MODULE FOR MEDICAL RECORDS MANAGEMENT:

INTRODUCTION

Medical Records are an essential component in modern health care management. It is the only reliable proof of treatment given to patient and is the basic indicators in accessing health status of the community. The safer existence of the institution is depends on this. Health information of different nature at various levels could be generated from Medical Records. Accurate and reliable information is needed for comparison of health status of the community and basic data for planning health care activities and health budgeting could be obtained only from Medical Records. The present scenario people need evidence based treatment. All these factors and the present day challenges imposed by Right to Information act 2005, Consumer protection act 1986, Medical Councils of India regulations, etc. emphasis the strengthening of Medical Records Maintenance System so as to beneficiate all walks of people in the community. Central Bureau of Health Intelligence- the nodal agency for health information in the country also insist the strengthening of Medical Records system and implementing ICD-10 of WHO in classifications and coding of morbidity & mortality cases.

II. GOAL

1. Maintain Medical Records in the expected standards and quality and to make use at all level by beneficiaries.
2. Generate high quality Health information.
3. Ensure the quality of care by evaluating Medical Records.
4. Protect the privilege of Patients, Doctors, Hospital staff and Administrators.
5. To help Medical / Paramedical students and Teachers for case study
6. To ensure good Medical Research and Clinical study by providing required data.
7. Help Health care authorities / health care providers in formulating heath policies and planning preventive measures
8. Systematic preservation and storage of health records for future use.
9. Systematic maintenance and preservation of Medico-legal documents.
10. To help Judicial authorities, Insurance authorities, Investigating Officials, Enquiry officials etc by providing the required documents / information in time.

11. Offer awareness about medical records maintenance to the staff of other sections.

III. OBJECTIVES

- Registration of every patient approaching hospital with ailments / trauma. It is a proof of his / her visit to hospitals also.
- Facilitate accurate and adequate documentation of patient care.
- Ensure quality of care rendered to patient with in the facilities of the hospital.
- Help the Physician to offer continuity of care.
- Help the patients to get reasonable care easily by knowing history of previous treatment.
- Patients census at various levels and made available at any time.
- Codify and classify diseases, injuries and external causes according to latest pattern formulated by WHO known as ICD-10.
- Prepare disease index as per ICD-10 code.
- Prepare and publish periodical bulletins of diseases treated.
- Help Physicians and Researchers in the event of Special Case Study and Research works by providing documents and information.
- Help Medical Students and Teachers in the course of their training for case study.
- Protect Physicians and other staff and hospital from law suits filed against them
- Evaluate the performance of Doctors and Nursing Staff.
- Provide valuable information to Judicial authorities as evidence of proof in Medico- Legal case
- Help settling medical insurance claims.
- Reporting vital events (Birth/ Death) to Local Self Govt. authorities.
- Entertain the request of patients for making alterations / corrections in hospital records in the matter of name, address, income etc.
- Issue certificates of various Medical examinations involving Medico-legal aspects to Police for early charge-sheeting.
- Help in the conduct of Medical Boards of different kinds.
- Help the authorities in the preparation of Annual indent (Annual requirements) by providing sufficient data and participating in the Committee.

- Act as a creator and provider of forms and registers related to patient care.
- Medical Records librarian act as an active member in the Medical Records committee, Quality assurance committee, Medical Audit Committee, Financial committee etc
- Gear the activities of Medical Record Auditing / Medical Audit.

IV. ORGANISATION OF MEDICAL RECORD DEPARTMENT

Medical Record Department is directly obliged to the Head of the institution. Chief of Medical Record Department is Medical Record Officer / Medical Record Librarian. The Medical Record Department of higher institution has supporting staff. He/she has to organize and manage the whole activities of health record generation and maintenance and generating required health data.

V. REGISTRATION CONTROL

Out-patient and In-patient registration process and issuances of OP ticket / Case record are to be done under the direct supervision and control of Medical Records Department. The staff in both registration centers should work under the supervision of Medical Records Department chief. He /she should make regular visits to the registration centers and see that the process are going in the right track; abnormalities if any found in regular practice should be rectified in consultation with the ahead of the institution.

VI. PROCESS FLOW OF MEDICAL RECORDS

1. **OP :** Medical Record originate at the OP counter by the registration and issuance of OP ticket. With OP ticket patient goes to the Doctor in the OPD for consultation. Doctor after examination note the provisional diagnosis, prescribe medicines, advices and sent them home. The Doctor in the OP enters the patient Name, Age, OP number and provisional diagnosis in the OP register. As per the Code of Ethics Regulations, 2002 of Medical Council of India, IN Government hospitals, the name of the prescribing doctor must be written below his/her signature.

