



MEDICAL RECORD DEPARTMENT

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WHAT IS MEDICAL RECORD ?

The medical record is a legal document providing a chronicle of a patient's medical history and care. Physicians, nurse practitioners, nurses and other members of the health care team may make entries in the medical record.

The medical record includes a variety of types of "notes" entered over time by health care professionals, recording observations and administration of drugs and therapies, orders for the administration of drugs and therapies, test results, x-rays, reports, etc.



USE OF MEDICAL RECORDS

- To document the course of patient's illness & treatment.
- Communicate between attending doctors and other health Care professional providing care to the patient
- Collection of health Statistics.
- Legal Matters & Court Cases
- Insurances Cases





COMPONENTS OF MEDICAL RECORD

Front Sheet or identification Summary Sheet

Consent for Treatment

Legal Documents like referral letter, request for Information etc

Discharge Summary, referral slip

Admission notes, clinical progress notes, Nurses progress note

Operation report if operation has been performed

Investigation reports like, X-ray, pathology etc

Orders for treatment and medication forms listing daily medications ordered and given with signatures of the doctor prescribing the treatment and the nurse administering it



LABELING OF MEDICAL RECORD FOLDER

The following should be written on the medical record folder:

- Patient's name;
- Patient's medical record number
- Year of last attendance





ISSUE OF MEDICAL RECORD NUMBER / UID NUMBER

Medical Record Numbering Systems are
HOW WE GIVE A NUMBER to Medical
Records.

The MRN should be issued in straight numerical order from the NUMBER REGISTER commencing with the number 1. For example, if the last number given to a patient were 342, the number issued to the next patient would be 343 and the next 344 and so on.

In a Computerized System, UID / MR Number is auto generated and there is OPD visit number & IPD Visit Number

