admission criteria are required.

Discharge criteria are to be recorded when patients are shifted out of critical care areas.

19. Death Summary for a Deceased Patient: A complete summary is required on all cases when the patient expires, regardless of the length of time the patient was hospitalized. The Death Summary shall include the Cause of Death.

20. Autopsy report: In case of clinical autopsy is carried out; there should be a report copy of the same in the medical record. But this does not include postmortem done for medico legal cases.

20. Medico legal Cases: Physicians must ensure correct medico legal documentation when required as per the policy of the hospital.

Altering Medical Records: (Important note for Doctor) Do not alter notes retrospectively. The courts would view very seriously any attempt to rewrite notes that will be used as evidence in legal proceedings. If it is later discovered that something that has been written was inaccurate, misleading or incomplete, Insert an additional note as a correction.

Make sure that it is clear to the reader that the new note is a later amendment, and that there is no attempting to tamper with the original record. For altering cross the original words/ statements by a single stroke of the pen, so that the crossed text is still legible and re-write the new one – date and sign both.

Completion of Medical Records:

- The doctor must complete all required documentation in the medical record before it may be permanently filed, or be considered complete.
- When possible, records shall be completed before leaving the patient unit. Any medical record not completed within fourteen days of the date of discharge of the patient is a **delinquent record.**

Disposal of Written Documents:

- Quality assurance team decides on the issue of disposing of the documents. When disposal is appropriate, all written or printed documents that contain confidential or restricted information must be disposed of by trashing the documents in a shredder bin, not in regular trash containers by taking approval of the Chairman – HDS.

The Medical Record In-charge Responsibility:

- The MRD in-charge will submit a report of incomplete records each month to the Medical superintendent as well as Head of the Department.
- Early warning must be send to treating consultants in case of incomplete case sheet.
- The admitting privileges will be suspended in case there is still a non compliance.
- Only after the medical record technician confirms in writing that the record has been completed, can they be reinstituted.

MEDICAL RECORDS RETENTION AND DISPOSAL POLICY

S. No	Particulars	Period of Retention	Policy
1	OP Records (Non-MLC)	5 years	Destroy after completion of 5 years from last visit of the patient, shredding after advertisement
2	OP Records (MLC)	Permanent	Do not destroy
3	IP Records (Non-MLC)	10 Years	shredding after advertisement
4	IP Records (MLC)	Permanent	Do not destroy
5	Expired patients Record	Permanent	Do not destroy
6	Pediatric Records	Until the patient is 25 (or 26 if they are 17 when treatment ends) or 8 years after their death	shredding after advertisement
7	Birth Register	Permanent	Do not destroy

8	**Death Register**	**Permanent**	**Do not destroy**
9	**Medico Legal Register**	**Permanent**	**Do not destroy**

CONFIDENTIALITY, PRIVACY & INTEGRITY OF MEDICAL RECORDS

Patients have the right to complete confidentiality Medical / departmental records and information regarding patients/ matters are legally protected for protection of privacy.

- Any information related to patient is disclosed only on the direction of Honorable court or under RTI Act-2005.
- In the course of performing work responsibilities, information is considered confidential with regard to patients, their families, their physicians, personnel details, and/or matters. As a condition of employment, personnel are cautioned not to discuss any such information with others.
- Personnel extend their ethical responsibility of patient confidentiality to hospital /organizational confidentiality by not disclosing any hospital related matters where patients can hear, other than as a professional response to general inquiries.
- Personnel avoid making any public statements related to hospital /organizational confidential matters, leaving the responsibility for such statements to the Head of the Department's and the administrative staff so authorized.
- Personnel **DO NOT** release any general information such as verification that a patient has visited the hospital, the general nature of the disease, and the degree of seriousness of his/her condition, such as "critical" "satisfactory" or "not serious'; **NOR** disclose detailed information to the press without the signed authorization of the patient or his next of kin. Any such enquiry is directed to the Medical Superintendent.
- Personnel are prevented to disclose any personal or medical information obtained during the course of their professional duties, with anyone except other health

professionals directly involved in the care. The patient right to privacy extends beyond their discharge from hospital, and beyond their death.

- Personnel are not permitted to discuss patients' details in common areas.
- A Medical record is a privileged communication. Any information contained in it cannot be disclosed to a third party, without express consent in writing of the patient or his legal representative, except when:
- Officially required in a court of law
- Referred to another doctor for treatment
- Clinical meetings of co-professions and related professional for scientific, educational or treatment purpose.