ASSOCIATED HOSPITAL
GOVERNMENT MEDICAL COLLEGE KATHUA

SOP FOR MEDICAL RECORDS DEPARTMENT

	GOVT. MEDICAL COLLEGE, KATHUA JAMMU AND KASHMIR	**Doc. No.**	**01**
		Issue Date	22-06-2020
		Revision Date	22-12-2020
		Revision No.	
		Next Review	22-06-2021
		Page No.	20

Document Approval

Manual Name	**SOP FOR MEDICAL RECORDS DEPARTMENT**	
Prepared By	• **Dr. Yangchen Dolma (I/c Medical Superintendent and HOD Department of Community Medicine)** • **Aditya Bhanotra (Record Clerk)**	Signature
Reviewed By	**Dr. Yangchen Dolma (I/C HOD Community Medicine)**	Signature
Approved By	**Dr. Suleman Choudhary (Principal, GMC Kathua)**	Signature

List of contributors

S.no	Name	Designation
1	Dr.Yangchen Dolma	Assistant Professor
2	Aditya Bhanotra	Record Clerk

MEDICAL RECORDS DEPARTMENT

Medical records department is an important area of the hospital, which directly assists in the delivery of quality medical care.

MEDICAL RECORD

Medical Record is a scientific, clinical, administrative and legal document relating to patient care, in which is recorded sufficient data, written in sequence of events to justify the diagnosis, treatment and results.

IMPORTANCE

- Aid to treatment.
- Eyes and ear to hospital administration.
- Generates hospital statistics.
- Very important in
  - Legal Issues.
  - Medical Audit
  - Quality certification and accreditation.

PURPOSE

Medical Records serves different purpose for various categories of people who have stake in the hospital.

- **For the patient**
  - Document the clinical story of the patients' illness.
  - Assist in follow up care.
  - As evidence in legal cases.
  - To supply information or issue certificates to patients eg. Disability certificates, sterilization certificates etc.

- **For the Doctor**
  - Assurance of Quality including adequacy of diagnostic/therapeutic measures undertaken.
  - Assurance of continuity of medical care.
  - An aid in research and continuing education of health professionals.
  - Teaching and publication purposes.

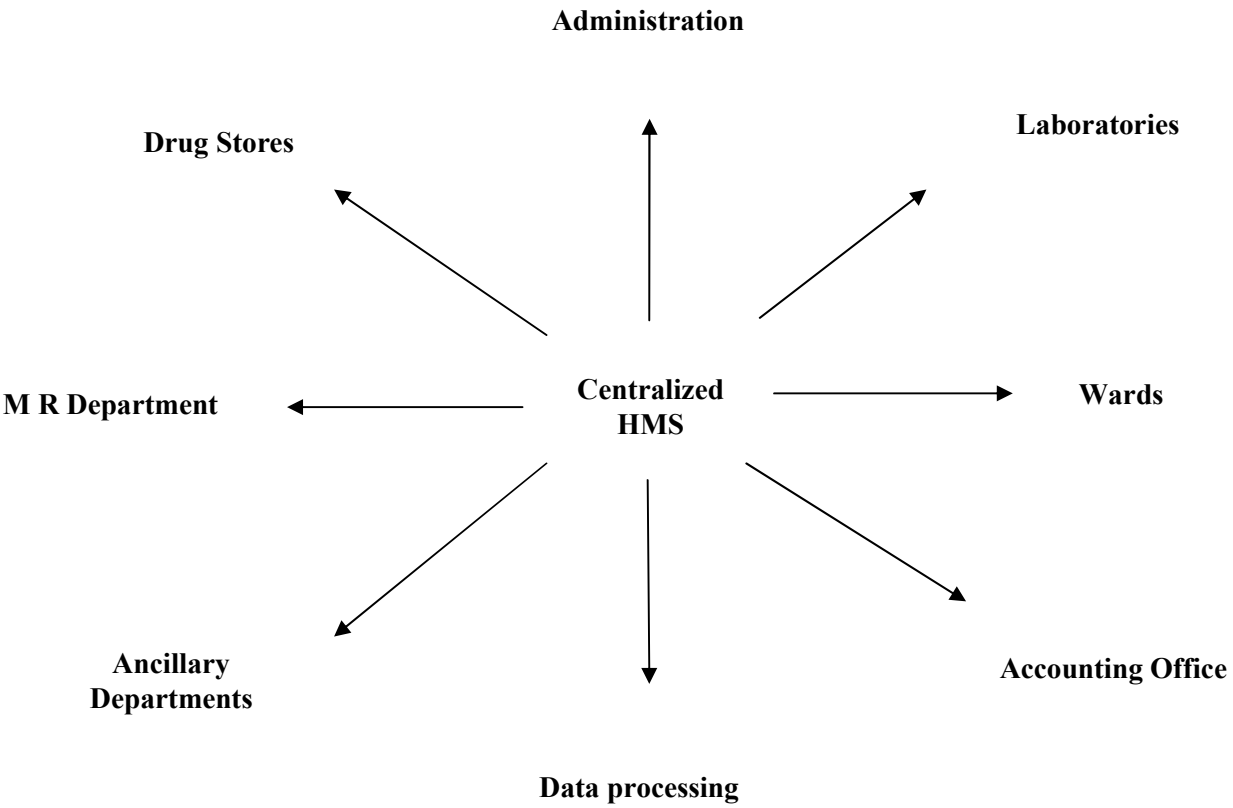
- **For the Hospital**
  - Document the type and quantity of work undertaken and accomplished.
  - Evaluate the proficiency of the individual doctor, for administrative as well as clinical purposes.
  - Evaluate the services of the Hospital.
  - Facilitate budget preparation.
  - Generate statistical data.
  - Assist in future program planning.
  - To conduct Medical Audit.

