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Standard Operating Procedure

MEDICAL RECORDS DEPARTMENT

MASTER

CONTROLLED

Prepared By	Reviewed By	Approved By	DP
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PROTOCOL OF ISSUING MEDICAL RECORDS OR INFORMATION

1 Abbreviations & Definitions

1.1 Abbreviations : MRD - Medical Records Department
MRO – Medical Records Officer
IP – In-patient
MLC – Medico Legal Case

1.2 Definitions: Applicable to issue of patient information from MRD.

2. Expected Outcome

In order to deliver the patient details to respective for their needful benefits.

3. Objective/Purpose

a. Issue to Doctors for case study purpose.
b. Issue to patients for follow-up care and insurance claiming.

4. Scope:

Issue of patient information to the doctors for study purpose and to patients for reimbursement purpose.

5. Procedure:

a. Issue of Records to Doctors:

1. Original IP, MLC & Expired files are issued to Doctors only on the basis of Written approved letter from the Medical Superintendent.

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2. Doctors, who are requesting for the patient files, should bring a written letter which is approved by Medical Superintendent.
3. Written letter should contain the following details;
    a. Hospital number & IP number
    b. Patient name
    c. Type of case (Normal IP or MLC or Expired)
    d. Reason for requesting file
4. MRD clerk will verify the letter & get approve from the MRO before retrieving the file.
5. Letter will be documented.
6. File will be retrieved from the filing area & tracer card will be placed with all the details filled in it. Only 10 files will be issued at a time.
7. Issued files should be returned back to MRD within a time period of three working days.
8. Once the file has returned back, tracer card is repaced by the file.

b. <u>Issue of Records or Information to Others:</u>

1. Birth and death certificates will be issued at **GMC,** Deorali after 15 days of birth or death. Birth and death reports to be preserved permanently.
2. Original IP medical records will not be given to the patient/patient party. A summary or a Xerox copy of records will be issued only on a written request to the Medical Superintendent.
3. Any certificate will be issued to the patients on prior written request to Medical Superintendent.
4. Wound Certificate will be issued to the police on request from the police department to the Medical Superintendent.
5. Death Claim form with respect to L.I.C. is to be filled up and issued to the relatives of the diseased or to the L.I.C. on written request to the Medical Superintendent.

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6. **Responsibility:** MRO, In-charge, Senior Clerk

7. **Records and References**

I. File issue requesting letter
II. Tracer cards

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FILE RECEIVING DESK

1. Abbreviations & Definitions

1.1 Abbreviations: IP – In-patient
MLC – Medico Legal Case
GDW – General Duty Worker

1.2 Definitions: To receive the IP files after their treatment from OPD & from Discharge section

2. Expected Outcome

To store the in-patient files after their discharge from the hospital and retain it as per the policy.

3. Objective/Purpose

a. To receive IP files from discharge section.

4. Scope:

To store the in-patients' file and retain it as per the policy

5. Procedure:

a. For Discharged Medical Records

1. Receiving discharged Medical Records file along with the discharge checklist from discharge desk.
2. Checking IP records as per the discharge checklist in presence of discharge clerk.

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3. Sorting out MLC records, Expired case records and other discharged records
4. IP files sent for Assembling & coding.

b. For Out-patient Medical Records (Psychiatry department)

1. Receiving OPD files with respect to OPD's with maintained registers at MRD.
2. Cross check will be done with the registers.
3. Total received OPD files will be undersigned by file receiving staff.

6. Responsibility: Senior Clerk/Clerk & Attender/ GDW

7. Records and References

I. File receiving register
II. OPD files
III. Tracer cards

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ASSEMBLING DESK

1. Abbreviations & Definitions

1.1 Abbreviations: IP – In-patient,
OP – Out-patient

1.2 Definitions: Assembling the discharged IP files in a single format.

2. Expected Outcome

To arrange all IP records in standard format so that it would help to review the file easily.

3. Objective/Purpose

Arrange the IP records in a standard format

4. Scope:

To assemble the discharge patient records to find for deficiency and completeness of the Medical records.

5. Procedure:

1. Receive discharged Inpatient Records.
2. Arranging all In-Patient sheets according to the checklist order list.
3. The continuity of date in all In-Patient sheets is maintained.
4. After arranging properly, at the left corner of the inpatient record, a corner slip is attached.
5. Assembling clerk checks for and mentions any deficiencies as per the checklist and signs the process checklist on completion.

