

Policy on Information Management System

This document serves as a template to guide healthcare organizations in managing patient records, safeguarding data, and ensuring proper access and disposal protocols. It emphasizes confidentiality, integrity, and compliance with NABH standards.

Usage: Hospitals can customize this sample to align with their operational requirements, using it as a reference for drafting comprehensive and standard-compliant policies.

Sample for Reference

XYZ Hospital

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Amendment Sheet

Sr. No.	Section No & Page No	Details of the Amendment	Reasons	Signature of the Preparator y Authority	Signature of the Approval Authority

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Control of the Manual

1. 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.
2. 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.
3. Administrative Manager is responsible for issuing the amended copies to the copyholders, the copyholder should acknowledge the same and he /she should return the obsolete copies to the Administrative Manager.
4. The amendment sheet, to be updated (as and when amendments received) and referred for details of amendments issued.
5. 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

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'.

Distribution List of the Manual

Sr. No.	Designation

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Introduction

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.

Scope

- Hospital Management
- Health Care Providers
- TPA– Insurance companies
- Patients
- Government Agencies

Responsibility

- Doctors
- Nursing Staff
- IT Staff
- Medical Records Department



Abbreviations

- **NABH** National Accreditation Board for Hospitals and Healthcare Providers
- **AAC** Access, Assessment and Continuity of Care
- **IP** Indoor Patient
- **OP** Outdoor Patient
- **HMIS** Hospital Management Information System

Reference

NABH: Pre-Accreditation Entry Level Standards for Small Health Care Organization, First Edition, April 2014.

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POLICY

Processes for Effective Management of Data

A. 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.

B. 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.

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

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

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

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

A. Unique Identifier

- Every patient is registered and assigned a unique ID Number.
- The patient is given a registration card which he / she has to carry every time they visit the hospital.

B. Authorized entries in medical records

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.

C. Contents of medical records reflect continuity of care

- 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
- 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.
- All forms in the record must have been previously approved.
- No part of the medical record is ever to be removed after entry.
- Written Signatures validate written orders and written notes.

D. 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 reassessments.
- 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 achronological order demonstrating the continuity of care.
- h. Transfer notes should be in accordance with 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. Medical notes by the duty doctors have to be counter signed by the consultant-in charge within 24 hours.

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

Inpatient Medical Records

Sr. 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

- Only controlled forms and formats, which are approved by the management, shall be used by the service providers for the medical records
- The medical record contains information regarding reasons for admission, diagnosis and plan of care
- Operative and other procedures performed are incorporated in the medical record.
- 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
- The medical record contains a copy of the discharge note duly signed by clinician & the nursing sister in-charge
- In case of death, the medical record contains a copy of the death certificate indicating the cause, date and time of death.

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Maintaining confidentiality, integrity and security of information

A. 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.

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.

B. Access to information

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.

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.

Retention time of records, data and information

A. 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 for life or till the final judgment from the Supreme Court.

B. Destruction of Records

- Destruction of all records shall be done as under (If and when required)
- Medical records / registers etc. shall be disposed off after a request is put up by the department head.
- Approval process will be as follows:
 - Approval from the condemnation committee in writing.
 - For patient records, i.e., patient case files only advertisement in Hindi & English newspaper about destroying the Outpatient / Inpatient papers giving one month notice.
 - Those who wish to collect and do so papers will be handed over after verification.
 - List of documents destroyed is prepared and preserved.
 - Shredding of papers done in the hospital premises in the present of two persons one from MRD and One can be a security person.
 - After this, papers are discarded as general waste
 - Destruction of all records shall be done as under (If and when required)
 - Medical records, registers, etc. shall be disposed off after a request is put up by the department head

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Approval process will be as follows:

- Approval from the Quality committee in writing. For patient records, i.e., patient case files only advertisement in bilingual newspaper about destroying the Outpatient/Inpatient papers giving one month notice. Those who wish to collect and do so papers will be handed over after verification.
- List of documents destroyed is prepared and preserved. Shredding of papers done in the hospital premises in the present of two persons one from MRD and One can be a security person. After this, papers are discarded as general waste.
- Shredding of papers done in the hospital premises in the present of two persons one from MRD and One can be a security person in a manner that patient's confidential information is not identifiable
- The records which have crossed the retention period shall be selected and destroyed as per documented procedure.

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.

Disclaimer

The contents are sample references to aid understanding of the Standards and are not prescribed by NABH as mandatory practices. Healthcare organizations are encouraged to modify them as per their scope and practices. NABH is not liable for misinterpretation, erroneous use, or non-conformities during assessment due to unmodified use of these contents.