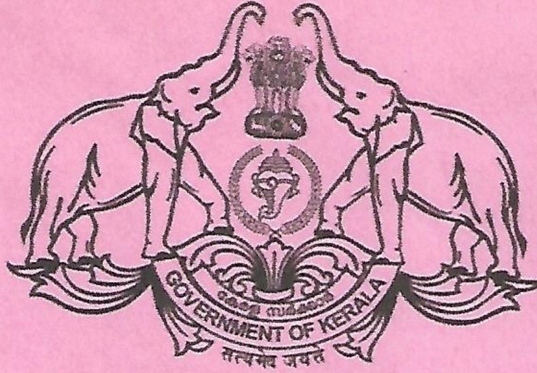

GOVERNMENT OF KERALA

GUIDELINES FOR MAINTENANCE OF MEDICAL RECORDS IN KERALA HEALTH SERVICES DEPARTMENT

No.MR/089891/2021/DHS Dated, 18/12/2021

Guidelines For Maintenance of Medical Records In Health Services Department

Introduction

Medical Record is a systematic documentation of a person's medical history, clinical care and outcome. The primary purpose of a medical record is to document clearly and accurately health related details, management and outcome. Information contained in the medical records are used for continuation treatment of patients, medical education, clinical research, planning, budgeting and for taking preventive measures and health related administrations. Health care provider's interaction regarding the patient care is contained in the medical records. Lack of efficient and accurate medical records is a major impediment for estimating accurate disease burden at different levels. Availability of proper medical records in hospitals is the building blocks of hospital statistics.

Purpose

1. Accurately and adequately document a patient's life and health history including past and present illness and treatments with emphasis on the events affecting the patient during the current episode of care.
2. To provide means of communication among health care professionals.
3. To serves as easy reference for providing continuity in patient care.
4. It is the documentary evidence of care provided by health care facility.
5. Used as an informational document in quality review/audit.
6. Render hospital statistics required for planning and budgeting, administration, medical research, medical education etc.
7. Used as medico-legal document in court.
8. Used as an informational document in insurance, workmen compensation and third party payers claim processings.

Medical Records are important to

1. Patient – for the progressive patient care and continuity of care in future illness, Insurance. It is valuable evidence in a court of law etc.
2. Health care professionals
3. Health care facility and its staffs.
4. Teachers, Students, Researchers
5. Administrators.
6. Court – Medico Legal cases.
7. Insurance (Third party payers)
8. National Health Agencies
9. International Health Organizations

Uses of Medical Records

Patient care management, Quality Review, Legal Purposes, Insurance, Education, Research, Reimbursement, Public Health Activities, Planning and Budgeting, Performance and prescription Audit and Utility Study, feasibility Studies of certain diseases.

Medical Records Department

Medical Records Department should be located in the most approachable part of hospital and should have proximity and liaison with administrative block of the hospital and to the office of the head of the institution.

Medical records department should have adequate space, separate office room, filing area, sorting room, conference hall, necessary furniture items etc.

Medical records are kept confidentially and securely and stored out of reach of unauthorized persons.

Medical Record Department should be posted adequate number of supporting staff such as Nursing Assistants/ Hospital Attenders/ Office attendant with better educational qualification or with some working experience and knowledge. (Circular No: MR - 33283/13/DHS, Dated: 31/05/2013 and No. MRO-4415/17/DHS Dated: 16/01/2017). Once staffs should be posted it will be made permanently, instead of making adhoc arrangements on daily/weekly/monthly basis. The staff posted to Medical Record Library shall not be transferred frequently. Staff posted shall be transferred only with the opinion of MRL.

The supporting staff posted to the Medical Records Department work under the direction and supervision of Medical Record Officer/ Medical Record Librarian.

Medical Records Department is under the direct control and supervision of the Head of Institution.

Functions of Medical Records Department

Medical Record Officer/Medical Record Librarian is under the direct control and supervision of the head of the institution. They are the custodian of all medical records and registers kept in the medical records department and should be very careful in handling them. They are responsible to maintain and preserve records in a manner which protects the safety of records and confidentiality of the information contain in it, till their retention period. All medical records are stored out of reach of unauthorized persons. Lack of efficient and satisfactory medical record system is a major impediment for estimating disease burden accurately. Accurate coding and classification of the diagnosis is critical for the retrieval and utilization of medical records. Thus every effort should be taken to improve the completion and accuracy of medical records.

The major functions of the MRD are the following:

1. Outpatient and Inpatient Registration, control and monitoring the flow of medical records.
2. Collection of information regarding OPD, IPD patients and prepare hospital statistics.
3. Collection of case records and daily discharge slip of all patients and review for completeness.
4. Assembling: All the medical records are to be arranged in chronological order (i.e. inpatient number wise is preferred). Quantitative and Qualitative analysis of records has to be done while sorting and arranging.
5. Deficiency Checking: MRL shall identify deficiencies and inform the same to concerned doctor, ward sister and ensure that all deficiencies are completed before storing. Maintained Deficiency Checking Register/Qualitative and Quantitative Analysis Register. This register contains Sl.No, IP.No., Date of return, Unit, Name of patient, ward, reason for rejection, signature of charge sister columns are entered.
6. Coding: Assign the code number for disease and operation as per International Statistical Classification of Diseases by WHO – 10th revision
7. Indexing: Disease wise index card is maintained by MRL. Indexing should be digital format/manual format by MRL
8. Storing and Filing: Based on inpatient number records are stored for easy retrieval to meet the need of immediate patient care, medical education, re-admission, certificate issue, administrative purpose, medical training, research, Medico-Legal issues, evaluation of patient care etc.
9. Statistics :- Various types of statistics prepared by MRL are as follows:

   (A) Daily Census - Daily OP, IP, Delivery, operation, discharge and death data's prepared sex wise on the basis of Ward census.