**Manual
System**

**UID Number is permanent
but OPD Visit number/ IPD
number may change**

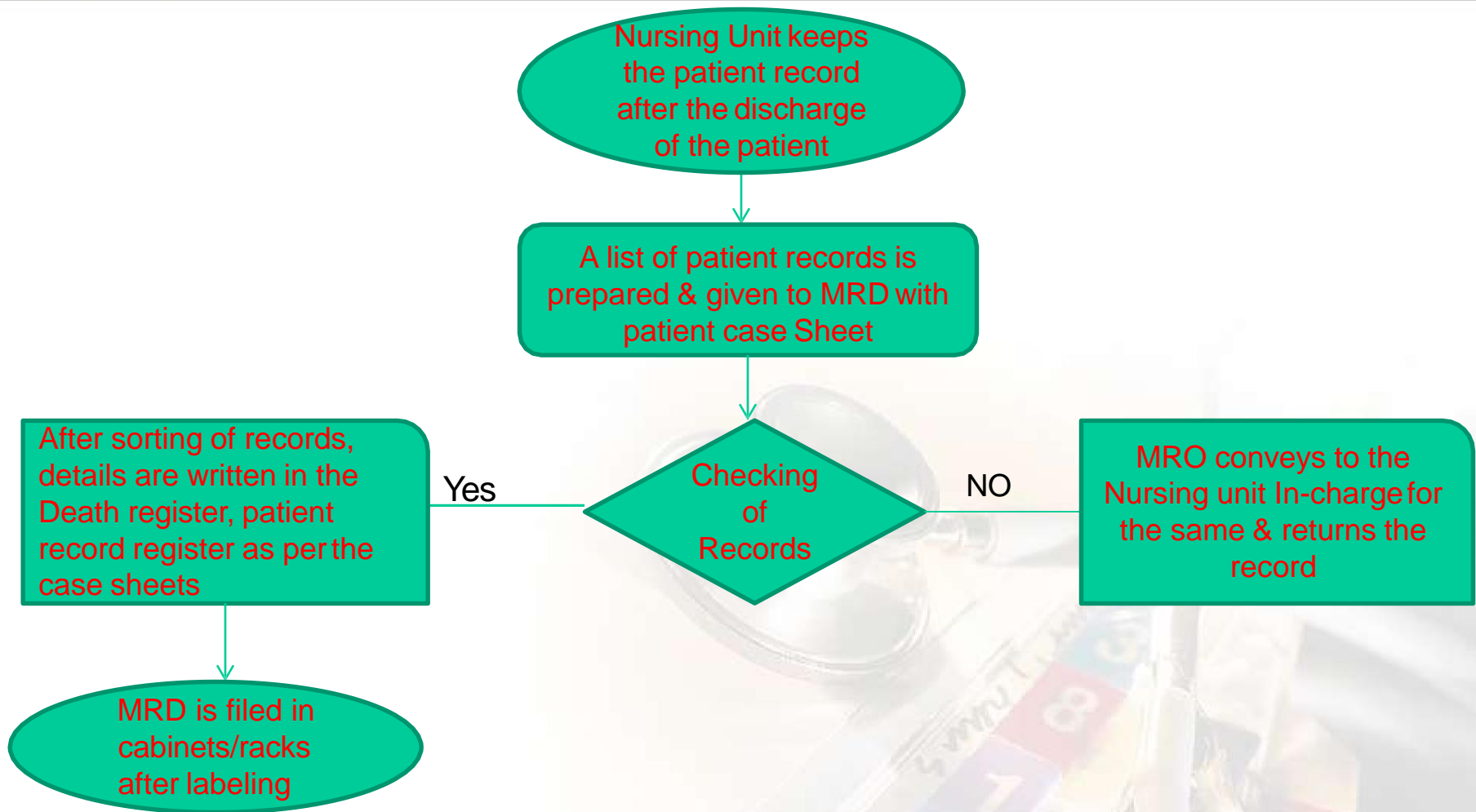


FUNCTIONS OF MEDICAL RECORD DEPARTMENT

- Filing of Medical records.
- Retrieval of medical records for patient care and other authorized use.
- Completion of medical records after an inpatient has been discharged or died.
- Coding diseases and operations of patients discharged or having died
- Evaluation of the Medical Record Service.
- Completion of monthly and annual statistics.
- Medico-legal issues relating to the release of patient information and other legal matters.



RECEIVE OF PATIENT RECORD IN MRD





RETRIEVE OF PATIENT RECORD



- The treating consultants and the other clinical doctors are authorized to have access to the discharged inpatient health record charts
- The non-clinical doctors and other administrative staff can access the charts with the written approval of the Medical Superintendent
- In all MLC and death cases the Medical Superintendent's written permission is a must to access them
- Concerned person from outside should get written approval from Patient in order to get the patient record
- In Insurance cases, the release of such information without the prior consent of the patient is permissible because the patient had waived his claim of this privilege at the time of taking out a policy with the corporation.



SEQUENCE OF MEDICAL RECORD

- Information & identification sheet
- Clinical Notes
- Diagnostic reports
- Blood Transfusion notes
- Nurse Notes
- Informed Consent

