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SECOND EDITION

Medical Records

Organization and Management



GD Mogli

JAYPEE

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CHAPTER 3

General Medical Records Standards and Policies

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INTRODUCTION

A well organized medical record department should have clearly laid down written medical record standards, that should be developed in accordance with the institutional mission, goals, objectives and resources and to meet the standards proper comprehensive medical record policies and procedures have to be introduced.

STANDARDS FOR MEDICAL RECORD SERVICES

Standards are generally, a measure set by a competent authority as the rule for measuring quantity or quality. Conformity with standards is usually a condition of licensing, accreditation, or payment of service.

The hospital must maintain medical records that are documented accurately and in a timely manner and are complete and readily accessible for prompt retrieval of information including statistical data. Adequate patient case records must be maintained for all inpatients, outpatients and emergency patients. All significant clinical information pertaining to the patient must be incorporated into the patient's medical record. The content of the medical record must be sufficiently detailed and organized to enable the medical care team responsible for the patient to provide continuity of care, to determine at any time the status of the patient, and to review the diagnostic and therapeutic procedures performed and the patient's responses to treatment. The patient's health record must contain sufficient information to identify the patient, support the diagnosis, and the justify the treatment and end results.

The inpatient medical record must include at least the following:

Complete and accurate identification data.

1. A thorough medical history completed within the first 24 hours of admission to inpatient services.

2. A physician assessment completed within the first 24 hours of admission to inpatient services.
3. Evidence of appropriate informed consent.
4. Reports of all diagnostic and therapeutic procedures.
5. Reports of pathology and clinical laboratory examinations as well as radiology and nuclear medicine examinations.
6. Consultation reports and progress notes.
7. Operative and anesthesia reports.
8. A discharge summary written at the termination of hospitalization concisely recapitulating the reason for hospitalization, significant findings, procedures performed, and treatments rendered, the condition of the patient on discharge, and specific instructions given to the patient and family. Medical records must be confidentially assured, currently authenticated, legible and complete. The medical record is the property of the hospital yet is maintained for the benefit of the patient, the medical staff and the hospital. The hospital is responsible for safeguarding both the record and the information contained within it against loss, defacement, tampering or use by unauthorized individuals. The records of discharged patients must be entirely completed within 30 days following discharge.

Written policies and procedures for effective maintenance of medical records which are commensurate with overall policies of the health care facility should be made available to all concerned. The medical record department must be provided with adequate direction, staffing and facilities to perform essential functions. The medical record department must be provided with sufficient space and equipment to enable personnel to function in an effective manner and to maintain patient health records that are readily available for continuity of patient care. Basic medical statistical information must be readily obtainable through the medical record department with the type and amount to be determined by the medical staff and hospital administration, as well as by governmental authorities. The medical record director should encourage staff development through in-service training. The performance of medical record workers should be evaluated periodically to seek ways to improve medical record services. The role of the medical record director and medical record staff in quality assurance and utilization review functions and committee functions must be clearly formulated with screening patient records for compliance with established criteria. The medical record service should participate in the selection and design of forms used and in the determination of the sequence and format of the contents of the medical record. This department also should have a role in developing mechanisms to protect the privacy of the patients and practitioners whose records are involved in quality assurance activities.

Medical Record Policies

This chapter deals with hospital general rules and regulations for the following topics:

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Registration system

A central registration system with 24 hours service should ideally be maintained for all outpatients and inpatients. With this system, each patient will have one unit record and one permanent number used for all episodes of care. A separate registration for accident and emergency patients with 24 hours service should also be provided. On each visit to the casualty department, a new record is generally created and a new A/E number is usually assigned.

Numbering system

Six digit numbers are generally used for outpatients and inpatients starting from 00 00 01 and continuing to 99 99 99. A new patient receives a new hospital number only at the first time of registration. The casualty department also begins numbering with 00 00 01 on first day of the year and continues this sequence until the end of a given year. On the first day of the next year, a new numbering begins.

Patient master index

The patient master index is created with the important identification information for each new patient registered in the central registration area and filed alphabetically in the manual system and electronically through computer.

Patient ID and appointment card

An identification information card should be given to each new patient registered for outpatient or inpatient service.

Appointment system

The appointment system should be practiced in all referral/specialty hospitals. All patients should observe the appointment system except labor and emergency cases.