2. **IP Case :** If the patient needs treatment as IP case, the doctor shall give a direction to admit the patient in the OP record, and patient or relatives shall report to the IP counter with OP record for registration. At the IP counter patient's details like Name, Address, Age, Sex, Occupation, Income, Date and Time of admission etc were entered in the register and case record. The Ward and unit of admission also entered in the

case record. OP record of those patients admitted to the hospital should be attached with Case record.

3. **Documentation:** Scientific / Clinical part of the case record generate while patients is in the ward. When patient reaches the ward the Nurse has to receive the patient and note his details in the Ward IP register and carry out the orders of the attending Doctor. Documentation of Medical Record is mainly done in the ward by all attending Doctors and Nurses and other Paramedical staff. Who ever attends the patients, should authenticate their orders / advice and there with signature, name and designation with time. Case record shall be completed in all respects. It is very important to issue Discharge Summary to the patient noting all relevant details. Copy of the Discharge summery must be kept in the case record.

   Discharged Case Records should be handed over to the Medical Record Department next working day after the discharge and acknowledged by MRD Staff. Papers like private consultation chits, private lab reports etc shall not club with Case record and those must be returned to the patients before discharge. However the investigation results and other details shall be recorded in the relevant pages of the case record. The responsibility of sending case record to the MRD is with Head Nurse/ Nurse in-charge of the ward.

4. **Receiving case record by MRL:** MRL shall receive the case records and acknowledge the receipt. If any of them found damaged or found tampered, it must be noted in the Local Delivery book of the ward and inform the superiors immediately in writing. The incomplete case sheet shall be returned to the ward for completion and resubmission.

5. **Assembling, Quantitative check:** Case Records received from the ward are assembled in specific manner by MRD Staff. Quantitative check for the component part also done simultaneously. Any part found missing or damaged should be noted and inform the superiors. Concerned ward also must be informed for getting the same rectified.

6. **Deficiency check by MRL:** After assembling and quantitative checks it is subjected to Deficiency check to ascertain all necessary entries Date and time of discharge, Diagnosis, Surgery notes, Delivery note, baby chart, anesthesia note etc are recorded. If any deficiency found it should be specially noted and presented before the Medical Record Conference. The mode of discharge (cured, relieved, referred, discharged as per request against medical advise etc) shall be noted. In case of death, the

underlying cause of death as per the Medical Certification of Case of Death shall be entered in the case record.

7. **Weekly Unit Medical Record conference** is conducted at the institution. MRD Staff are responsible for conducting Medical Records Conference. Head of the concerned specialty and his team will have to participate in this meeting. Incomplete case records / those specially noted for any deficiency and those records which the team demands are to be presented for verification and / rectification. Certificates of various kinds of pending MLCs if any are to be prepared in this meeting.

8. **Coding and classification of Morbidity / Mortality cases- By MRL:** Coding and classification of diseases is one of the most important responsibility which Medical Record Librarian should do. All diseases, injuries and external causes noted in the case record should be coded according to ICD-10 pattern of WHO. No Medical Record left without ICD-10 code. Disease index card done by MRL: Coded cases records shall be tabulated in Disease- index card for future references.

9. **Disease-index card by MRL**: Coded case records arranged in the sequence of code numbers to facilitate the process of disease indexing. This is done by attenders/ assistance in the MRD. Index-card preparation is done by MRL. If electronic index system is available it can be entered in the computer.

10. **Sorting in serial order- by attendants:** Case records are sorted out in units of hundreds in serial order of IP Number and arranged in bundles. This process makes retrieval of records easy and also missing records can be found out.

11. **I.P. register completion by MRL:** Sorting case records in Unit-Serial System facilitate the completion of Admission Register (IP Register) whether it is Electronic or manual. This register get completed only when Diagnosis, Date of discharge result of treatment etc are incorporated in it. This process also facilitate to identifying missing case records.

12. **Missing record- alert:** All MRD Staff must be vigilant in finding out missing records from those received from wards. But if any of them not received from the ward even after long period must specifically noted and ward authorities must be alerted. Live correspondence must be kept for this and a register must be maintained for this. This events must be brought to the notice of the Medical Record committee in the next meeting.

13. **Storage by Attendant:** After completion of all the process case records sorted in serial order are transferred to storage area for filing. There they are kept in

systematic way that any of them could retrieved early and fastly in future. This work is to be done by the Attendants under the supervision of the MRO/ MRL.

