GSR INSTITUTE OF CRANIOMAXILLOFACIAL AND FACIAL PLASTIC SURGERY

IMS MANUAL

IMS-1

Information Management

POLICY:

All information pertinent to patient care and hospital administration are well maintained across the GSR Hospital. Manual and electronic system is used by keeping records in registers. This information are kept in following

1. Medical records
2. Registers
3. Files

Following laws that are applicable for information management are abided

1. IT act 2000
2. Code of Medical Ethics
3. RTI act2005

All information and data that are required to be contributed to external databases are maintained and communicated to appropriate authorities.

RESPONSIBILITY:

Manager Operations/Hospital Administration

PROCEDURES

Following guidelines is followed for effective management of information and data.

- Only authorized personnel can gain access toit
- The Staff and other hospital personnel in general access to the Hospital information on after written / confirmed approval fromAdministrator.
- Information are kept appropriatelysecured
- The confidential information (Hospital policy documents, hospital statistics etc) is kept under strict security of limited personnel and on limited systems to prevent itsmisuse.
- Special cases, like patients and/or their relatives, third parties is allowed to see records (e.g.; medical records) only after a documented procedure has been adheredto
- Manual and electronic both systems are used by keeping records in registers or Computers.
- The departmental head mention corrective actions during faulty use by unauthorized personnel and the same aredocumented.
- All the important data related to the national, state or local regulations are kept in external storage devices in order to safeguard them against loss, theft or damage.

Information needs of the patient, visitors, staff, management external agencies and community

- Mechanism to identify the information needs include feedback forms,patient calls. Eg.information needs of patient is met through OPD timings, availability of services,visiting hours for visitors, information on leave, standard operating procedures for the staff etc.
- External agencies are provided information as per the methodologies and guidelines laid down for the purpose.eg nagarnigam for general waste and other agency for biomedical waste handling are given the required information regarding the biomedical waste from our hospital-the weight of bags carrying the waste through bar code scanner etc.
- Organization uses electronic as well as manual record handling. Hospital information system for patient records in form of discharge summary, pictures, demographic data, history; central store software; accounting software; so on and so forth.
- Annual maintenance contract is present for all the printers, telephone etc. Annually maintenance is done for the same.
- The contingency plan -we switch over to manual system in an event of failure of software support or HIS system. As soon as the electronic system is recovered then the manually prepared data is uploaded on the software.
- Information resources include the website, OPD files etc. The website and file design has been done by a committee formed among the doctors of the hospital and administration staff.
- Design is coordinated with the I.T designing company, relevant information is passed and then a website and file is made.
- Similarly everytime a committee is formed with the pre existing purchase committee along with expert members in a particular field pertaining to which the work is to be done.
- The organization identifies all notifiable diseases after taking into consideration the local/state/national laws,rules and regulations.

- Process for data collection includes manual and electronic method. The capture of data can be done as per defined frequency such as weekly monthly yearly etc.
- Clinical and managerial staff is responsible for selecting relevant indicators etc. Medical record department committee does this.

IMS-2

Medical Records

1. 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.

2. IDENTIFICATION OF MEDICALRECORDS

A unique identity number is allotted to each patient.

3. POLICY

Complete and accurate Medical records are maintained for every patient and it should reflect continuity of care.

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

- Entry of Medical record: The medical records can be enteredby
  - Treating consultant and Cross referredconsultant
  - Resident Medical Officer
  - Speech therapist
  - Dietician
  - Nurse (only in nursingrecords)
  - The physical examination should reflect a comprehensive current physical assessment.
  - The recorded history and physical examination must be authenticated by a practitioner privileged to doso.
  - When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the

medical record provided the original information is readilyavailable.

- History (Inpatient Pediatric &Adolescent) – up to age16.

4. CONTENTS OF THE MEDICAL RECORD FORINPATIENTS

Charts and Forms

- Patient Registration Form with his/her personal and DemographicDetails
- General Consent for admission
- Consent for Discharge against Medicaladvise
- History and Physical ExaminationSheet
- NursingAssessment
- NutritionAssessment
- Pain assessment and FunctionalAssessment
- Physician's Order Sheet
- Patient and Family EducationForm
- Nursing MedicalRecord
  - Treatment Chart
  - Intake OutputChart
  - GraphicChart
  - InvestigationsChart
- Operating Roomrecords
  - Surgery and Anesthesiaconsent
  - High Risk Consent
  - Checklist for prevention of SurgicalErrors
  - Intra-operative nursingnotes
  - AnesthesiaForms
  - OperationNotes
  - Recovery roomnotes
- Discharge Summary/Death Summary
- Consent forms

Content of the Medical Record

- The content of the medical record, which includes written, must be sufficiently

detailed, legible and organized toenable:

- The practitioner 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;
- Another practitioner to assume patient care at anytime;

- ° And the retrieval of information required for utilization review, quality review, transfer recommendations,etc.