6. Responsibility: Senior Clerk/Clerk

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7. Records and References

I. File receiving register
II. IP files
III. checklist

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ICD CODING

1. Abbreviations & Definitions

1.1 Abbreviations: ICD – International classification of disease

1.2 Definitions: To code the diagnosis for discharged patient.

2. Expected Outcome

This coding to disease provides the outcome of disease prevalence at particular place.

3. Objective/Purpose

To code the disease using ICD

4. Scope:

To do ICD coding for the In-patient medical records

5. Procedure:

1. Assembled inpatient records are received at coding desk.
2. Maximum 3 disease codes and 3 operation codes are entered in the IP record, as per the International Classification of Diseases, 10th Edition.
3. With reference to the ICD book, disease code numbers and operation codes are entered in the system.
4. For death cases, actual cause of death is coded first and then antecedent causes are coded.

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5. Coded records are signed by the coding technician and forwarded to discharge analysis desk.

6. Disease codes are alpha numeric while the operation codes follow only numerical system.

6. Responsibility: ICD Coding Clerk

7. Records:

I. ICD-10, 2nd Edition for diseases.
II. Patient record

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DEFICIENCY ANALYSIS DESK

1. Abbreviations & Definitions

1.1 Abbreviations: IP - Inpatient

1.2 Definitions: To check the deficiencies in IP records

2. Expected Outcome

This deficiency check will help to improve the completeness of patient records and quality of patient care provided.

3. Objective/Purpose

To check the deficiencies in patient records.

4. Scope:

To check for deficiency in the discharged patient medical records before they are stored.

5. Procedure:

1. Receiving discharged files along with the computerized discharge list after discharge analysis.
2. Sorting out inpatient records for deficiency.
3. Attaching the deficiency checklist at the first page of the file.
4. All deficiencies as per the checklist are mentioned in the remarks column.

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5. Unit wise sorting of entire deficient record and sending them to respective units for completion and collecting back on the same day.
6. After completion of deficiency by the concerned Doctor, the deficiency checklist is removed.
7. Signature by the deficiency clerk over process check /deficiency column and forwarded for storing at IP section.

6. Responsibility: Clerk

7. Records & Reference:

I. Deficiency Checklist.

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PSYCHIATRIC OUTPATIENT RECORDS DISPATCH DESK

1. Abbreviations & Definitions

1.1 Abbreviations: MRD – Medical records department

1.2 Definitions: To dispatch the OP files

2. Expected Outcome

To dispatch the Psychiatry op files so that patient will carry to the respective OPD.

3. Objective/Purpose

To issue the patient Psychiatry op files to patient.

4. Scope:

To dispatch the Psychiatry op files to patient.

5. Procedure:

A. For repeat registered patients:

1. Sticker generates in M.R.D. as soon as registration at registration counter.
2. Sticker contained Hospital No., Patient name, Department is then pasted on tracer card.
3. File is retrieved & tracer card is placed in that file place (to track the file existence).
4. Follow-up note has to attach in file & dept. visit sticker is pasted on follow-up note. Also the mini stickers were generated of the same patient & placed in file.

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5. Then files are forwarded for dispatching.
6. If the op folder is damaged then a fresh folder is attached.

B. For new registered patients:

7. New file is directly handed over to patient/ patient party at the time of new registration.

6. Responsibility: Clerk & GDW

7. Records & Reference:

I. OPD files.

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FILING OF OUT-PATIENT RECORDS

1. Abbreviations & Definitions

1.1 Abbreviations: OPD – Outpatient department
GDW – General duty worker

1.2 Definitions: To store the OP files

2. Expected Outcome

To file the OP files in filing area in order to Hospital numbers.

3. Objective/Purpose

To secure the patient files for their follow-up care.

4. Scope:

To store the patient files

5. Procedure:

1. Receiving OP files from all OPDs, Casualty, Trauma Centre against acknowledgement.
2. It will be cross checked in the computer and "Returned" entry is made.
3. It will be arranged according to the Hospital Number.
4. Filed in the shelf and tracer card is removed.
5. The investigations reports received from all Laboratories and OPDs.
6. Reports will be pasted and filed.
7. List of pending files is generated and informed accordingly.