(B) Monthly Report: Month wise total OP, IP, death, delivery, medico-legal cases, Postmortem conducted, Specialty-wise details, Bed Occupancy Rate, Bed Turn Over , Average length of stay, No. of inpatient stay per day, Communicable and Non- Communicable diseases are reported.

(C) Annual Administration Report of every financial year should be prepared in assistance with various departments, Hospital statistics including the bed strength and bed distribution, Specialty-wise Details etc. In addition to the routine statistical preparation we are providing statistical information to Medical Superintendent, DMO, DHS and when required

10. Help in conducting Medical Audit/ Death Audit: - A medical Audit Committee has been constituted, chaired by Medical Superintendent and medical records are audited by members of the committee for improving the quality of medical care. Medical audit is conducted every month. Records are selected randomly and deaths reported in every month are scrutinized for case selection. Circulars regarding audit committee are given to all the members by MRL
11. Conducting meetings of the Medical Record Committee:- A Medical Record Committee has been constituted, chaired by Medical Superintendent and medical records are audited by members of the committee for strengthening and systematic functioning of medical record department, form designing, improving the quality of medical information.(As per circular No. 51215/09/DHS, Dated:30/07/2009). Medical Record Committee meeting should be convened monthly and minutes and action taken report should be sent to Directorate of Health Services promptly.
12. Help in Conducting Medical Board. Maintain and handling Medical Board Files and records pertaining to that.
13. Checking the records, certificates and registers for completion, missing pages, unauthorized corrections and cancellation and getting the incomplete records completed without delay.

14. Medico-Legal cases includes

(A) Preservation of records pertaining to medico-legal importance

(B) Production of document/Assist in producing documents before court. Documents to be submitted/handed over to other staffs as per summons only with the deputation order from the Head of Institution. Receipts may be obtained of the document received at court and suffix at the issue register.

(C) Certificate Issuing: Various types of certificates such as Accident Register-cum-Wound Certificate, Drunkenness Certificate, Post Mortem Certificate, Treatment Certificate, Physical Examination by a Medical Officer, POCSO Act cases etc. are issued to police and court.

15. Assist the Medical Officer in charge of Hospital in the preparation of Birth and Death to be sent to the local authorities concerned within the stipulated time.

16. MRO/MRL should supervise O.P and I.P Registration and the defects is noticed if any should be brought to the notice of the head of institution for immediate rectification.

17. Preparation of Out-Patient/In-Patient Attendance Register from the details received from the Out-Patient/In-Patient department

18. Medical records shall not be issued, taken out to other sections or official's departments and judicial, police authorities without proper request in document and with permission of the head of the institution. Every issue should be recorded in the issue register and proper receipts should be obtained.

19. Assist in State/National Accreditation such as NABH, NQAS, KASH, LAKSHYA etc.

20. Retrieval of information as per Right to information Act 2005, Protection of Indian Evidence Act, Consumer protection Act and Sevana Act etc.

21. Correction of entries should not be made in the medical records once it has recorded. Request of correction of name, address, income, age, sex etc. shall be entertained only in the medical record library under the authentication of the Head of Institution.

The Head of institution can insist for the produce of necessary proof in support the request for correction.

22. The key of the Medical Record Section should be kept with the Medical Record Officer/Medical Record Librarian and its spare with the Head of institution.
23. Completion of main IP Register with discharge particulars.
24. Maintained Sub-stock Register.
25. Maintained Plan fund Register (DHS Plan Fund & DHS NHM Fund) and Stock Register of Furniture Register.
26. In certain situations training conducted to OP/IP Registration counter staffs.
27. Preservation of medical records, certificates and registers till retention period as mentioned in relevant Government orders and circulars. (G.O. (Ms.)No.06/2014/H&FWD, Dated: 03/01/2014 TVM.)
28. Assist the head of institution in issuing various certificates.
29. Monthly Hospital Activity reports in the new format should be furnished to the Director of Health Services on 5th working day of every month from all major institutions from the level of Taluk hospitals. (also e-mail to additionalmedical@gmail.com and mrodhskerala@gmail.com)
30. Uniform format and protocol according to the G.O. (MS) No. 232/11/Home Dated: 22/10/2011 (Kerala Medico-legal Code) and circular No.MR.47183/09/DHS should be followed in the maintenance of various records and registers in hospitals.
31. Maintained Missing case records, Inactive and Disposed records register.
32. Supervision of all correspondence in the medical record section and other duties allotted by the Head of Institution from time to time.