14. **Retrieval by Attendants:** Case records retrieved from the filing area only for specific purposes. An out guide noting the date of retrieval, purpose, IP number, Name and address, date of admission, date of discharge etc must be substituted in the place of that record to know its movements. It is vary important to keep and Register for the purposes. A request from the Medical Officer is needed in case of review and readmission. In case of MLC and other purposes, the written direction from the Medical superintendent or Head of institutions is required.

VII. MEDICAL RECORD AUDIT / MEDICAL RECORD COMMITTEE

It is mandatory to conduct Medical Record Audit every month by a committee appointed for the purpose. The committee must be appointed by the Head of the institution with 3 to 5 Doctors of each Department, nursing superintendent/ Nursing officer/ Head nurse in charge as members. MRO/ MRL must be the convener, who gear the programmes and activities of the committee. The head of institutions will be the chair person of the committee. Committee should review the records of discharged patients (random and selected), all death cases, cases with long term stay and other relevant cases if any. The committee also reviews the existing registers, forms and existing policy of Medical Records, case record, documentation etc.

VIII. FORMS REGISTERS & STATIONERIES

MRL shall request for the forms registers and stationeries required for the MRD to superintendent of the institution in advance.

IX. NATURE OF WORK & WORK VOLUME IN THE MRD

Work volume in the MRD depends on the following indicators / functions.

- Out patients number (Daily average attendance) of new case and old case.
- Daily Tabulation of diseases of out-patients
- Number of In-patients admission
- Number of daily discharge
- Average Birth per day
- Average Death per day
- Medico legal cases and issue of wound certificates.

- Number of Drunkenness certificate issued per day.
- Number of Post Mortem certificates issued per day.
- Applications from patients or public for issue of various certificates.
- Applications of patients for making corrections in the data (Name, Address, Income etc.)
- Applications received from patients under Right to Information act
- Clerical works and correspondence with other sections
- Producing Records to Judicial authorities.
- Routine functions of technical nature as collections of records, Assembling and Quantitative check, Qualitative analysis, sorting, Disease coding as per ICD-10 norms, Disease indexing, IP Register completion, Data Entry, End filing charge out system and retrieval etc.
- Daily census of out-patient and in-patient into be gathered and tabulated for ready reference.
- Reporting Birth and death events in hospital are reported to the local authority. Verification of reports, verification of statement, issue certificates are done through this section.
- Statistical Reports and periodicals are to be prepared in this sections and send to the concerned authorities.
- Weekly record conference are conducted in the MRD
- Retrieving case record is necessary when patient is readmitted or the record is required for issue of certificate and research.
- Works in relation with conducting Medical Boards
- Medical Record Audit / Medical Record Committe – MRD staff should gear the activities relating to the conduct of Medical Records**.**

X. ISSUE OF MEDICO-LEGAL DOCUMENTS TO POLICE AUTHORITIES

Issue of Medico Legal documents to Police Authorities as per the Kerala Medico legal code issued by Government of Kerala.

XI. List of Daily Admission / Discharge and Census:

These are prepared daily in wards in the prescribed format. The Nurse on Night duty shall prepare a list of patients admitted and discharged form that ward along with census as at mid-night and handed over to the Nursing Superintendent. Nursing Superintendent in turn handed over the collected forms to the MRL daily. One form is required for a ward daily. MRL on getting this should arrange them ward-wise, date wise and month wise. Daily census of in-patients are compiled and tabulated in a register.

Missing records shall be identified by scrutinizing these register. The forms shall be kept in the library for future use in bound book.

XII WORK DISTRIBUTION

Medical Record Officer / the senior Medical Record Librarian must be in-charge of the section. He /she should keep regular proximity with the Head of the institution and keep good liaison with all other officers and departments. All the staff in the section should work under his supervision and control. Work in the section should be distributed among the subordinates and a work protocol must be established with the approval of the Head of the institution. Work in the section can be distributed as follows:

1. Medical Record Librarian(s):

- Preparation of Out- Patients attendance register for the details obtained from OP registration counter.
- Prepare OP disease - register.
- Receiving Medico- legal documents from Casualty.
- Issue of Medco- legal documents to the court.
- Issue of Medico - legal document to the Police.
- Receiving case record from ward and ensure presence of all component parts are intact and its completeness.
- Disease and Cause of death coding according to ICD – 10 pattern of WHO.
- Disease index-card preparation.
- Completing I.P. register with discharge particulars viz diagnosis, Date of discharge, Operations etc.
- Preparation of Statistical data
- Scrutiny of Birth and Death report and reporting them to the Local Self Govt.
- Distribution Birth / Death certificate obtained from local Registrar of Birth and Death. Those certificates not received by the concerned parties must be returned to the Registrar.
- Receiving Medico-legal records from casualty viz. Accident Register - cum-wound certificate, Drunkenness certificate, Police intimation, Certificates victims examined under police / Judicial custody and keeping them under safe custody.
- Preparation of Stock register for articles in the MRD
- Prepare Issue register for records and register sent out of the section for any purposes.