Investigation reports

Diagnostic reports of outpatients should be received and mounted by the medical record department in the respective patient records. Inpatient diagnostic reports should be received and mounted on the ward by ward clerk (AMRT) or nurse.

Health center

The health center or clinic generally directs patients to the hospital with a referral letter. The hospital and health center should develop a clear referral and appointment system for both new and established patients.

Referral of patient

Patients referred from either outside or within the hospital should receive three referral copies, the first two copies are presented to the hospital by the patient whereas the third copy is retained by the referring health center

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or clinic. After treatment, the first copy is forwarded to the health center or hospital as feedback information and the second copy is retained in the hospital. All three copies of the referral from patients referred within the hospital become part of main patient file.

Outpatient clinics

The names of all outpatient clinics with the names of the clinic chiefs in the hospital should be exhibited in the main entrance of the outpatient department and in each clinic, the name of the chief consultant should also be exhibited.

Outpatient clinic schedule

Each unit in consultation with the administration and the medical record officer should decide the number of new and follow-up cases to be booked for the clinic.

Accident and emergency service

Of the three accident and emergency forms, the first copy is be retained in the casualty department, the second copy is presented by the patient in the pharmacy to obtain medications and the third copy is retained by the patient. If this patient is admitted to either an outpatient or an inpatient service, the second and third copies become part of the main patient file. The first copy, however, is retained in the casualty department. If a patient has a unit record in the hospital and the casualty medical officer desires to review it, the medical record department should forward the record to him. All diagnostic investigation reports of a casualty patient are attached to the casualty form. If a patient is referred as either an outpatient or an inpatient, the reports become part of main patient file. All of the casualty record including the X-rays must be kept for 1 year in the A/E department. Later they may be transferred to the medical record department.

Admission office

The admission office functions around the clock and is responsible for the admission of patients, for the maintenance of the bed occupancy board and for the safekeeping of patient's property in the absence of patient relatives.

Direct admission

The ward manager in charge is responsible for registering the case in the admissions office within 2 hours of the patient's admission onto the ward.

Absconded patients

Information about absconded patients must be recorded in the patient's file with details concerning the date and time the patient was discovered to be missing from the ward. The treating physician should note and sign the record accordingly. The matter must also be communicated to the police.

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Against medical advice

The patient who leaves against medical advice should be considered as discharged. It should be ensured that the signature of the patient or his or her nearest relative is obtained in the prescribed form.

Declaration by the patient

Any patient who wishes to make a declaration before his death, should have such statements recorded in the patient's file in the presence of a magistrate. In the absence of a magistrate, the declaration may be recorded in the presence of three persons including the treating physician, a nurse and the hospital administrator or his representative.

ASSEMBLING OF FORMS IN THE MEDICAL RECORD FOLDER

The arrangement of forms within the folder is as follows:
Dividers:

i. Outpatient
ii. Correspondence
iii. Investigations
iv. Inpatient.

- Outpatient—Contains outpatient form and outpatient follow-up in chronological order, other forms added as required.
- Correspondence—Contains referral letter form, admission request form, consultation form, consent to operations and investigations, preoperative checklist, notification of stillbirth form, birth notification, A/E report, medical report, infection control form and incident report.
- Investigations—Contains laboratory mount sheets in which all laboratory reports are mounted in chronological order, X-ray mount sheets with all radiology reports mounted in chronological order, ECG, EEG and ultrasound examinations forms, and any other diagnostic investigation reports (other than those stipulated above) which should be kept in the following order: Laboratory X-ray, ECG, EEG, ultrasound and others.
- Inpatient—Contains admission and discharge sheets, history and physical examination reports, progress notes, physician's orders, anesthesia records, operation report forms, recovery records, labor records, diabetes records, resuscitation records, intensive care unit records, growth chart records, paramedical service records, nurses notes and observation charts, medication records, fluid balance charts, intake, output, and vital sign records, and discharge summaries with the most remote admission filed on the bottom and the most recent admission filed on top.

Completion of Records

Physicians must complete records prior to the discharge of a patient wherever possible. Otherwise, they must visit the medical record department periodically to review all these discharged records for completion. In any case, patient files should not be kept incomplete for more then 30 days. The

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medical record department should ensure that concurrent completion of records for effective coding, indexing and completion of records.

