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AMENDMENT SHEET

Sr.No	Section no & Page no.	Details of the amendment	Reasons	Signature of the preparatory authority	Signature of the approval authority

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The holder of the copy of this manual is responsible for maintaining it in good and safe condition and in a readily identifiable and retrievable.

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The amendment sheet, to be updated (as and when amendments received) and referred for details of amendments issued.

The manual is reviewed once a year and is updated as relevant to the hospital policies and procedures. Review and amendment can happen also as corrective actions to the non-conformities raised during the self-assessment.

The authority over control of this manual is as follows:

Preparation	Approval	Issue
IMS Incharge Dr. Swati S. Ambekar	Principal/ MS Prof. Dr. S.G. Deshmukh	Accreditation coordinator Dr. J.S. Deshmukh

The procedure manual with original signatures of the above on the title page is considered as 'Master Copy' and the photocopies of the master copy for the distribution are considered as 'Controlled Copy'.

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1	Principal/ Medical Superintendent
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1.0 INTRODUCTION

1.1 To meet the information needs of the care providers, management.

2.0 SCOPE

2.1 Hospital Management

2.2 Health Care Providers

2.3 Patients

3.0 RESPONSIBILITY

3.1 Doctors

3.2 Nursing Staff

3.3 IT Staff

3.4 Medical Records Department

4.0 ABBREVIATIONS

4.1 **NABH** : National Accreditation Board for Hospital and Healthcare Providers

4.2 **IPD** : Indoor Patient Department

4.3 **OPD** : Outdoor Patient Department

4.4 **DMS** : Deputy Medical Superintendent

5.0 REFERENCE

5.1 NABH : Pre Accreditation Entry Standard for Hospitals, Second edition, April 2016

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6.0 POLICY

6.1 Processes for effective management of data:

6.1.1 Management of Data: All the form and formats for data collection are standardize and controlled. The analyzed data is presented to the top management on a regular basis by the quality managers.

6.1.2 Storing and retrieving Data: The records are stored in Medical Record Department and are ensured free from dust, insects and other pests/rodents. The IT department is responsible for electronics backup of data and for storing them in a secured location. Electronic data is available on the server and external hard drive.

The Assembling Order for Case Sheet:

1 Case sheet
2 Consent Form
3 Doctors Continuation Sheet
4 Nurses daily Record (T.P.R Chart, Intake/ Output chart, Drug Chart)
5 Investigation Reports (X-Ray, Lab)
6 Discharge Summary

6.1.4 Retrieval of data shall be done with the patient's OPD or IPD number.

6.1.5 Tracer are Placed when the files are retrieved, which easily helps to track the record.

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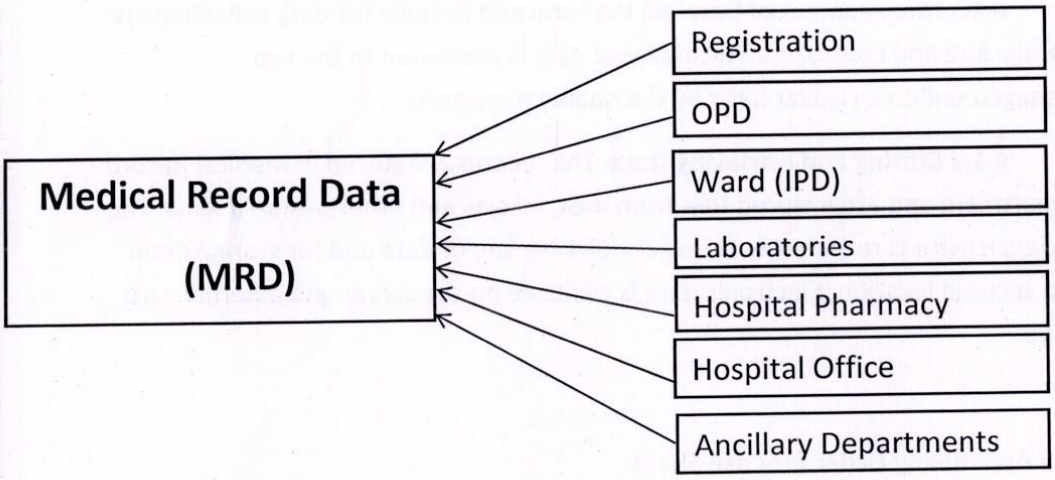
6.2 The organization has a complete and accurate medical record for every patient as below:

Location of MRD

The system of medical record in a hospital should be centralized. The data is collected from various departments as follows:



Equipment/ Furniture required

- Tables and chairs
- File rack
- Computer scanner
- Calculator
- Rat trapper
- Exhaust fan

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STAFFING PATTERN

Adequate and trained staff is essential for proper handling of medical records in hospital. The officer incharge hospital records section should be specifically trained professional who can guide the department in establishing & following correct practices.

NUMBERING, FILING, AND CODING SYSTEM

Numbering System

The aim numbering medical records is for systematic storage and easily retrieval. The serial number system is used here wherein patients receives a new number of each admission and the previews record is brought forward and filed together in the folder of a most recent admission.