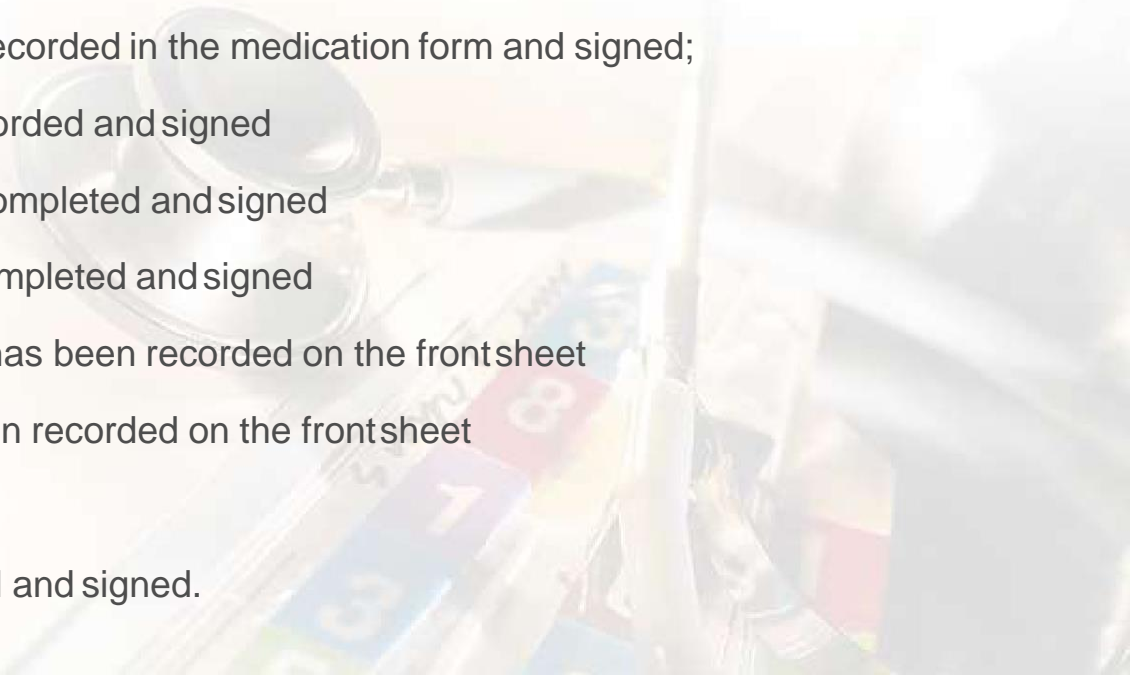
X-ray Films are stored Separately





COMPLETION OF MEDICAL RECORDS

- The consent form for treatment has been signed by the patient;
- Patient identification details (name and medical record number) are correct and entered on all forms
- Doctors have recorded all essential information
- Doctors have signed and dated all clinical entries
- The front sheet has been completed and signed by the attending doctor
- Nurses have recorded and signed all daily notes regarding the condition and care of the patient;
- All the orders for treatment have been recorded in the medication form and signed;
- Medication administration has been recorded and signed
- The anesthetic form (if any) has been completed and signed
- The operation form (if any) has been completed and signed
- The main condition/principle diagnosis has been recorded on the front sheet
- Operations and/or procedures have been recorded on the front sheet
- Diagnostic reports have been attached
- Discharge/referral summary is duly filled and signed.





RELEASE OF INFORMATION IN MLC CASE/COURT

- Requests from lawyers are usually registered and date of receipt of request recorded by the hospital administration and forwarded to the MRO for processing.
- The medical record is located and the patient's signature checked against the signature on the consent form in the medical record.
- The information requested is identified and the attending doctor is asked to write a report. A pre-designed form may be used (see example) or if a discharge summary is already in the medical record, it is checked and if it includes all the requested information, a copy is made. This will save the doctor having to write a new report.
- The MRO may write a brief letter acknowledging the request and enclosing the doctor's report. In some hospitals, a "With Compliments" slip is used instead of a letter from the MRO.
- The letter (or "With Compliments" slip), report and account (if required) are sent to the lawyer and a copy of each document is filed in the correspondence section of the medical record.
- The MRO notifies the hospital administration that the report has been sent.



PREPARING A MEDICAL RECORD FOR COURT

- On receipt of a subpoena, the MRO records the date and time the subpoena was received and records in a diary the date and time the medical record is due incourt.
- The MRO should notify the attending doctor and hospital administration that a subpoena has been received for the release of the medical record to court
- The MRO should locate the medical record. If the medical record is not on file, the MRO should find it and keep it in a safe place awaiting preparation for court. A tracer is made out showing that the medical record is with the MRO for medico-legal purposes
- The MRO should check that all necessary information, as specified in the subpoena, is in the medical record and that it is complete.
- Medical record is given in Duplicate and page numbers are written on the casesheets.
- When the original medical record is returned to file, the copy is removed from file and destroyed. To protect the privacy of the patient, it is important that if a medical record is copied, the copy **MUST** be treated with the same respect as the original and **MUST** be destroyed on return from court. These steps apply to original and photocopied medical records



RETENTION OF MEDICAL RECORDS

- Usually records are retention policy of the records depending upon the space availability within the Hospital, but every hospital more or less maintain
 - OPD records – 5 years
 - IPD records- 10 years
 - MLC cases – 30 years
- As per Forensic Department of India
 - Where there is chance of litigation arising for medical purpose of negligence, record should be preserved for at least 25 years, especially because there are rules where the minors have the rights to sue the doctor within three years from the date of majority, for the injuries sustained due to negligence of the doctor during the period of his minority.
 - Other medico legally important records should be preserved upto 10 years after which they can be destroyed after making index and recording summary of the case.
 - Routine cases records may be preserved upto 6years after completion of treatment and upto 3 years after death of the patient.
 - There are certain records in hospital, which are of public interest and are transferred to public records library after 50 years for release to public and those involve confidentiality of the individuals are released only after 100 years



Monitoring & Audit of Medical Records

- **Medical Record Committee** is established which is responsible for all matters relating to the content of Medical records and the provision of medical record services in the hospital.