Coding of Medical Records

All the patient records including outpatient, inpatient and day care cases have to coded as per the latest International Classification of Diseases and Operations.

Filing System

There are many types of filing systems, such as serial, serial unit, unit, terminal, middle or straight numerical and alphabetical filing systems. Majority of the hospitals prefer serial or terminal digit filing system. Many hospitals where the unit record system is in vogue, have been tremendously benefited by the terminal digit filing system with color coding.

Missing Records

Despite the strenuous measures adopted to have good control of records, and not to loose, some percentage of records, however do not find in the respective place where they are suppose to be. This could be due to nonreceiving, not keeping in appropriate place and wrongly filing. Under this circumstances, when a patient attends either for outpatient or inpatient services, it becomes difficult to provide treatment without patient record. At times the physicians insist on original record for rendering care. The MRO might be able to retrieve them later, but at that stage the only option left for him to create a duplicate record with a similar number and with all previous ID data. The duplicate record should be retained by the MRO without filing and immediately should trace out the original records and incorporate all this forms of duplicate record into the original record and then the record should be filled.

Patient Having Multiple Records

As a general rule each patients should have one record and one number, due to improper system or negligence of the MRD staff, the patients may have more than one record. In that situation, it becomes necessary to retain one record by canceling others. The appropriate procedures is to retain a record as a priority, which is medicolegal nature, secondly obstetrics records, thirdly admitted record and fourth priority is oldest record, the remaining records have to be cancelled and given a cross reference numbers and bring all the documents including the investigation reports into the retained record. The cancelled empty folders with the cross reference number should be placed in their respective area. Any cancelled record number should never be allocated to a new patient.

Supply of Records

The medical record department is responsible for the supply of medical records to authorized persons for (a) patient care, (b) medicolegal, (c) administrative including investigation and financial, (d) clinical meetings. In case of medial education and research the records should not be sent out of the MRD.

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Legal Aspects of Medical Records

Medical records are the who, what, why, where, and how, of patient care. With the advancement and complexity of medical and surgical treatment in modern health care facilities, adequate and accurate medical records are essential as a documentary reference of the care rendered. The medical record is both a personal document and an impersonal document. As a personal document, the record identifies the patient by name and presents physical findings and treatment given. Such information is confidential; no one is allowed access to the record (not even next of kin) and no information is released without the written authorization of the patient. As an impersonal document, the patient's record is utilized for research or educational study and authorization from the patient is not mandated unless the patient will be specifically identified in reports or publications emanating from these scholastic endeavors.

A court of law has the right to summon patient medical records of patients. Records are not to be handled by anyone except those authorized as determined by the hospital (Fig. 3.1).



Figure 3.1: Patient record is also medical legal document, hence the court has the right to summon medical records to assess the factual information

Medicolegal Cases (MLC) Registration

Medicolegal register: There should be a central medicolegal register kept in the Accident and Emergency (Casualty) Department under the supervision of the Chief Medical Officer. All medicolegal cases admitted from casualty, outpatient, and inpatient services should be registered in the central medicolegal register. A medicolegal stamp should be affixed on each registered case to ensure that the case has been registered. The completed central medicolegal register should be kept under the custody of the Medical Record Officer.

All medicolegal cases registered in the hospital must be communicated to the police through the hospital administrator to ensure that the medicolegal case records are complete. These cases should be kept under safe custody of a responsible officer in the medical record department.

Temporary permission to leave the hospital

As a policy, any patient, who is hospitalized should not be permitted to leave the hospital. At the discretion of the treating doctor the patient maybe

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permitted to leave the hospital temporarily for a period of not more than 24 hours. If permitted and the patient fails to return within 24 hours, he or she should be treated as discharged and the necessary entries made in the record. In the case of patients, who return according to schedule, necessary entries of date and time of leaving and returning to the ward should be made in the patient file.

Consent

Written consent must be obtained from the patient or nearest relative for medical examinations, investigations, treatments and procedures performed in the health care facility. In the case of children, persons of unsound mind, unconscious patients, the consent of the guardian, the spouse or the nearest relative may be obtained. The consent of the husband is required if an operation deprives his wife of her marital functions.

General consent

Relating to medical examination, investigations and treatment, must be obtained by the admission office as routine, in all cases admitted to the hospital.

