CHAPTER XII

MEDICAL RECORD SERVICES

12.1 Medical Record keeping has importance in efficient patient health care

12.2 In India, Medical Record keeping has not developed to the same extent as that in the western countries hospitals. Bhore Committee (1946) first stressed the importance of keeping adequate medical records, which was also reiterated by Mudaliar Committee in 1962.

12.3 Subsequent health and Hospital Review Committee (Jain Committee, Rao Committee) noticed the poor state of medical record in the Hospitals and recommended establishment of proper medical record section in each hospital

12.4 Safdarjang Hospital and J.I.P.M.E.R, Pondicherry are running Medical Record Technician Training (6 Months) and Medical Record Officers Training (1 Year duration) since 1968 and 1973 respectively on a regular basis sponsored by Central Bureau of Health Information under DGHS, Ministry of Health & F.W., New Delhi

12.5 C.M.C. Vellore is also conducting similar training programmes.

INDOOR PATIENTS RECORD

12.6 This department is to be headed by a trained Medical Record Officer.

12.7 The organization of this department will be divided into various desks as follows :

- Central Admitting and Enquiry Services and preparation of patients name index cards
- Census of in-patients
- Assembly of records
- Typing out discharge list for internal use
- Admission and discharge statistical analysis
- Completing of records
- Coding of diseases and operative procedures
- Indexing- Diagnostic and operations coding
- Filing

12.8 It is the personal responsibility of Medical Record Officer to keep records pertaining to medico-legal cases in safe custody.

12.9 This department should never allow medical records to be incomplete. Regular drill should be prescribed by this department to ensure that doctors complete the case records as soon as the patient is seen or discharged.

12.10 It is desirable that this department locates its technicians in OPD and accident and emergency department to see to the prompt completion and safe custody of records

12.11 It is the responsibility of Unit Chief to see that the case records of in-patients are complete in all respects and sent to Medical Record Department by 10:00 A.M., the day following the discharge of the patients.

12.12 Loss of medical records should be promptly enquired into by the medical records officer and brought to the notice of the hospital administration.

12.13 Court summons for production of medical records should be honoured. This is the personal responsibility of the technician concerned.

12.14 The department will compile a monthly report of medical statistics required by hospital administration.

12.15 The department will assist the medical staff in their research work when needed.

12.16 There should be a regular task force for weeding out old records. The minimum recommended period of retention is ten years except MLC record which is pending in court. The retention period for medical record is stated in DGHS letter No.10-3/68-MH dated 31.8.68

1.	Inpatient Medical Record (case sheet)	10 years
2.	Medico legal Registers	10 years
3.	Out patient record	5 years

12.17 This department should not part with their records to any outside agency without permission of hospital administration

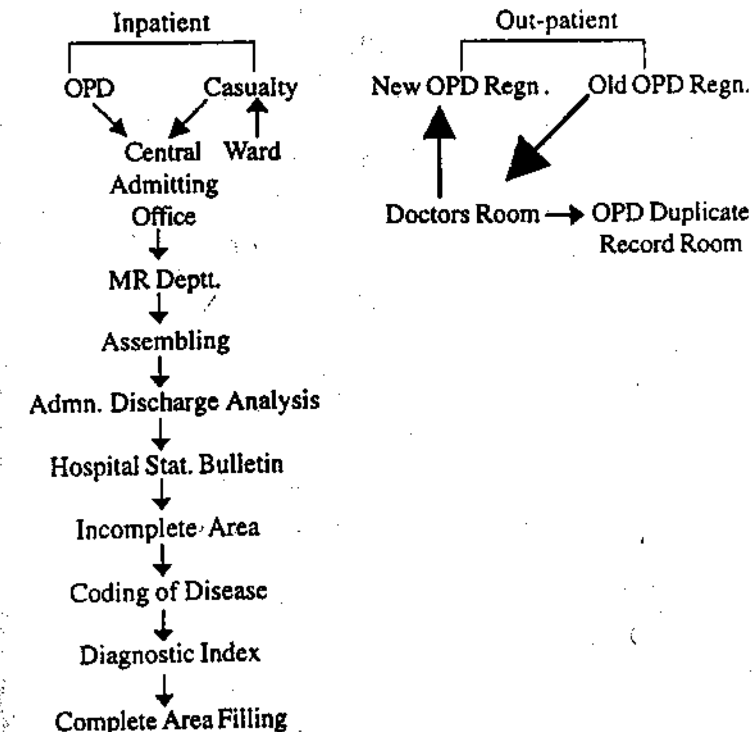
12.18 Medical Records should not be issued to hospital staff indiscriminately. They should be issued only on the written requisition of the Heads of the Department or hospital administration.

12.19 This department should not divulge the contents of any medical record to anyone without the permission of hospital administration.

12.20 Completion of forms sent by Life Insurance agencies and disability certificates with reference to medical records of patients should be done with speed and promptness. Fees for this purpose should be laid down by Hospital administration. The recommended fees are Rs.8/- for each Life Insurance report and Rs.32/- for disability certificate.

12.21 Medical Officer only will be competent to sign the reports/ certificates referred to in above. All other routine certificates like birth and death certificate may be signed by trained Medical Record Officer if they do not infringe any statutory requirement

12.22 The Medical Record can be managed through the following Flow Chart of Medical Record



12.23 It is desirable that Medical Record Department & Admission Office should be computerized for quick retrieval of information whenever demanded by the office.

OUTPATIENT RECORD

12.24 In the Outpatient department, every patient is given a registration number in the form of a card/ticket. This is returned to the patient with the history, examination finding, provisional diagnosis and treatment written on it. For attending special clinics, proper follow up record file to be kept in OPD.

MEDICO LEGAL CASES

12.25 All medico-legal case record registers should be sent to Medical Record Department and a Medical Record Officer/Technician should be made responsible for safe custody of the record

12.26 It is to be prepared in duplicate on a medical legal register where columns for entry are already printed

12.27 One carbon copy is kept as hospital record and first copy is given to Investigating Officer from Police Station of the respective area

GUIDELINES TO BE FOLLOWED WHILE MAKING RECORD OF MEDICO LEGAL CASE

12.28 Be sure that notes are legible.

12.29 All aspects are complete eg. history, examination, diagnosis, Lab. test results, treatment and disposition.

12.30 All entries to be signed with date and time by the person recording the entry and his/her name and designation should be written in capital letters.

12.31 Document disposition, advice and referral for further care to be noted.

12.32 Note the time of discharge and patients' condition at discharge.

12.33 Avoid vague and unsubstantiated statements.

12.34 Obtain written consent prior to examination.

12.35 Release original records only with court's order

FORMS

12.36 Design of forms should be with reference to the use it is put to. It is desirable that outside agencies specializing in this field are associated with hospital administration for designing forms that are used in the hospital.

12.37 It should be the aim of the hospital administration to provide adequate quantities of forms needed for hospital's working.

12.38 When forms are out of stock, for reasons beyond the control of hospital administration, substitutes should be procured and supplied to the indenters.

12.39 Medical and nursing staff should use the forms with utmost economy.