CHECKPOINTS FOR DESIGNING GOOD MEDICAL RECORDS SYSTEM

- Records should be concise, but clear.
- Ease of access to users.
- Finding or locating the record should be easy.
- Patient confidentiality must be maintained.

ORGANIZATION / LOCATION OF MRD

The system of medical records in a hospital should be centralized.



EQUIPMENT / FURNITURE REQUIRED

- Tables and Chairs.
- File rack (Steel).
- Computers, scanners and Printers.
- Photocopiers.
- Calculators.

STAFFING PATTERN

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

NUMBERING, FILING AND CODING SYSTEM

Numbering System

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

Filing 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.

PROCEDURES AND PRACTICES TO BE FOLLOWED

PROCEDURE FOR OPD RECORDS

OPD daily census will be reported to MRD every day at 2:30 PM. The census will be noted by MRD staff at Master Records.

PROCEDURE FOR IPD RECORDS:

Admission details

Register for IPD records is maintained in Emergency OPD & IPD registration. Registration details at end of Previous day(02:00 PM) of Emergency OPD and IPD patients are submitted on next day at MRD at 10:00 AM. This information is then entered in Master computer.

Submission of files

- Information regarding necessary documents and notes to be filled properly in IPD files of every ward for submission in MRD.
- Head of Department to identify suitable person responsible for submission of IPD records for each of their wards (Ward records in-charge).
- Ward records in-charge has to submit completed files to concerned record clerk on weekly basis. The Record Clerk will then submit those files to MRD Section at the end of every month.
- Ward records in-charge to maintain a dispatch register and get the same signed at reception desk while submitting file. Reception desk to sign on 'File submission register' for received files after due verification.

Procedure for OPD records.

- OPD census is also to be submitted by 2:30 PM everyday

Procedure for Laboratory/ Radiology census

- Census collected at Reception desk.
- All Laboratory/ Radiology census records to be submitted on the next day at 11:00 AM at MRD.

RETRIEVAL OF MEDICAL RECORDS

A Tracker Card System should be used for easy accessibility of data. The tracker card should be used as a place marker whenever the record file is retrieved for any purposes:

RETENTION OF MEDICAL RECORDS

Permanent Record Is needed in MLC and if funds permit then it can be done by microfilming and computerization. The court of Law do not admit in evidence anything other than the manuscript records in its original form. However general convention is to retain the Hospital records for following periods:

a) OPD Records 5 years] from the date of last activity.
b) IPD Records 10 years] from the date of last activity.
c) Medico Legal Records Permanently/till case is finalized.
d) Psychiatric patients Life long.
e) Paediatric patients For 10 years after they attend majority.