Medical Record Officers in Hospitals

1. Medical Record Officer in hospitals are responsible for management of medical record department.
2. He /She have to supervise and control the subordinate staff.
3. He /She have to monitor Disease coding and indexing according to international disease classification pattern.
4. Medical Record Officer is the chief of medical record maintenance in hospitals.
5. Issue of copies of Wound Certificate, Post-Mortem Certificate to the applicants after as per stipulated Government orders.
6. Supervision of the duties of Medical Record Librarians and other staff working in the medical record library.
7. Acting as chief of Medical Record Keeping in the institution.
8. Over all supervision and Management of Medical Record section and maintenance of attendance of staff working under them.
9. Any other relevant duty assigned by the Head of the Institution.

Medical Record Officer in Directorate of Health Services

1. In-charge of the Medical Record Cell.
2. He/ She have to control and manage medical record system in the state.
3. He/ She has to control and supervise all subordinate MRO's and MRL's and has to give technical guidance/corrective methods at times.
4. He/ She give suggestion and proposals for further development of Medical Record System in the state.
5. He/ She have to visit all hospitals for conducting periodical inspection on medical records.
6. MRO have the state Jurisdiction power in managing statewide Medical Record System.

Medical Documentation Process

The outpatient and inpatient registration and data keeping should be controlled by Medical Records Department. Necessary Hospital Attenders and Nursing Assistants should be posted for OP & IP registration. The Attenders/Nursing Assistants posted in the Out Patient and In Patient registration counter will work under the direction and supervision of Medical Record Officer/Medical Record Librarian. The number of staff posted to these counters should be in relation to the total number of out patients attending and the bed strength of the institution.

One single OP nominal register is to be maintained with all relevant data of patient attending the Out Patient Department irrespective of the department they are treated. The OP number of repeat cases with sex wise classification shall be maintained in a separate register. O.P. Nominal register is to be maintained with the following title columns. Date, O.P. Number, Name of patient, Age, Sex, Income (APL/BPL), Place of residence and Remarks. New O.P. Register should be started at the beginning of each calendar year starting with O.P. Registration number – 1(one). A patient attending Out Patient Department should give only one OP Register number for one calendar year. After O.P. registration the patients are to be directed to the appropriate specialty and it should be noted in the nominal register. Each doctor attending in the OPD is provided with an OP Diagnosis register. The Medical Officer should be responsible to note down the OP number and diagnosis of new cases and OP number of repeat cases in the register. If the same patient came with a new disease for the second time, that should also be noted in the diagnosis register. This register is the source of information of disease burden of that area. Diagnosis, investigations to be carried out and direction of treatment with signature and name of Medical Officer should be noted down in the OP ticket. The total number of patients entered in the different diagnosis register should be checked with the total number of patients registered in the OP nominal register and if

any gross discrepancy is detected it must be brought to the notice of the Head of institution then and there for immediate rectification. Daily OP census with sex wise classification of new and repeat cases should be furnished to Medical Record Department everyday by the staff working in OPD. An outpatient attendance register is to be prepared by the Medical Record Librarian from these details.

Round the clock working admission counter should be opened for admission of the patients. In- patient register should contain the following details IP No, Name and Address of the patient, Age, Sex, Ward, Unit, Occupation, Income, Date and time of Admission, Date and time of Discharge, Final Diagnosis, Condition on Discharge. A Patient need not be admitted unless a provisional diagnosis, ward and unit in which the patient is to be admitted is specified in the admission(OP) ticket with name and signature of the Medical Officer. Essential data are to be gathered from the patient of nearest relative and entered in the Main IP register and Case Record. Meticulous are should be taken to record the correct information so as to avoid future corrections. The O.P. ticket of the patients admitted to the hospital **WITH ADMISSION NOTES** should be attached with the case record. The patient with the case record should be directed to the ward in which the patient is to be admitted. When a person is admitted to the hospital the person is considered as inpatient.

In the ward, necessary data from the case records are to be entered in the ward IP Register by nurse in charge of the ward. Attending Medical Officer should record all details of the patient regarding onset, cause of present illness, personal and family history, physical examinations conducted, physicians orders, daily progress report, investigations done, consultation report, surgery details, anesthesia report and directions regarding treatment to be carried out. All entries must be timed, dated and authenticated.

Nurses should record graphic chart and Nurse's record. Temperature Chart issued to record different parameters regarding the patient. Temperature, Pulse, Respiration, Blood Pressure are charted

in this form. Input and output of solids and fluids are also included. The nurses record should contain an admission note, observations made by the nurses, details of treatment and services rendered by them to the patient and also the patients response to the therapy. The nurse's record should describe the patient's needs, problems, capabilities and limitations in terms of the patient's actual behavior. Documentation of medication given orally, topically, by injection, inhalation and infusion also to be done. All the entries must be timed, dated and authenticated by the nurses who render services.

In operation cases pre-operative diagnosis and pre anesthesia checkup details should be entered before operation. Surgical procedure followed, anesthesia note and findings of surgery and intervention done should be entered immediately after operation. A post-operative diagnosis should be recorded in all operation cases.

In delivery cases the ante-partum record, delivery record, postpartum record and details of new born baby should be recorded by the attending Medical Officer. Vital events (Birth and Death) should be reported to the Registrar of the local authority within the stipulated time. Responsibility of sending **VITAL EVENTS OCCURRED IN THE HOSPITAL** to the medical record department is vested with Head Nurse in charge of the concerned wards on the next day itself.