Special consent

In addition to a general consent, obtained for surgical procedures (operations), amputations, sterilizations, patients leaving against medical advice, donations of organs, postmortem examinations, etc. These must be obtained by the ward nurse in the presence of a witness. The legal responsibility is shouldered by the treating or operating surgeon.

Emergency operation

Procedure which has to be performed to save the life of a patient (for whom consent was not possible), this should be written in the patient medical file "an emergency operation is essential to save the life of patient and cannot be delayed" and should be signed by two physicians including the operating surgeon and the hospital administrator or his representative.

Patient leaving the hospital against medical advice

If a patient is discharged against medical advice, the signature of the patient or nearest relative should be obtained in a prescribed form. The patient or nearest relative should be informed of the consequences or risk involved and the hospital is not responsible for any adverse effects. In the event the patient or nearest relative refuses to sign a release, the patient record should contain a statement signed by the physician and duly witnessed setting forth the circumstances, reasons and warnings against such premature departure.

Release of Information

Confidentiality

Medical records and health information whether in verbal form or written documentation pertaining to any identified patient is confidential. As such

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the information available either in the form of medical records, disease and operation indexes, computer stored data, microfilm, photographs, videotapes, audiotapes, or any other device used for these purposes should be treated as confidential documents Therefore, only authorized staff are allowed to deal with such patient information.

Authorized staff

Authorized staff are those who are involved in taking care of the patient, normally including medical, nursing and paramedical personnel as well as the staff of the medical record department.

Release of information without the patient's permission

1. Conditions (e.g. injuries, poisoning, abortions or cases involving accidents, suicides and homicides); must be reported to the police or other legal authorities.
2. Communicable and other notifier diseases: Must be reported to the concerned authorities.
3. Events (births, deaths, fetal deaths): Must be reported to civil registration authorities, either directly or through family members.
4. Court order: The hospital is also obliged to provide information in response to a court order. All reports may be made available to the court without the patient's permission.

Model Policy for Redisclosure of Primary and Secondary Health Records

When photocopies or other reproductions of health records are provided to authorized external users, these copies will be accompanied by a statement:

- Prohibiting use of the information for other than the stated purpose
- Prohibiting disclosure by recipient to any other party
- Requiring destruction of copies after the stated need has been fulfilled.

As per the hospital policies, a written permission should be obtained before releasing patient information to the third parties which includes any private/government organization or employer.

The informed consent to release information from the medical record should be in writing. Informed consent means that the patient is aware, in a general way, what information will be released and the use that will be made of the information.

The written authorization (informed consent) should include:

1. Name of hospital that is to release the information.
2. Name of the organization/employer that is to receive the information.
3. Patient's full name, age, sex, nationality, hospital number.
4. Purpose for which the report is sought.
5. Type of information to be released whether complete or partial, in case of partial specific period mentioning the dates, or episode of treatment.
6. Validity of the consent (preferably 30 days).
7. Date of consent. The signature must be later than the date of medical information required.

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8. In case of report of the patients who is minor/mentally unsound, the authorization of release of information should be signed by the parent or guardian.
9. The information released should be used only to the purpose for which it was issued and later destroyed.

To simplify all the above information, that can be incorporated in the following "Authorization for Release of Information" form.

.....Hospital

Authorization for release of information

I / on behalf of ..... (full name), ... national, aged ....., Sex ....., ...,Hospital Number, undergone/ undergoing treatment in .....Hospital/Health Center in Accident and Emergency /Outpatient /Inpatient department from ..... to ....., for ..... hereby authorize your Hospital / Health Center, to release my complete /partial (.....) medical information as dates and episode mentioned above from my medical records in accordance with your hospital policy, to the ..... (organization / company / employer) for .....(purpose). By this authorization, I hereby release the hospital from legal liabilities that may arise due to disclosure of my information.

Date: Signature of the Patient/Guardian

Relationship of the Guardian/Nearest Relative

Note: In case of minor/mentally unsound patient authorization has to be signed by the guardian or nearest relative

In case of partial report please mention the specific episode of care

This authorization is valid for one report and 30 days from the date signed.

The original authorization for release of information form signed by the patient and a copy of the information released from medical record, should become part of the patient file.

Generally, as a policy, even police should also have patient consent to obtain the patient confidential information. However, with the magisterial authority, the medical information concerned about the patient whom is under investigation of police, can be released without the patient permission.