Filings System

The files are arranged sequentially by medical record number, starting with the lowest and going to the highest.

Color Coding

Color - coding is used to facilitate sorting and minimizing misfiling of medical records. Specific color codes are given to each department.

6.2.1 Unique identifier:

6.2.1.1 Every patient is registered and assigned a Permanent Registration Number.

6.2.1.2 The patient is given a registration card which he / she have to carry every time they visit the hospital.

6.2.3 Contents of medical records reflect continuity of care:

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- All entries are with O.P.D /I.P.D. Number of patient on every document page.
- No pencil entries.
- Dated and signed (include day, month, and year)
- Timing of entries is required on Medication Administration, Operation notes, and Nursing documentation.
- Legible and include clear, concise and pertinent patient information, Authenticated, signature, Chronological.

6.2.3.2 Entries written in error shall have a single line drawn through never erase.

6.2.3.3 All forms in the record must have been previously approved.

6.2.3.4 No part of the medical record is ever to be removed after entry.

6.2.3.5 Written signatures validate written orders and written notes.

6.2.3.6 Inpatient care is documented in the Medical Record and includes:

a) Reason for admission, diagnosis and plan of care must be included in the documents.
b) Evidence of the initial patient assessment and all subsequent re-assessments.
c) Documentation of nursing care provided.
d) Any operation / procedure performed in detail.
e) Name, signature, data, time on every entry made in record.
f) The records are in chronological order demonstrating the continuity of care.
g) Transfer notes should be in accordance to the policy of transfer and should include date reason for discharge.

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h) Medication administration is recorded on the Medical Administration Record.
i) Specific care provided is evidenced on the patient care flow sheet.
j) Aspects of patient care during operative or other invasive procedures, is documented on forms specific to each specialized area.
k) Patient discharge instruction.
l) Discharge summary should be prepared and signed or countersigned by the doctor in charge.
m) Death summary should –include –causes of death, time, and date and should bear the signature of the doctor in charge.
n) The medical notes by the duty doctors have to be countersigned by the consultant in charge within 24 hrs.

6.3 The medical records provide up-to date and chronological account of patient care and are organized in the order (from admission to discharges) as below:

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6.3.1 in patient medical records:

Sr. No.	Name of the record	Authorized person for entry
1	Admission form with Consent form	Doctors (provisional and Final diagnosis) Medical records technicians- information related to date of discharge, mode of discharge and hospital stay.
2	History on finding on admission	Doctor, Resident doctors and Medical officer.
3	Initial assessment of nurses	Staff Nurses
4	Dietary initial assessment form	Swasthavritta Department
5	Laboratory Investigation Reports	Pathologist
6	Radiology Investigation Reports	Radiology Doctor
7	Cardiology Investigation	Physician

Only controlled forms and formals, which are approved by the management, shall be used by the service providers for the medical records.

6.3.2 The medical record contains information regarding reasons for admission, diagnosis and plan of care.

6.3.3 Operative and other procedures performed are incorporated in the medical record.

6.3.4 When patient is transferred to another hospital, the medical record contains the date of transfer the reasons for the transfer.

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6.3.5 The medical records contain a copy of the discharge note duly signed by doctors.

6.3.6 In case of death, the medical record contains a copy of the death certificate including the Cause, date and time of death.

6.4 Maintaining confidentiality, integrity and security of information.

6.4.1 Procedure to ensure confidentiality, security and integrity of data:

The Medical Records is a private document related to the patient history and treatment both in a physical and electronic format and should not be disclosed as it breaches the Code of Medical Ethics.

6.4.2 No part of the information contained in the MR should be reproduced in any format by any individual who is handling the contents or details of the patient record without the consent of the management and the patient concerned unless otherwise needed for any case of subpoena or any other legal proceedings the information may be presented before the actual trial of cares without the consent of the patient.

6.4.3 Only on written consent/ authorization from the patient /legal heirs and an authorization from the management can the information be released to any external individual. The access to the Records by the visiting doctors should be provided once the doctor has been referred by the treating doctor; the case sheets are available in the nurse's station.

6.4.4 No record will be issued to any authority after discharge of patient after then hospital staff authorized by management, without requisition duly signed by authority and approval from M.S./ Dy. M.S. The same is than kept with original record of the patients for future reference.

6.5 Retention time of records, data and information:

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6.5.1 Retention period of records:

- The entire outpatient case sheets are maintained for a period of 5 years.
- All the Inpatient case sheets are maintained for a period of 5 years.
- The records which have crossed the retention period shall be selected and destroyed as per documented procedure.

6.5.2 Review:

- Medical records are reviewed once in a month.
- The review is done by Quality coordinators for the timeliness, legibility and completeness of medical records in the IPD & OPD patient files.
- **Deficiencies**: A report is prepared for the deficiencies observed during review process observed deficiencies are analyzed for the root cause and corrective action and prevention action shall be identified.

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