CONFIDENTIALITY OF MEDICAL RECORDS

The information which is transmitted by the patient to the physician, nurse and other related health staff is confidential and should be protected from disclosure. However, this information can be divulged only under following conditions.

- If the patient authorizes disclosure.
- Court orders its revelation.
- In the public interest, to avoid harm/injury.

SECURITY OF MEDICAL RECORDS

Security of all Medical Records especially the medico-legal records is a concern of all hospital administrators. Security has to be maintained against fire, water, pests, as well as unauthorized access. To ensure physical security, lockable department/ room, restricted access with one open entrance and one fire exit, and no smoking policy should be adopted. A fire fighting system should be installed in the MRD and regular Pest Control measures should be undertaken.

All medico-legal records of the hospital should be controlled by a single person, preferably Medical Records Officer or any other person designated by the hospital administration.

HOSPITAL STATISTICS

The generation of hospital statistics should be purely on the basis of administrative requirement of the hospital. Broadly hospital statistics can be divided into following types:

HOSPITAL STATISTICS

- Administrative and General Statistics.
- Financial Statistics.
- Hospital Services Statistics.

PATIENT STATISTICS

- Socio-economic Data.
- Patient Movement Statistics.
- Morbidity and Mortality Statistics.

USE OF HOSPITAL STATISTICS

- Admin control over functional activities.
- Assess utilization of hospital facilities.
- Index for evaluation of Quality of Care.
- Basis for preparing Budget.
- Plan for future requirements and justification.
- Data for public health authorities.

IMPORTANCE OF HOSPITAL STATISTICS

Administrative – Allocation of beds/Staff/Services, etc.

Planning – Budgetary, Expansion/Extension, Centralization/Decentralization.

Morbidity Data – Diagnosis Analysis, Epidemics.

LIST OF HOSPITAL STATISTICS

- Reports related to Hospital Beds.
- Admission
- Discharges
- Deaths
- Workload Statistics.
- Hospital Care Evaluation Statistics.

REFERENCE:

Hospital Management : National Institute of Health and Family Welfare

ANNEXURE 1

Daily census collected from various wards and received at MRD Section

Previously Occupied Beds **(X)**	New Admissions ***(A)***		Transfer-in ***(B)***		Total **(Y)= A+B**
	M	F	M	F	

Discharged ***(C)***		Transfer-out ***(D)***		Death ***(E)***		LAMA ***(F)***		Absconded ***(G)***		Referred ***(H)***	Total **(Z)=C+D+E+F+G+H**	Census **X+Y-Z**
M	F	M	F	M	F	M	F	M	F			

LABOUR ROOM:

New Born Details:

Live Born		Still born		Type of Delivery		
Male	Female	Male	Female	Normal	Assisted	C-section

ANNEXURE 1A

New Admission MRD No.		**Discharge MRD No.**		**Absconded MRD No.**		**Lama MRD No.**		**Referred MRD No.**		**Death MRD No.**		**Blood Transfusion**			
M	F	M	F	M	F	M	F	M	F	M	F	**MRD No.**	In Side	Out Side	Total BT Given

ANNEXURE 2

Daily census from Pathology Labs:

Date:

	Clinical Pathology	*Hematology*	*Cytology*	*Histopathology*
OPD				
IPD				
Emergency				

ANNEXURE 3

Daily census from Microbiology Labs:

Date:

	CBNAAT	*Malaria*	*Bacteriology*	*Mycology*	*Mycobacteriology*
OPD					
IPD					
Emergency					
	Parasitology	*Virology*	*Serology*	*Immunology*	TrueNat/RTPCR
OPD					
IPD					
Emergency					

ANNEXURE 4

Daily census from Biochemistry Labs

OPD	IPD	Emergency

ANNEXURE 5

Daily census from Radiology:

Date:

