SRI LAKSHMI MEDICAL CENTRE AND HOSPITAL

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AMENDMENT SHEET

S.No.	Section no & page no	Details of the amendment	Reasons	Signature of the preparatory authority	Signature of the approval authority

CONTROL OF THE MANUAL

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

The holder of the copy of this Manual shall maintain it in current status by inserting latest amendments as and when the amended versions are received.

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

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

The authority over control of this manual is as follows:

Preparation	Approval	Issue
Administrative Manager	Chairman, Sri Lakshmi Medical Centre & Hospital.	Accreditation coordinator

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

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S.No.	Designation
1	Chairman
2	Administrative Manager
3	Accreditation Coordinator

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1.0 INTRODUCTION:

1.1 To meet the information needs of the care providers, management as well as other agencies that require data and information from the organization as per the prevailing laws and regulations.

2.0 SCOPE:

2.1 Hospital Management

2.2 Health Care Providers

2.3 TPA – Insurance companies

2.4 Patients

2.5 Government agencies

3.0 RESPONSIBILITY:

3.1 Doctors

3.2 Nursing staff

3.3 IT staff

3.4 Medical records department

4.0 ABBREVIATIONS:

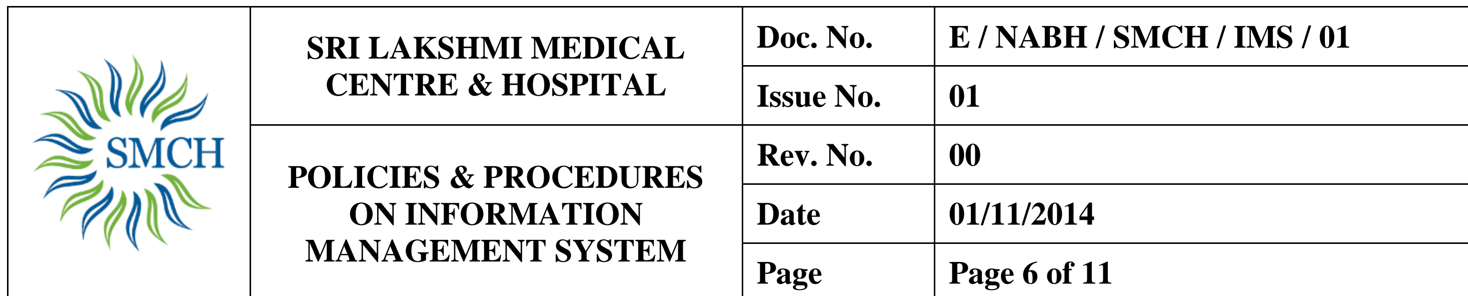
4.1 **NABH :** National Accreditation Board For Hospitals and Healthcare Providers

4.2 **AAC :** Access, Assessment and Continuity Of Care

4.3 **IP :** Indoor Patient

4.4 **OP :** Outdoor Patient

4.5 **HMIS :** Hospital Management Information System



5.0 REFERENCE:

5.1 NABH: Pre Accreditation Entry Level Standards for Hospitals, First edition, April 2014.

6.0 POLICY:

6.1 Processes for effective management of data:

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

6.1.2 Procedure for Timely and Accurate Dissemination of Data: The top managements and policymakers are obviously important users of information but certainly not the only ones. Depending on the specific department of the organization, information needs could be diverse. At the individual level, needs information in tapping the fullest business potentials available in an economy. Equally, organization needs information in identifying gaps which might be overlooked in policy programmes. Having examined the information available from various sources, people will make informed decisions in the pursuit of their individual interests. At the collective level, they will voice out their views through various channels regarding the present state of affairs and aspirations for future development, aiming to influence the continuous process of policy review and planning for a better future. Together all these contribute to the development of the organization. It is therefore not a coincidence that in an organization striving for sustained development, the genuine needs of information is translated into a right to know.

6.1.3 Storing and retrieving data: The records shall be stored in a place free from dust, insects and other pests/rodents. Proper infection control practices including pest/rodent control measures and frequent dusting shall be done. All the Medico Legal case records shall also be stored under lock and key. The IT department is responsible for electronic backup of data and for storing them in a secured location. Electronic data shall be available on the server, external hard drive and in a separate DVD Data storage device.

The assembling order for case sheet shall be:

1. Discharge Summary

2. Case sheet
3. Doctors Continuation Sheet
4. Consent form for Procedures
5. Pre-Operative Checklist
6. Post-Operative Checklist
7. T.P.R Chart
8. Intake/ Output chart
9. Drug Chart
10. Nurses Report
11. Investigation Reports (X-Ray, Lab etc.)
12. General consent

6.1.4 Retrieval of data shall be done with the patient MRD number.

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

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

6.2.1 Unique identifier:

6.2.1.1 Every patient is registered and assigned a unique ID Number.

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

6.2.2 Authorized entries in medical records:

6.2.2.1 All authorized personnel who can make an entry in the MR shall certify it by putting the sign, name, date and time against every entry made.