- Help in the convening of Medical Audit committee / Medical Board.
- Conduct Medical Record committee meeting.
- Help in the production of documents before Court
- Attend all correspondence and file works of the section.
- Assist the in the preparation of Annual Administration reports and other reports.
- Over all supervision of Medical Records section

2 . Medical Record Assistant / clerk

- As per the existing norms.

3. Hospital Attendant

- Retrieval of records as per the direction of MRD/MRL.
- Collecting of register of any nature from wards casualty etc as per the direction of MRD/MRL.
- End filing.
- Movements with files or office intimation to be distributed.

XIII. SUB COMMITTEES

MRO / MRL shall be included in the committees as he/she can play an appropriate role in the development of the institutions by providing various Health information enabling in the formulations of various policies and programmes.

XIV. VISITORS'S DIARY

A Visitors Diary must be kept in the MRD for noting the remarks and suggestions of superior officials while they visit the section. The remarks and suggestions mentioned in the diary should be brought to the notice of the Head of the institution.

XV. IMPORTANT REGISTERS TO BE MAINTAINED IN THE MRD

1. **Stock Register of records and documents.** Periodical physical verification of the recodes and documents shall be done. The register must be reviewed periodically.

2. **Issue register of records and documents :** The records and documents shall not be issued without proper request from competent authorities specifying purpose. Issue of the records and documents shall be recorded in this register. Signature, name and designation of the person receiving the record should be clearly

obtained in the appropriate column. If the record is for re-admission, the new I.P.number shall be recorded. Receipts of acknowledgments received from Court investigating officials etc must be pasted in the concerned part of the register without hiding the entries.

3. **Daily census register of Out-patients and In- patients.** MRL should keep an updated statement of Out-patients and In Patients census by evaluating data from Admission- Discharge list.

4. **Registers regarding the conduct of Medical Record Committee meetings:** Registers and minutes of the Medical Record Committee meeting shall be maintained by MRL

5. **Register for convening Medical Boards.**

6. **Registers pertaining to the Viscera samples and samples of Medico-legal cases sent for Chemical examination.**

7. **Register of staff attended Post- mortem examinations**

8. **Register for the issue of certificates**

Other registers to be maintained as per requirement of the institution.

XVI. Supervision and Control.

Medical Record Officer in the Directorate of Health Services has Supervisory control over all the Medical Record staff in the state. He shall guide them in developing good medical record maintenance system. He will conduct periodical inspection of Medical Record Department and submit report with remarks and suggestions to the DHS.

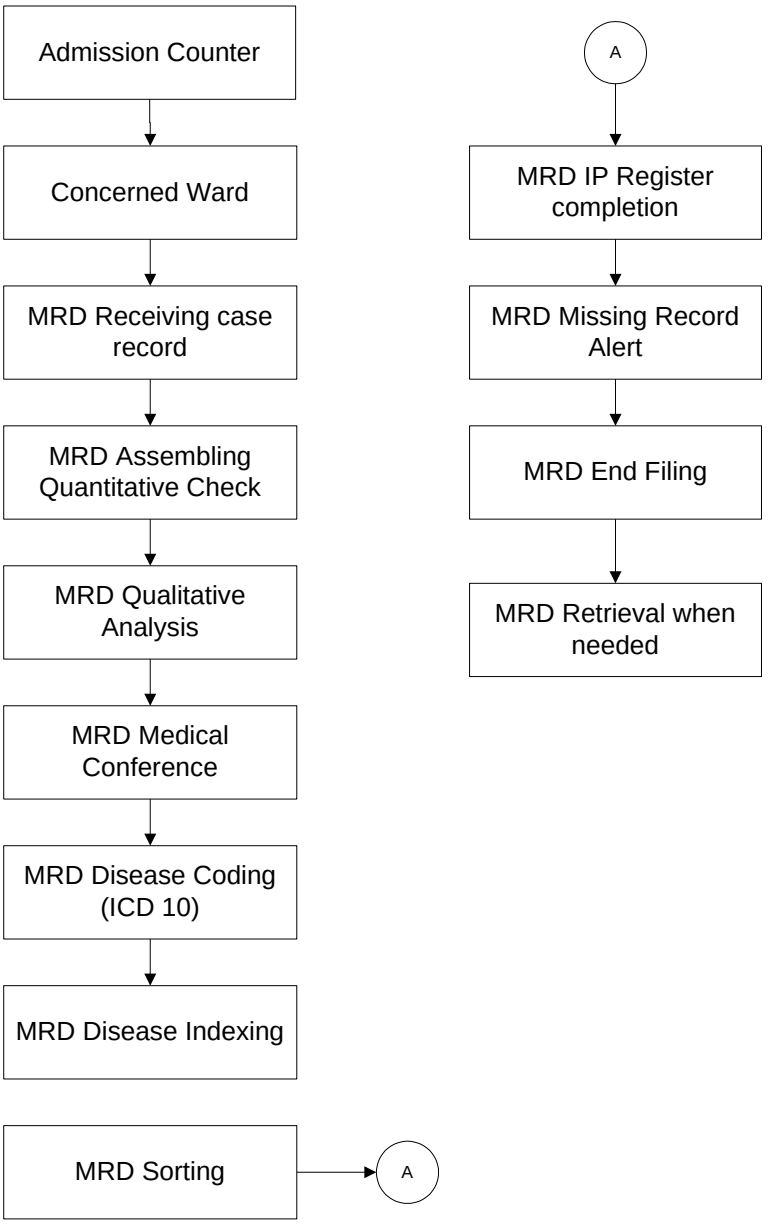
XV .Preservation of Medical records :