Members of the Committee should consist of

Doctors from surgery & Medicine

Nursing Administration

Management Staff

Medical Record officer

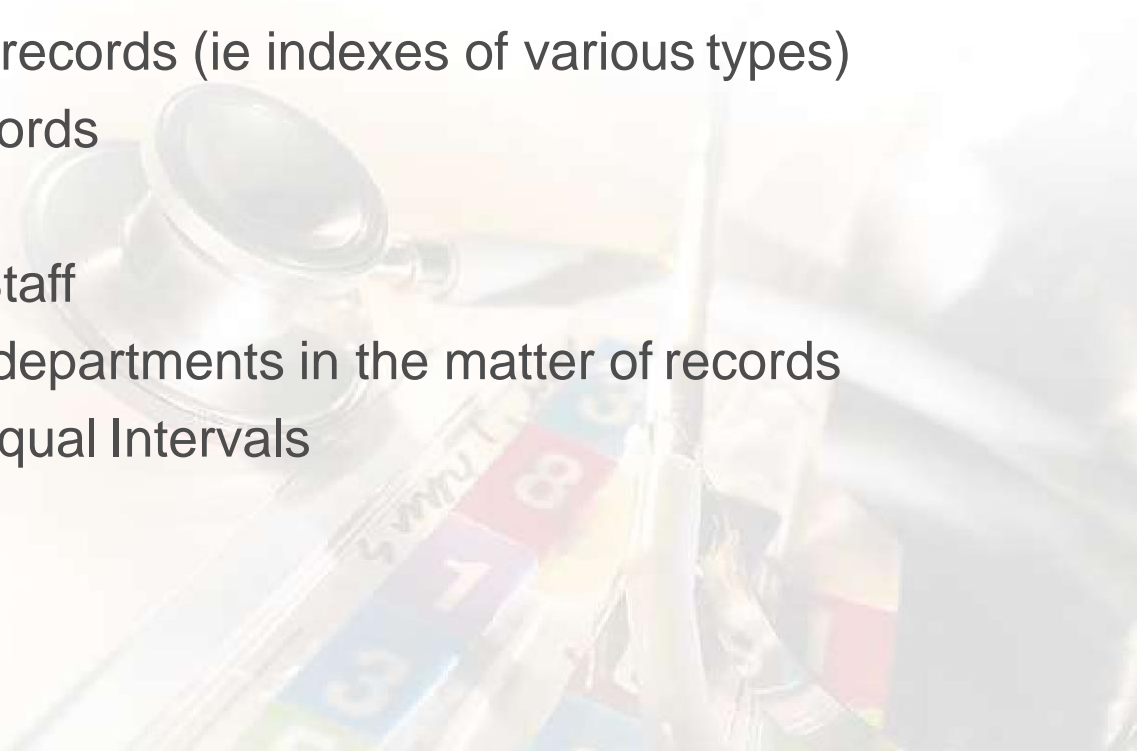
- **Responsibilities**

- Review of medical records to ensure that they are accurate, clinically pertinent, Complete and readily available for continuing patient care, medico-legal requirements, and medical research;
- Ensure that medical staff complete all the medical records of patients under their care by recording a discharge diagnosis and writing a discharge summary (where required) for each discharged patient within a specified period of time;
- Determine the standards and policies for the medical record and the medical record services of the health care facility;
- Recommend action when problems arise in relation to medical records and the medical record service;
- Determine the format of the medical record and approve and control the introduction of new medical record forms used in the health care facility (all forms should be cleared by the Medical Record Committee before being put into use)
- Assist and support the MRO in liaising with other staff/departments in the health care facility.



RESPONSIBILITY OF MEDICAL RECORD OFFICER

- Management of Medical Record Department (including Central Admitting and Enquiry Office)
- Development, analysis and technical evaluation of clinical records
- Development of secondary records (ie indexes of various types)
- Preservation of medical records
- Development of statistics
- Assistance to the Medical Staff
- Co-operation with all other departments in the matter of records
- Pest Control measures at equal Intervals





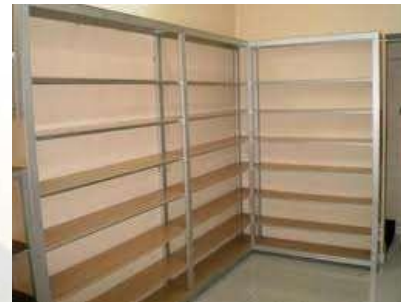
QUALITY INDICATORS OF MEDICAL RECORD DEPARTMENT

- Are medical records filed promptly?
- Is the file room clean and tidy?
- Are Master Patient Index cards filed promptly? An MRO checks the information on records with a doctor.
- Are all discharges returned to the Medical Record Department the day after discharge?
- Are the Medical Records Complete
- Are medical record forms filed in the correct order?
- Are all medical records completed within a specified time after discharge?
- Are medical records coded correctly?
- Are all discharges for last month coded by the middle of the next month?
- Are the monthly and yearly statistics collected within a specified time?



INFRASTRUCTURE REQUIREMENT FOR MRD

- Usually the space allocated for MRD is 1m²/ bed but depends on level of computerization





THANK YOU