Details of special consultations if any, written consent for examination, treatment, investigations, procedure etc. also should also be recorded. All the health care professionals attending the patient should document their observations, examinations, investigations, procedures, directions, advice and orders in the medical record with signature, name, designation & date and time. The recording of House surgeons and other temporary officers should be countersigned by the respective permanent officials. All the investigation reports and results should be recorded in the case record and authenticated. Medical record should contain no unexplained gaps.

Final diagnosis recorded should be complete in all respects and should be accurate and inconformity with the accepted terminology of standard nomenclature of diseases and operations. In accident cases external causes of the accident and the nature of injury should be specifically noted in the case sheet. In referred cases the cause of reference, the institution to which referred and the details of reference should be recorded in the case record and a separate register should also be maintained for all referred cases. Date and time of discharge, condition of the patient on discharge, and mode of discharge should be recorded in the case record. In death cases cause of death like (Immediate cause, Antecedent cause, Underlying cause) with date and time of death should be invariably recorded. A discharge summary should be issued to the patient noting all necessary details. Copy of the discharge summary should be kept in the case record.

When the patient is discharged from the hospital or transferred from one ward to another the details should be entered in the ward IP Register by the Nurse on duty. Discharged case sheets with daily discharge slip should be sent to the Medical Record Department on the next day of discharge. A daily discharge slip should be prepared from each ward, which contains IP number, name, age, unit, diagnosis and date of admission of the cases discharged from the hospital for that particular day and should also specify the ward and the date to which it relates. Details of outstanding cases, admissions, transfer in, discharges, deaths, and transfer out, remaining balance (classified in to male, female and children) should be recorded in the discharge slip, from which statistical reports to be prepared. The responsibility of sending the discharge case record with discharge slip is vested with the Head Nurse/Nurse in-charge of the ward.

Quality of Medical Records depends, upon the information entered by those professionals authorize to provide care and responsible for documenting that care.

Flow of Medical Records in the M R D

Medical Record Librarian receives the case records and acknowledges receipt. If any of them found damaged or tampered, it should be noted in the local delivery book of the ward and immediately inform the Head of the Institution in writing and get it rectified. Quantitative analysis to identify areas of the medical record that are incomplete or inaccurate are done by Medical Record Librarian and the incomplete case record to be returned to the ward for completion and return. Assembling of the case records are done by the Medical Record Department staff. Case records should be verified for deficiency and completed it by presenting it in the weekly unit conference or by sending back to the ward. A deficiency check form to be attached with the case record for identifying the deficiencies.

Weekly unit conference is to be conducted in the Medical Record Department, unit chief and his assistants will participate in the meeting and rectify the defects noticed in the records.

Case records are arranged in serial order by the supporting staff of the Medical Record Department in order to facilitate coding. Coding of diseases of diagnosis, injuries and external causes with International Classification of Diseases (latest revision) of World Health Organization. No case records are to be left without ICD Code number. Coded case records are arranged according to ICD code number for the preparation of Disease Index card. Coding and indexing should be done in the Medical Record Department by Medical Record Librarian.

Case records are stored out in serial order of In Patient Number, incorporate the discharge particulars in the In Patient Nominal Register and finally the case records are filed according to serial unit system of filing. Case records not received from the ward even after three months must be specially noted and ward nurses must be alerted

for sending the record. A register of missing / delayed records is maintained in the Medical Record Department.

The filed case records are to be retrieved as and when required. An out guide is to be placed when records and registers are removed. Identity of the record and the purpose of retrieval with date are noted in the out guide. The out guide remains in the files until the retrieved record is returned and replaced.

MRD Receives the following

When the following registers and records in use are completed it should be immediately handed over to the Medical Record Department.

1. O.P. Nominal Register prepared in the Out Patient Department.
2. Main I.P. Register prepared in the admission counter.
3. Daily Census Register prepared by the Head Nurse on night rounds.
4. Birth Register.
5. Death Register.
6. Casualty Register.
7. Observation Room Register.
8. Referred Patients Register.
9. Operation Register.
10. Anesthesia Register.
11. Brought Dead (Patients died on the way to the hospital) Register.
12. Case Records of all patients.
13. All Medico Legal Certificates & Registers (Mentioned in the Kerala Medico Legal Code).
14. Daily Census slip of all patients.
15. PPS Register/Sterilization Register
16. MTP Register/Abortion Register

Medical Record Librarian should verify the records and registers for completion, damage, missing of pages etc. A deficiency check should be done and the deficiency identified records and registers to be sent back to the ward/section for rectifying the defects and return back. The records and registers are to be maintained and preserved until retention period.

Registers to be prepared in the MRD

1. OP Attendance Register
2. Daily Discharge Register
3. Inward Register
4. Register of Returned Records.
5. Register of Missing Records.
6. Register of Outstanding Records.
7. Register of Chemical Analysis Register.
8. Record Issue Register.
9. Register of Medical Board.
10. Deficiency Checking Register.
11. Certificate Issue Register.
12. Register of RIA Answering.
13. Birth & Death Reporting Register.
14. Stock Register of Medical Records Registers.
15. Stock Register of furniture of MRD.
16. Plan Fund Register

Ownership

The Medical Record developed in the institution is the physical property of that institution. The information contained therein is the property of the patient. The institution owns the medium on which the record is prepared and the patient cannot take the possession of the original record. The patient has control over the information in the record, except in those instances where this is limited by law.