Preservation of medical record is as per Government Order. (Annexure 1)

XV1. Case sheet Model as per NABH

A model case sheet developed by NRHM in consultation with DHS is given in Annexure 2. The case sheet shall be customized as per scope and requirement of the hospital. The hospital may be

Flow chart of Medical Records



Annexure 1

GOVERNMENT OF KERALA

Abstract

HEALTH & FAMILY WELFARE DEPARTMENT - PRESERVATION OF MEDICAL RECORDS AND REGISTERS-REVISED - ORDERS ISSUED.

HEALTH & FAMILY WELFARE (M) DEPARTMENT

G.O.(Ms) No.06/2014/H&FWD. Dated, Thiruvananthapuram, 03.01.2014

Read: G.O.(Ms)No.389/2009/H&FWD dated 06.11.2009.

ORDER

As per the G.O. read above, Government fixed the period of preservation and disposal of case records and registers in Government Hospitals under Health Services Department specifying the period of preservation of Birth Register as 25 years. But it came to the notice of the Government that as per Rule 17(1) of Kerala Birth and Death Registration Rules, 1999 the Birth Register, Death Register and still Birth Register are records of permanent importance and shall not be destroyed and vide 17(4) of the same Rule every Birth Register, Death Register and Still Birth Register shall be retained by the Registrar in his office permanently.

2. In the above circumstances, Government are pleased to revise the order read as 1st paper above, modifying the period of preservation and disposal of case records and registers in Government Hospitals under Health Services Department as detailed below:

	Registers/Record	Period of preservation
1.	Case Records (other than medico legal)	Five years
2.	Case Records with medico legal importance	Fifteen years
3.	Outpatient nominal Register	Two years
4.	Outpatient Register for repeated cases	Two years
5.	Outpatient Disease register	Two years
6.	Casualty Register	Three years
7.	Casualty Register maintained by Duty Medical Officer	Two years
8.	Inpatient Nominal Register	Ten years
9.	Ward I.P. Register	Five years
10.	Night Report and Census Register	Ten years
11.	Diet Register (Maintained in wards)	Five years
12.	Operation Register (Major and Minor) (irrespective of speciality)	Ten years
13.	Anaesthesia Register	Ten years
14.	Obstetrics Register (Birth Register/Labour Register)	Permanently
15.	Death Register	Permanently
16.	Mortuary Register	Fifteen years
17.	Post mortem Register	Fifteen years
18.	Discharge Case Sheet Register	Two years
19.	Register of Medical Board Examination	Five years
20.	Police intimation register	Fifteen years
21.	Accident Register-cum-Wound Certificate	Fifteen years
22.	Post mortem Certificate	Fifteen years
23.	Drunkenness Certificate	Ten years
24.	Common Forms/periodicals/proforma	Five years
25.	Application received from public/Govt. officials for certificates etc	Three years
26.	Other documents of medico legal importance (potency test, examination for suspected rape)	Fifteen years
27.	Diet Sheet	Five years

(By Order of the Governor)

Dr. K. ELLANGOVAN

Secretary to Government