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6. Responsibility: GDW

7. Records & Reference:

I. OPD files
II. Tracer card

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FILING OF LABORATORY REPORTS

1. Abbreviations & Definitions

1.1 Abbreviations: OPD – Outpatient department
MRD – Medical records department

1.2 Definitions: To store the lab reports in patient files

2. Expected Outcome

To file the lab reports in patient files for further treatment.

3. Objective/Purpose

To place the lab reports in patient files.

4. Scope:

Filing reports in OPD files.

5. Procedure:

1. Lab reports are been received to MRD from Central Lab after duty hours .i.e. after 5pm
2. After receive, reports will be serially arranged on the basis of Hospital numbers.
3. Serially arranged hospital numbers are been entered in Registers.
4. On the next day, these lab reports are been filed to the respective OPD patient files.

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6. Responsibility: GDW

7. Records & Reference:

I. OPD files
II. Tracer card

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CORRECTION IN PATIENT DETAILS

1. Abbreviations & Definitions

1.1 Abbreviations: MRD – Medical records department
MLC – Medico legal Case

1.2 Definitions: To correct the patient details

2. Expected Outcome

To correct the patient details in HIS system so that it will help to identify the actual details of patient.

3. Objective/Purpose

To correct the patient demographic details.

4. Scope:

Correct the patient's demographic details.

5. Procedure:

A. In case of Normal Cases

1. Patient/Patient party will be asked for valid attested documents or affidavit. Original documents will be verified & photocopy of those documents will be maintained at MRD.
2. By using name correction form, previous name & changing name will be entered and sent for the approval from Medical Superintendent (All valid documents should be enclosed with correction form).
3. Name will be corrected.

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B. In case of MLC cases

1. Patient/Patient party will be suggested to change their name in the Intimation, which was sent to nearest police station.
2. Patient/Patient party will be asked for the photocopy of that corrected intimation and with all valid documents.
3. All the documents will be verified & photocopy will be documented at MRD.
4. By using name correction form, previous name & changing name will be entered and sent for the approval from Medical Superintendent (All valid documents should be enclosed with correction form).
5. Name will be corrected.

C. In case of New Birth cases

1. Patient party will be asked for original Birth Certificate & valid attested documents for verification & photocopy will be documented.
2. By using name correction form, previous name & changing name will be entered and sent for the approval from Medical Superintendent (All valid documents should be enclosed with correction form).
3. Name will be corrected.

6. Responsibility: Medical Records Officer, In charge-MRD

7. Records & Reference:

Copy of Valid attested documents (Aadhar card, Voter Id) Affidavits & Birth Certificate

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MEDICAL RECORDS RETENTION / DISPOSAL

1. Abbreviations & Definitions

1.1 Abbreviations: MS – Medical Superintendent
OP – Outpatient, IP - Inpatient
MRD – Medical records department
MLC – Medico legal Case

1.2 Definitions: To discard the dormant files

2. Expected Outcome

To discard the dormant patient files with the necessary authorization.

3. Objective/Purpose

To discard the patient files for storage purpose.

4. Scope:

Applicable to retention of Medical Records.

Policy on Retention of Medical Records:

"It is the policy of Central Referral Hospital to preserve the medical records data and information in a safe and secure manner as per the MCI requirements and to destroy the record without a compromise in confidentiality and security of information".

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Guidelines:

1. Outpatient Medical Records to be preserved for a period of 3 years.
2. Inpatient Medical Records to be preserved for a period of 5 years.
3. Medico-legal case medical records (both IP & OP) to be preserved permanently.
4. Pediatric records to be preserved up to attaining the age of 21 years.
5. All records beyond the stipulated period to be disposed off with the permission from the Medical Superintendent.

5. Procedures:

Procedure	Responsibility	Documents/Record
Destruction of Medical Records planned and informed to M.S. for permission.	Request Letter	M.R.O, MRD.
After the planning, MS will ask for quotation from various scrap dealers.	Quotation	MRO , Scrap Dealer , Finance Executive
Once the scrap dealer is selected, the records are shred and then sold to the scrap dealers for disposal in the presence of persons designated by Finance Executive, Security Supervisor and M.R.O., MRD.	Receipt of scrap and Bill	M.R.O., MRD.

6.Responsibility: Medical Record Officer, Finance Executive, Security & Scrap dealer

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7. Records & Reference:

I. Dormant hospital numbers
II. Maintained registers

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