SOP 15 MEDICAL RECORD DEPARTMENT

1.0 POLICY: Complete and accurate Medical record for IP no .is maintained and it reflects continuity of care.

2.0 PURPOSE: To establish standardized Policies and procedures for use of Medical Records of the patient and smooth functioning of the department of Medical records without violating the basic patients rights of confidentiality of information.

3.0 DEFINITION: Nil

4.0 ABBREVIATION:
IP= Inpatient
MRD= Medical Record Department

5.0 SCOPE: All medical records

6.0 RESPONSIBILITY: MRD in charge

7.0 DISTRIBUTION: Medical Records department, All Patient care areas

Identification of medical records UHID no. is allotted to each patient.

8.0 PROCEDURE:

I. An inpatient's medical record is complete when the following criteria are met:
   - Its contents reflect the patient's condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress and condition at discharge; and
   - Its contents, including any required discharge summary or final progress notes, are assembled and authenticated.

II. Entry of Medical record: The medical records can be entered by
   - Treating consultant and Cross referred consultant
   - Resident Medical Officer and General Duty Medical Officers
   - Physiotherapist
   - Dietician
   - Nurse (only in nursing records)

The physical examination should reflect a comprehensive current physical assessment.
The recorded history and physical examination must be authenticated by a practitioner privileged to do so.

Contents of the medical record for inpatients:

a) Patient OPD card with his/her personal and Demographic Details
b) General Consent for admission
c) History and Physical Examination
d) Progress Notes
e) Nursing Assessment
f) Nutritional Assessment
g) Pain assessment and Functional Assessment
h) Nursing Medical Record
    - Treatment Chart
    - Intake Output Chart
i) Operating Room records
    - Surgery and Anesthesia consent
    - High Risk Consent
    - Anesthesia Forms
    - Operation Notes
    - Recovery room notes
j) Discharge Summary/Death Summary
k) Consent forms as applicable
l) Any other as per the requirement

The content of the medical record must be sufficiently detailed, legible and organized to enable:

a) The consultant responsible for the patient to identify the patient, provide continuing care, determine the patient's condition at a specific time, review the diagnosis and therapeutic procedures performed and the patient's response to treatment;

b) Another consultant to assume patient care at any time;

c) Any transfer from the hospital is documented.

d) And the retrieval of information required for utilization review, quality review, transfer recommendations, etc.

3. The medical records are readily available for all the health care providers of the respective patients (Ref: policy for access to information in medical record.)

4. All medical records is updated and maintained in a chronological order.

10.0 RECORDS AND FORMATS: Case Files