- Hospital inpatient medical records are required to contain at least thefollowing:
  - The patient's name, address, date of birth, sex and name of any legally authorized representative;
  - The patient's language and communicationneeds;
  - Emergency care provided to the patient prior to arrival, ifany;
  - Documentation and findings of the patient'sassessment;
  - Conclusions or impressions drawn from the medical history and physical examination;
  - The diagnosis, diagnostic impression orcondition;
  - The reason for admission or care, treatment andservices;
  - The goals of treatment and the treatmentplan;
  - Evidence of known advancedirectives;
  - Evidence of informed consent whenrequired;
  - Diagnostic and therapeuticorders;
  - Diagnostic and therapeutic procedures and test results relevant to the management of the patient'scondition;
  - Operativeandotherinvasiveproceduresperformed,usingacceptablediseaseand operative terminology that includes etiology, asappropriate;
  - Progress notes made by authorizedindividuals;
  - Reassessments and plan of care revisions, whenindicated;
  - Relevant observations;
  - Response to care, treatment and servicesprovided;

- o Consultationreports;
- o Allergies to food andmedicine;
- o Medications ordered orprescribed;
- o Medications dispensed or prescribed ondischarge;
- o Every medication order documented as administered or not administered and any adverse drugreaction;
- o All relevant diagnoses/conditions established during the course of care, treatment andservices;
- o Documentation of referrals and communications made to external or internal care providers and to community agencies;
- o Conclusions at termination ofhospitalization;
- o Discharge instructions to the patient and family;and
- o Discharge summaries or a final progress note or transfersummary;

5. CHART RULES AND REGULATIONS FOR INPATIENTS

- History and PhysicalExamination
- o A complete history and physical examination are documented and filed on the patient's medical record within the first 24 hours of admission and prior to the performance of anysurgery/procedure.
- o In the case of an emergency a preoperative note is recorded prior to the surgery/invasive procedure. In addition, the preoperative diagnosis &indicated diagnostic tests are completed and recorded in the patient's medical record before surgery/invasiveprocedure.
- o The history should include thefollowing:
- ▪ Chiefcomplaint

- Presentillness
- Relevant past, family, and social histories, appropriate forage
- Inventory of bodysystems
- Evaluation of patient's developmental age (pediatric/adolescent records only)
- Consideration of education needs and daily activities(Pediatric/adolescent recordsonly)
- Family and/or guardian's expectation for and involvement in, the assessment, treatment, and continuous care of the patient (Pediatric/adolescent recordsonly)
- Head circumference until fontanels close (pediatric) as appropriate to patient’s age &needs

o The physical examination should reflect a comprehensive current physical assessment.

o The recorded history and physical examination must be authenticated by a practitioner privileged to doso.

o When a patient is readmitted within 30 days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record provided the original information is readilyavailable.

o History (Inpatient Pediatric &Adolescent) – up to age16.

- Documentation of consideration of educational needs and dailyactivities.
- Documentation of patient's immunizationstatus.
- Documentationofperiodicreviewoftheplannedcourseofaction,asappropriate.

Thetreatment-planning process is completely individualized, based on current patient needs and clinical status. The treatment plan is updated when the patient's needsand response to treatment change. Document good daily progress notes with appropriate annotation of the parent's response to changes in the patient'sprogress.

- Post Operative Documentationincludes:

o Vitalsigns;

o Level ofconsciousness;

o Medications (including intravenousfluids);

o Blood and bloodcomponents;

o Any unusual events or post operative complications and management of such

events;

- Patient's discharge from the Post sedation or post anesthesia care area by the responsible licensed independent practitioner or according to dischargecriteria;
- If discharge criteria are used, they are approved by the medical staff. Compliance with discharge criteria is documented, and If the patient is discharged by a licensed independent practitioner, the practitioner's name is recorded in the post operative documentation.

- ProgressNotes
  - The admission progress note should summarize the present illness, pertinent past history, the pertinent physical and laboratory findings, the initial impressions of the physician and the initial diagnostic and therapeuticplan.
  - Progress notes (reassessments) should give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition, theresult
    oftreatment and plans for future care. Whenever possible, each of the clinical problems are clearly identified and correlated with specific orders as well as results of tests andtreatment.
  - An authenticated legible progress note is required daily to document medical necessity and acute level ofcare.
  - Progress notes must reflect the involvement of the attending physician in the patient'scare.
  - All progress notes must be signed anddated.

- Consultations
  - Consultation reports are a part of the patient's medical record and shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, the consultant's recommendations and the signature of theconsultant.
  - A request for a review by another consultant are noted in the physician's orders. The consultation request form are completed and placed on the patient's medical record.