Responsibility for Medical Records

The Hospital Administration is legally and morally responsible for providing acceptable standards of quality medical care. The hospital has the responsibility to provide a record for each patient and safeguard the record and the information contained within it against loss, damage, tampering and unauthorized use. The professionals who give care to the patients and those generating patient identification and sociological data should have the documentation responsibilities. To fulfill this responsibility Medical Record department have to be constituted with qualified Medical Record personals in all medical institutions. Medical Record Departments are defined as the section of the hospital for proper custody of patient care records, coding, classifying and reporting of diagnostic and associated data for various purposes. Errors, deficiencies and incompletion in documentation are discovered and get corrected and completed. Medical Record Department keeps the records in secure manner and provides access only to the authorized.

Kerala Medico Legal Code

Government published Kerala Medico Legal Code (G.O. (Ms.) No. 232/11/Home, Dated: 22-10-2011,Thiruvananthapuram,) applicable to the entire state, also published in the official web site of Health & Family Welfare Department from where all the officials can be downloaded. This code prescribes the procedures to be followed in the conduct of each and every medico legal examinations, various formats to be used for the purpose of medico legal examination and certification, guidelines for their maintenance, documentation, issue and the supply of documents allied materials and facilities necessary for the process. Every doctor practicing Modern Medicine should fulfill the six legal responsibilities such as Intimation, Documentation, and Preservation of evidence, Consultation, Dying declaration and Death intimation. The code is to be followed for making a uniform process of medico- legal examination and certification throughout the state and is applicable to all registered Medical Practitioners. The code identifies the following as medico- legal examination and certification.

1. Wound Certification.
2. Examination and certification of drunkenness.

3. Examination and certification of a male accused in sexual offence including examination of his potency.
4. Examination and certification of a female victim of sexual assault.
5. Examination and certification of a victim of unnatural Sexual Offence.
6. Examination and certification of a female to look for signs of recent delivery.
7. Examination and certification of a victim alleged to have been drugged.
8. Certificate of physical examination of any person, by a Medical Officer on the written requisition from a Judicial or Police Officer.
9. Certificate of physical examination of any person, by a Specialist Medical Officer or Team of Specialist Medical Officers on the written requisition from a Judicial or Police Officer.
10. Certificate of age.
11. Post-mortem Examination.
12. And any other medical examination of a person, conducted by a registered medical practitioner defined as per clause (b) part 2 of section 53 for the purpose of identifying or excluding findings or collection of material objects which may aid in the administration of justice.

The material objects/swab/specimen etc collected for chemical examination in medico- legal cases should be sent immediately **ALONG WITH MEDICO-LEGAL CERTIFICATES** from the collecting point itself, by the examining Medical Officer. If the specimen collected from the casualty or mortuary will transferred to any other places, in any way, will lead to violation of law and chances of manipulation occurs. All documents relating to chemical examination process will keep and managed in the MRD itself. The Medical Officer who **ATTEND SHOULD ACCOMPANY OR AUTHORISE NURSE-IN-CHARGE**, in order to avoid mismatch and delay. Acknowledgement /Receipt must obtain from the police.

Medical Audit

Medical audit is the systematic analysis of the quality and efficiency of medical care and is a yard stick to evaluate negligence of care, including procedures used in diagnosis and treatment, use of resources and resulting outcome for the patient. A medical audit should be conducted in each hospital by the Head of Institution for evaluating the care given to the patients and putting up

suggestions for better patient care. Medical Record Librarian should make available all case records of death occurred and other important cases for medical audit.

Movement of Records

From admission to the ward till discharge of the patient, the record should be under the custody of Nurse in charge of the ward. Discharged records should be sent to MRD next day of discharge along with the discharge slip. No records are to be send out of Medical Record Department without the written request of a Medical Officer, and it is to be recorded in a separate register. A request from the Medical Officer is needed in case of review and readmission. For Medico Legal Cases and all other purposes written authorization of the Head of the institution is required. No records are to be handed over to patients, relatives or unauthorized persons. Only the hospital staff should be engaged for this purpose. Persons who are not working in Medical Record Department are not given access to Medical records.

Correction of entries in the Medical Records

Correction of entries should not be made in the medical records once it has recorded. Request for correction of name, age, income, address etc shall be entertained only in the Medical Record Department under the authentication of the Head of Institution. The Head of Institution can insist for the production of necessary proof in support of the request for correction.

Sex correction certificate shall be issued based on the document of proofs as mentioned below.

1. Request from the parents
2. Certificate from the Tahasildar concerned specifying 'Sex' of the child, the date of birth and Name of parents.
3. An Affidavit from the Notary Advocate.
1. School Certificate (If available) proving date of birth and sex. If available, a Gazetted Officer should cross-check & verifies the identification marks in the school certificate.

   (As per Circular No. MRO - 31033/15/DHS TVM Dated: 29/01/2016)

Name Correction Certificate shall be issued based on the document of proofs as mentioned below.