6.2.3 Contents of medical records reflect continuity of care:

6.2.3.1 All entries shall be: Unique identifier of patient on every document page. Written in black / blue indelible ink for handwritten documentation. No pencil entries. Dated and

signed (include day, month, and year). Timing of entries is required on Medication Administration, Operation Notes, and Nursing documentation. Legible and include clear, concise and pertinent patient information. Authenticated.Signature.Chronological.

6.2.3.2 Entries written in error shall have a single line drawn through and "ERROR" written above. Never erase, obliterate or use liquid paper correction fluid on a patient's record.

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

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

6.2.3.5 Written Signatures validate written orders and written notes.

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

a) Reason for admission, diagnosis and plan of care must be included in the documents.

b) Evidence of the initial patient assessment and all subsequent re-assessments.

c) Documentation of nursing care provided.

d) Any operation /Procedure performed in detail.

e) Name, signature, date, time on every entry made in the record.

f) The records should be legible.

g) The records should be in a chronological order demonstrating the continuity of care.

h) Transfer notes should be in accordance to the policy of transfer and should include-Date, reason for discharge and name of the receiving hospital.

i) Medication administration is recorded on the Medical Administration Record or area specific forms.

j) Specific care provided is evidenced on the patient care flow sheet.

k) Aspects of patient care during operative or other invasive procedures, is documented on forms specific to each specialized area.

l) Patient discharge instructions.

m) Discharge summary should be prepared and signed or countersigned by the clinician in charge.

n) Death summary should include – causes of death, date, time and should bear the signature of the clinician in charge.

o) The medical notes by the duty doctors have to be countersigned by the consultant-in charge within 24 hrs.

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

6.3.1 In patient medical records:

S.No.	Name of the record	Authorized person for entry
1.	Admission form	Doctors (provisional, differential diagnosis and Final diagnosis) Medical records technicians – ICD code, information related to date of discharge, mode of discharge and hospital stay.
2.	Admission Slip	Doctor
3.	History and finding on admission	Doctor, Resident doctors and Casualty Medical officer.
4.	Initial Assessment of Nurses	Staff Nurse In charge
5.	Dietary initial assessment form	Dietician
6.	Transfer information sheet	Doctors and nursing staff
7.	Progress report	Doctors
8.	Laboratory Investigation reports	Pathologist and Registrar
9.	Radiology investigation reports	Radiology Doctor
10.	Cardiology investigation reports	Cardiologist
11.	Neurology investigation reports	Neurologist
12.	Consent forms	Consulting doctor

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

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

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

6.3.4 When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital

6.3.5 The medical record contains a copy of the discharge note duly signed by clinician & the nursing sister in-charge

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

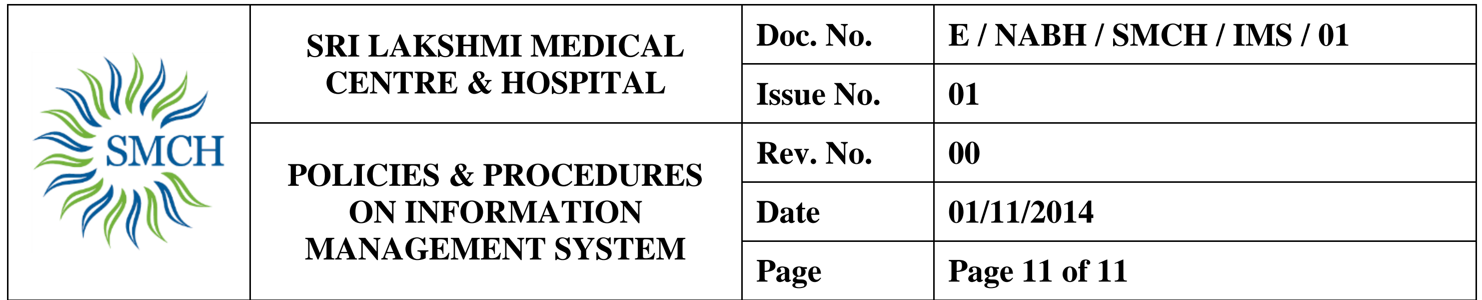
6.4 Maintaining confidentiality, integrity and security of information.

6.4.1 Procedure to ensure confidentiality, security and integrity of data: The Medical Record is a private document related to the patient history and treatment both in a physical and electronic format and should not be disclosed as it breaches the Code of Medical Ethics.

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

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

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



6.5 Retention time of records, data and information:

6.5.1 Retention period of records: The entire Outpatient case sheets shall be maintained for a period of 5 years after the last visit made by the patient. All the Inpatient case sheets shall be maintained for a period of 7 years after the last visit made by the patient. The MLC case sheets shall be retained lifelong or till the final judgment from the Supreme Court. The records which have crossed the retention period shall be selected and destroyed as per documented procedure.

6.5.2 Review: Medical records shall be reviewed once in a month. Review shall be done taking samples as per statistical table depending upon the population (No. of files generated during the month). The selection of samples shall contain both active and discharged patients. The review shall be done by Quality coordinators for the timeliness, legibility and completeness of the medical records in the IP Op patient files. Deficiencies: A report shall be prepared for the deficiencies observed during review process; the observed deficiencies shall be analyzed for the root cause and corrective action and preventive action shall be identified; the corrective and preventive action shall include if necessary to check entire population of files of the month to regularize the records.