	X-ray	*Ultrasound*	*CT Scan*
OPD			
IPD			
Emergency			

ANNEXURE 6

Daily census from Operation Theatre **Date: _____**

Sr No	*Treating Team*	*Major Procedures*	*Elective/ Emergency*	*Outcome**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
Sr No	*Treating Team*	*Minor Procedure*	*Elective/ Emergency*	*Outcome**
1				
2				
3				
4				
5				
6				

**(Shifted to ICU/ Ward/ Death)*

(OT- Incharge)

ANNEXURE 7:

OPD attendance **Date: _____**

	Adult		Child	
	Male	Female	Male	Female
Medicine				
Surgery				
Paediatrics				
Orthopaedics				
Gynaecology & Obstetrics				
E.N.T				
Ophthalmology				
Dermatology				
Psychiatry				
Dentistry				
Chest and T.B.				
Emergency				
AYUSH				
Homeopathy				
TOTAL				

(Sign)

OPD registration

ANNEXURE 8 :

Information regarding incomplete file
Date:
From:
Medical Records Department
Associated Hospital, Government Medical College Kathua

To:
The Head of Department of _____
Government Medical College Kathua

SUB: Regarding completion of incomplete files
Sir,
With regard to the subject cited above, you are requested to kindly make the corrections in the below mentioned files by 4:00 PM today. The files are to be corrected at the Reception Desk of MRD.

MRD No	Admission Slip	Discharge Summary	History	Nursing Records	Operative Notes & Anaesthesia notes	Investigations	OPD card

Medical Record In-charge
Associated Hospital, Government Medical College Kathua

ANNEXURE 9 :

for access of records

Date:_____

From:
The Head of Department of _____
Associated Hospital, Government Medical College Kathua

To:
Medical Records Department
Associated Hospital, Government Medical College Kathua

SUB: Request for records

Sir,
I request you to kindly allow access to below mentioned files. The records are been accessed for _____purpose and the same shall be deposited by (date)_____.

S No	MRD No	Date of Admission	Department of Admission	Date of Discharge	**MRD NOTE:** Total no of pages

(Signature of MRO)

Signature & full name of
Applicant with stamp

(Signature of Incharge MRD)

(Signature & Full name of HOD with stamp)

ANNEXURE 10 :

DAILY CENSUS REPORT TO THE MEDICAL SUPERINTENDENT:

1] OPD CENSUS **Date: _____**

	Adult Male	Adult Female	Male Child	Female Child	Total	7 days back
NEW						
OLD						
Total						

2] IPD Census

	Previous Day Census	Admissions	Discharges	Death	Census	Bed Occupancy Rate %
2 days back						
Yesterday						
TODAY						

3] NEW BORN:

	Live Born	Still Born	Normal Delivery	Assisted Delivery

4] DIAGNOSTICS:

	Routine	Emergency	Total
Radiology- X-Ray			
Radiology-CT Scan			
Radiology- MRI			
Radiology- USG			
Microbiology			
Pathology			
Bio Chemistry			

General Rules to be followed

1. Any information pertaining to Medico Legal Cases will not be provided for RTI purpose.
2. For any request of duplicate or extra copy of MLC (in case of misplaced or lost), the request will be forwarded to the CMO.
3. Details/Photocopy of treatment file will be given only to the Police on written request having their D.D.E. No. & details(Sign, Name, Designation, Name of Police Station & Mobile No.)
4. All the MLC case/suspected case of foul play should be admitted and record will be maintained in MRD.
5. In case of Trauma involving multiple specialties involved CMO will be the final authority for admitting the patient in concerned specialty decision.
6. A copy of discharge summary to be attached to IPD file by nursing staff before depositing the IPD file in MRD.
7. Case summary must be written on the IPD file by residents.
8. Diagnosis on IPD file cover & inside should be identical and in legible.
9. Any change/correction/rectification in name, Identity/Address can be done only on the written request from the authorized blood relatives of the concerned patient. This can be done, while patient is admitted. After discharge, no request for correction in patient's record can/will be entertained.
10. All IPD files, complete in all aspects to be sent to MRD within 03(three) days of patients discharge.