1. Request from the parents.
2. One and the same certificate as per the Government norms(Affidavit of the applicant and attested by the Gazetted Officer)
3. Aadhaar Card.
4. Marriage Certificate.
5. Copy of School Certificate/Any other Identification Document.

Income correction certificate shall be issued based on the document of proofs as mentioned below.

1. Request from the patient
2. Proof of income(Ration card and Income Certificate)

Initial (minor) correction (Age, Spelling mistakes etc.) shall be issued based on the document of proofs as mentioned below.

1. Request from the patient
2. Copy of School certificate
3. Aadhaar Card / I.D. Proof

Medical Record Committee

For the effective functioning of Medical Record Department in all the institutions and make good its service to the patients, doctors, hospitals, to the public and to the State and Central authorities the Medical Record maintenance system have to be strengthened. Circular No. 51215/2009/DHS, Dated: 20/07/2009 of Director of Health Services issued direction to constitute Medical Record Committee for strengthening the activities of Medical Record Department. The structure of the committee will be as follows.

Chairman – Head of the Institution

Convener - Medical Record Officer/Medical Record Librarian

Members – RMO, 3-5 Senior Doctors, Nursing Superintendent

(To be nominated by the chairman)

Committee should meet on the third week of every month. Medical Record Officer/Medical Record Librarian should gear the programme and do all correspondence work related to the committee meetings. The functioning of the committee will be strictly in accordance with the policies and procedures of Medical Record Maintenance system existing in the State and guidelines offered from the Directorate in this regard.

Minutes of the meeting along with action taken on the various decisions must be intimated to Director of Health Services.

Quality Assurance

Quality assurance is the overall efforts of the facility to achieve effective care without compromising quality. Quality assessment activities include a review and evaluation function for physician, clinical and organizational services. The medical record is the principal document by which the performances of health care professionals are measured. The medical record itself must be monitored and measured in order to maintain a high standard quality that supplies a detailed account of the patients care and treatment. The medical record committee established in the institution review the content of the medical records for quality assurance. Quality medical record is mandatory for accreditation processes.

Hospital admission (including pay ward admission time and discharge time) discharge and stay policies are to be formulated for smooth functioning and data accuracy.

Total Quality Management (TQM) in Health care

Arrangement in Medical Records

One of the most recent techniques adopted for quality analysis in work space and work standardization procedure is so called **5s**. It focuses on having visual order. Organization cleanliness and standardization of medical records.5s is literally 5 abbreviation of 5 initials of 's'. SORT – SET – SHINE – STANDARDISATION – SUSTAIN.

SORT *(S1)

SET IN ORDER (S2)

SUSTAIN(S5)

STANDARDISATION(S4)

SHINE(S3)

S1. SORT

1. Eliminate unnecessary items/less frequently used records.

2. Categories records, equipments, furniture etc in working space into 3 categories.

- Necessary.
- Unnecessary
- May not use.

S2. SET IN ORDER

Based on findings effective storage of necessary items.

Apply 'can see', 'can take out', 'can return' philosophy.

- Labeling,
- Numbering,
- Flow charts,
- Distribution lay out etc.

S3. SHINE

Cleaning up work place daily to wipe dust in floor, machines and records

- Cleaning records store room from roof to floor
- Hand hygiene technique
- Waste segregation

S4. STANDARDISATION

Involve working instructions, standard operating manual, coding, indexing. Display symbols, warning boards.

S5. SUSTAIN

Maintain S1 to S4 through commitment, discipline and empower.

- Periodical evaluation.

Release of Information

The information contained in the medical record is confidential. The information can be released to the patient on written request, and parent/guardian if the patient is minor except in cases where it is prohibited by law. Medico legal information can be released to the investigating officer on written request. All the information can be made available to the court in response to a court order.

Medical records are the property of the hospital, hence all correspondence for medical information on patients in the hospital will be handled by the Head of the institution, or his authorized representative for insurance, workmen compensation, medical certificate, other departmental request for case summaries, medico legal cases etc. The information contained in the medical record must be safe guarded against tampering, loss, damage or use by unauthorized persons.

Infrastructure Facility

The head of the institution should provide adequate safe space for MRD office room and filing room, necessary items of furniture such as Table, Chair, Almirahas, Racks, Computer, Printer, Photocopier and Reference books such as

International Classification of Diseases (latest revision), Medical dictionary and other facilities for functioning Medical Record Department.

Health Statistical Indices

For implementing and monitoring all health activities in the State, the hospital functioning activities and indices are to be calculated. Circular No: MR-1248/10/DHS, Dated: 01/02/2010 directed to calculate the following indices measuring the quality and quantity of various aspects of health care services.

Following are the common indices

1. Average admission per day.
2. Average discharge per day.
3. Average number of patients staying in a day.
4. Average length of stay of a patient.
5. Bed Turn over Rate.
6. Bed Occupancy Rate.
7. Average Op attendance per day.
8. Average OP attendance per patient.

The In Patient indices are calculated on the basis of the daily census tabulated in the Night Report Book of the institution and Out Patient indices on the basis of the main OP register and repeat OP register.