The hospital has to determine all the Government and other organizations,

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to whom the confidential medical information can be released by the hospital without the patient consent.

If any hospital want to maintain the confidentiality of patient care effectively, the records should not be handled by the patient.

Medical records and health information

These are the property of the hospital, therefore, all correspondence for medical information on patients in the hospital will be handled by the hospital administrator or his authorized representative. This includes insurance forms, workmen's compensation forms, medical certificates, letters to schools or places of employment, government forms, questionnaires, requests for case summaries from attorneys and courts of law, etc. The physician is not permitted to release any information except information related to patient care. Any request for information including medicolegal cases must be referred to the hospital director.

Removal of medical records and health information

The informational content of the medical record must be safeguarded against loss, defacement, tampering or use by an unauthorized person. Only authorized employees have the right to read or copy the contents of any patient's record. Any violation of the rules of confidentiality should be prosecuted and punished as per the existing laws.

Quality Assurance

The term quality assurance, which is a broad term that encompasses several components including utilization review, medical care evaluation, risk management, and peer review. For medical record maintenance in relation to patient care from the medical record service point of view, the following are considered:

A. Quality control
B. Quantitative analysis
C. Qualitative analysis
D. Medical audit
E. Patient care evaluation
F. Formation of medical record committee
G. Role of the medical record department in QAP
H. Evaluation of medical record service.

Quality control

Quality control is defined as those evaluation procedures that are performed systematically to ensure conformity with the established policies and standards. This procedure includes the quantitative and qualitative review of medical records and the evaluation of the patient care in medical audit.

Quantitative analysis

Quantitative analysis is the review of medical records to ensure that they are complete and accurate and meet documentation standards established by the

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Medical Record Committee and the Ministry of Health. It is the responsibility of medical record and statistical personnel to perform this analysis regularly on both inpatient and outpatient records.

Qualitative analysis

Qualitative analysis is the review of records to ensure that:

- Sufficient information is contained to justify the diagnosis, the treatment, and the end result.
- Opinions are supported by the findings. There are no discrepancies or errors in the records.

This qualitative review should be carried out regularly by the physicians at least once weekly and by the medical record committee once monthly.

Medical audit

Medical audit a "patient care review meeting" in the hospital preferably every month to discuss the patient care carried out by the hospital. The main object of this meeting is to review the overall work carried out in the departments including outpatient, inpatient, and emergency departments, and also to discuss the institutional deaths of the previous month. The attendees at this meeting should include all the clinical staff including seniors and juniors, the director of nursing, the medical record officer, a senior representative from each of the departments of pathology, biochemistry and radiology. The director of the hospital should be the chairman of this meeting. He should be very tactful in conducting this meeting because of the potential of sensitive topics. The medical staff secretary should take notes of important discussions during this meeting, and these notes might serve in the initiation of action for any important points brought out during the meeting.

Patient care evaluation

The purpose of patient care evaluation is to ensure that care of acceptable quality is being provided. The evaluation has to be done by physicians or other health care professionals through the review of medical records on a regular basis. Various approaches can be used to select the records for the review, e.g. the records of patients who died, those who had prolonged hospitalizations, those who left against medical advice and so forth. Another alternative is to:

i. Select 5% of discharged patient records on a random basis to be reviewed by the staff selected by the Medical Record Committee.
ii. Establish the criteria of good care for that condition in that particular facility or type of facility.

Note: The results of the medical audit should be treated strictly confidential and presented only to the authorized authorities (the hospital director or Ministry of Health) for their perusal.

Formation of medical record committee

There should be a medical record committee in all the hospitals to carry out regular quantitative and qualitative analysis of hospital services. The

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Medical Records
Organization and Management

Main features are classified into three parts. Part 1 deals with traditional medical records organization and management procedures in depth; Part 2 with computerizing medical records management system, software companies designing system analysis, and development of hospital information system (HIS) including medical, nursing and paramedical, and Part 3 includes all phases of development and comprehensive implementation with problems and solutions of electronic health records. This book would be of immense value to all medical colleges including medical, dental, nursing and paramedical, HIM educational programs, administrative, patient relation services, medicolegal and consumer courts, insurance, accounts, and the healthcare software companies. This is a practical hands-on book for solving healthcare delivery organizers professionals problems of health institutions.



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