Average number of patients staying in a day:

Total number of patients staying in the hospital during the period
Number of days for that period

Average length of stay of a patient:

Number of hospital day service rendered from the hospital for the period
Total number of discharges and death for that period

Bed Turn Over Rate:

Total number of inpatients discharged and died for the period
Number of sanctioned bed for that period

Bed Occupancy Rate:

Average number of patients stayed in a day for that period X 100

Number of sanctioned bed for that period

Average out patients attendance per day:

Total number of outpatients (new + old cases) attended for the period

Total number of OPD working days

Average outpatients attendance per patient:

Total number of patients (new + old cases) attended during the period

Total number of new cases attended for that period

International Classification of Diseases

ICD X (latest revision of ICD) belongs to the family of International classifications introduced by the World Health Organization in1993 for the use of all member countries. India adopted the same for implementation in the year 2000.

Clinical coding is the translation of diagnosis of diseases, health related problems and procedure concepts from text to alphabetic / numeric codes for easy storage retrieval and analysis. Coding provides common language for describing diseases and health related problems to improve communication between different users.

There are three main elements to the structure of ICD X : They are

(1)Three Volumes:

Volume 1 :

Tabular list: - Alphanumeric listing of diseases and diseases groups along with inclusion and exclusion notes, coding rules, special tabulation list for mortality and morbidity, definitions and regulations. Contains 21 chapters identified by roman numerals. 1, 11, 111, 1V, V etc.

Chapter 1 to XVII – Diseases

Chapter XVIII – Symptoms, signs and abnormal Clinical and Laboratory Findings not elsewhere classified.

Chapter XIX - Injury, poisoning and certain other consequences of external causes.

Chapter XX - External causes of morbidity and mortality

Chapter XXI - Factors influencing Health status and Contact with Health services including screening and preventive care.

Volume II:- Instruction Manual:-

Provides instruction how to use volume I and III

Guidelines for certification and Rules for Mortality coding

Guidelines for recording and coding for Morbidity coding.

Statistical presentation

Volume III : Alphabetic Index:- Comprehensive alphabetical index of the diseases and conditions found in the tabular list.

Consists of an introduction explaining the purpose of index, have 3 sections

Section 1 – Alphabetic listing of terms relating to diseases nature of injury, reasons for contact with health services and factors influencing a person's health.

Section 2 – Alphabetic listing of external causes of injury morbidity and mortality

Section 3 – Alphabetically arranged table of drugs and chemicals

Vol . III contains more diagnostic terms than tabular list.

Volume I and III be used together in locating codes accurately.

(2) 21 Chapters:

Identified by roman numerals. When referring to a chapter call it by its chapter number and not by the letter of the code associated with it. This is because some chapters contain more than one letter and some letters are used in more than one chapter. Most chapters are associated with body systems, special diseases or external factors. The number of categories assigned to a chapter is influenced by the number of diseases and conditions that falls in the scope of the chapter.
14 chapters have single letter, 3 chapters have smaller range of categories and share letters – chapter – 111, V11, V111. 4 chapters use more than one letter in defining categories chapter -1, 11, X1X, XX.

(3) Alpha Numeric Code:

The first character of the ICD code is an alpha character followed by two, three, or four numeric characters

Basic Medical Coding Guidelines.

While coding use the alphabetical index as well as tabular list and follow the guidelines

1. Identify the type of statement to be coded and refer the appropriate section of alphabetical index.
2. Locate the lead term
3. Read and be guided by any note that appears under the lead term.
4. Read any term enclosed in parenthesis after the lead term, as well as any terms intended under the lead term, until all the words in the diagnostic term have been accounted for.
5. Follow carefully any cross references found in the index
6. Refer tabular list to verify the suitability of the code number selected.

7. Be guided by any inclusion and exclusion terms under the selected code.
8. Assign the code.

Birth and Death Registration

Every birth and death occurring in the hospital should be reported and registered to the local authority within the stipulated time. A Birth Register should be maintained in the labour room by the head nurse in charge of the labour room with the following details: SL. No., IP No., Name of mother and father, address, age, Qualification of mother and father, order of birth, gravida / para, date of admission, type of delivery, date and time of delivery, sex of baby, name of doctor and nurse attended, signature of doctor and remarks. The register will contain all live births, still births and IUD. When the registers are completed that should be handed over to Medical Record Department. All death cases occurring in the hospital must be recorded in the Death register. The Death Register should contain following details: Sl. No., IP No., Name and address of the diseased, age, sex, ward, date and time of admission, date and time of death, Cause of death, signature with name and Designation of Medical Officer and mode of disposal of the body with proper receipt of acknowledgement. Reporting of all birth and death occurring in hospital to medical record library is vested with head nurse in charge of wards and the medical record librarian sent it to the local body with in stipulated time.

Medical Certification of Cause of Death (MCCD)

Cause of death is one of the important aspects of Mortality. The scheme of medical certification of cause of death (MCCD) was introduced under the Civil Registration System to generate regular and reliable estimates of cause specific mortality in the country. Mortality data by specific causes is required to analyze health trends of population, prevalence of diseases, evaluation of risks of death from various causes at different ages, proportion of deaths occurring in hospital, etc. is useful for the public health planners and administrators as well as the medical scientists and the researchers. Medical Coding is a curriculum of our training programme and

is included in the syllabus of courses studied. Hence Medical Record Professionals are well versed in this topic.

It is the responsibility of the medical practitioner who attended the deceased during her/his last illness to fill the **Form 4** while in an Institution of Form 4A outside the Institution. After filling up the cause of death in Form 4 or 4A, the same should be sent to the concerned Registrar along with death report Form

A cause of death is disease, abnormality, injury or poisoning that contributed directly or indirectly to death. A death often results from the combined effect of two or more conditions. These conditions may be completely unrelated, arising independently of each other; or they may be casually related to each other, that is, one condition may lead to another, which in turn leads to a third condition and so on. The disease or injury which initiated the sequence of events will get selected for the purpose of tabulation.

The physician's primary responsibility is to complete the medical part of the certificate regarding all diseases, morbid conditions or injuries which either resulted in or contributed to death. Responsibility is placed on the certifying physician for indicating specifically all the several conditions and the chain of events if a sequence can be identified. The physician should record the diseases/conditions in an order leading back to the underlying cause. Causes of death are classified, coded and grouped according to the Tenth revision of the International Classification of Diseases ICD-10) recommended by WHO.

Evaluation of Records

Medical Record Professionals are responsible to maintain and safeguard accurate and complete medical records, prepare and keep up to date data of various diseases treated, and hospital functioning indices for various planning and administrative purposes. Coding and indexing of all case records should be done. Periodical reports should be sent to higher authority promptly. Medical record committee should be constituted and

convened monthly for the better medical documentation and maintenance practice.

Indicators for Evaluation of Services

1. Number of records found incomplete during random checks.
2. Number of records found damaged during random checks.
3. Percentage of records found missing/untraceable during random checks.
4. Time taken for retrieval of records during surprise checks.
5. Complaints from the consultants about delay in retrieval/supply of records for reference.
6. Complaints from patients/relatives about delay/non-availability of documents/certificates.
7. Complaints from health authorities about delay/non receipt of reports.
8. Observations by the Medical Audit Committee/Death Audit Committee about the quality of records generated, preservation of records or timely availability of records.
9. Quality and timely availability of the statistics are reported by the users.
10. Instances of breach of confidentiality of information.
11. Physical condition of records as seen during periodic inspections (dust, fungal growth, damage by pests or seepage of water).

Forms and Registers

It is mandatory to keep various records and registers related with the treatment, interventions and management of patients in hospitals. Some are to be kept permanent, and some for different life span. Even though records and registers are maintained in all the institutions, no uniformity exists in their format, size, and the information contained in them.

Circular No.MR/47183/09/DHS, Dated: 31/07/2009 issued from the Directorate of Health services for establishing uniform format and protocol for the maintenance of various registers.

The main guidelines are:

- All registers must be maintained in bound-books with 300-400 page
- Good quality papers must be used for making all registers.
- Necessary titles must be printed at the top of all columns on each page.
- All pages got pre-numbered while printing it.
- Page certification must be done before using them.
- All the documents should be handled carefully and keep clean always.
- Entries made in all registers must be legible and readable.
- Overwriting must be avoided.
  Entries must be made carefully so as to avoid correction.

All staff members in the section must be responsible for the fair maintenance of all documents at their level.

Preservation of Medical Records

All inpatient records including patient files, registers relating directly to the patient care have to be maintained by MRD. The records are to be maintained until retention period as per order, GO (MS) No.06/2014/H&FWD Thiruvananthapuram, Dated: 03/01/2014 and disposed as per the circular number MR-90940/09/DHS/TVPM, Dated:30/12/2009.

Disposal of Medical Records

Responsibility of maintaining and safeguarding the documents is vested with the in charge of the section, but the staff in the section also has responsibility of safeguarding every document in that section. On completion of the registers it must be kept under lock and key in the section/handed over to the concerned section.

When the preservation period of the document is over, it shall be treated as inactive and disposed. With the authorization of the Head of the institution those documents are removed from the stock register. The Head of

institution must issue proceedings to this effect and communicated to all officials concerned. The disposed items are to be destroyed by burning or giving to Waste-paper contractors authorized by Government. The files regarding this must be kept for future reference.

Supervision

The Medical Record Officer from the Directorate of Health Services should conduct periodical inspection of all Medical Record Departments in the state and should give instructions for the rectification of the defects notices and improvement of the medical record maintenance system.

Conclusion

Medical records play a vital role in patient care. Medical Records Department maintains patient's records and generates statistical information at different levels, from the administrative, public health, study, research and evaluation point of view. The medical records are liable to summoned to courts of law. The accuracy and validity to information of various illness and health related conditions relies on valid and accurate medical record system. Thus every effort should be taken to improve the documentation and completion of medical records at all level. Hence the existing medical record maintenance system should be strengthened at all levels and Medical Record Department should be constituted in all the medical institutions; If the post of Medical Record Librarian is not sanctioned in an institution the section can be constituted by utilizing the services of one of the clerks and attenders / Nursing Assistants or posting necessary Medical Record Librarians through Hospital Management Committee. For starting such units technical guidance can be sought from the Medical Record Officer of the Directorate of Health Services or from the Medical Record Librarian of the nearby institutions.

Dr.V.R RAJU
DIRECTOR OF HEALTH SERVICES

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