  - Emergency or 'stat' consultations should be requested only when there is an

emergency or urgent need for the consultation. The consultation form will remain on thechart.

- Informed Consent: Informed consent must be obtained by a physician prior to any invasive and/or operative procedure from each patient or the patient's legally authorized representative. Informed consent implies that the patient has been informed of the procedure to be performed, the risks involved, any alternative procedures and the intended outcome. Informed consent is documented by making

  1) Appropriate progress notes in the patient's medical record and

  2) by obtaining the signature of the patient or his/her legal representative on the approved consent form. The progress notes should reflect the content of the discussion with the patient and the physician's evaluation of the patient's understanding and response to the information provided. All notes should show the date and time of thediscussion.

- OperativeReports

o A brief legible comprehensive operative progress note are entered into the medical record immediately after surgery to provide pertinent information for use by any practitioner who is required to attend the patient. A complete operative report should also be dictated immediately after surgery and should include thefollowing:

▪ Name of the surgeon and anyassistants
▪ Procedure(s)performed
▪ Description of theprocedure
▪ Findings
▪ Estimated bloodloss
▪ Specimensremoved
▪ Postoperativediagnosis

o The surgeon must authenticate the completed operative report as soon as possible followingsurgery.

- Pre and Post Anesthesia Evaluation

o There must be a pre-anesthesia note in the patient's medical record prior to administering anesthesia that is reasonably expected to result in loss of protective reflexes. The note shall specificallyinclude:

▪ Provisionaldiagnosis,

  - A history and physicalexam,
  - Any abnormallab,
  - Brief description of the plannedprocedure(s),
  - Planned anesthesia type, including risks, benefits andalternatives,
  - Patient's previous drughistory,
  - Other anestheticexperiences,
  - Any potential anestheticproblems

- A documented post anesthesia visit shall note any intra- operative or post-operative anesthesia complications.

- DischargeSummary
- The discharge summary should be completed before or shortly after the time of inpatient discharge from the facility and should follow the following approvedformat:
  - Patient Name:
  - IPNumber:
  - Hospital Service:
  - AdmissionDate:
  - DischargeDate:
  - Date of Surgery (ifany)
  - Discharge Diagnosis (documented without the use of abbreviations or symbols):
  - Reason forHospitalization:
  - Significant Findings
  - Procedures performed and care, treatment and servicesprovided:
  - Condition on discharge
  - Information provided to the patient and family (i.e., diet, medication, activity and follow-up, other dischargeinstructions):

- In the case of death, the discharge summary is replaced by a death summary stating essentially the same information, plus a summary of events immediately prior to death, including the cause of death as well as the date and time ofdeath.
- In the case of a patient leaving "Against Medical Advise" (LAMA), the summary

or progress note should include the sameinformation,

- All discharge summaries are authenticated by the responsiblepractitioner.

IMS-3

Medical Records Keeping Procedure

At GSR Hospital, the medical record are kept in an up-to-date and chronological order and presents an account of patient care.

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 appropriate and qualified personnel.

In case of death, the medical record contains a copy of the death certificate indicating the cause, date and time of death.

Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same.

Care providers have access to current and past medical record.

DOCUMENTATION OF MEDICAL RECORDS

The person who is making entry in the medical records is identified by his/her name and signature.

The medical record has only authorized abbreviations like MLC etc.

The organization has an effective process for document control including consent forms,policies,procedures which have been created, reviewed for adequacy and released by designated individuals.

IMS-4

Maintaining Confidentiality, Integrity and Security of information

POLICY:

All patient and non-patient related data and information generated, provided or contained in the hospital are kept appropriately confidential, integrated and secured.

All information concerning a user, including information relating to his / her health status, treatment or stay in the hospital, is confidential, and is to be treated as such

Hospital administrator are responsible for monitoring compliance of the laid down policy. No person may disclose any information contemplated in above mentioned point unless,

- The user consents to that disclosure inwriting
- A court order or any law requires such disclosure;or
- Non-disclosure of the information represents a serious threat to publichealth.

Without prejudice to the generality of this section, special precautions for the maintenance of confidentiality are taken, with respect to

- Persons affected with HIV / AIDSand
- Persons with mental healthproblems
- Person is danger to the national security or to the society.

Patient records are kept confidential, complete and secure. This are in accordance with *Indian Evidence Act, Indian Penal code, Code of Medical ethics*.
These records are safe guarded against loss, destruction and tampering. Adequate space, cleanliness and storage furniture are maintained in Medical records department

Privileged health information are used for the purposes of medico legal cases only.

Patient /physician and other public agency requesting for access to medical records are done as per Document.

SCOPE:

This policy is applicable to following

- ✓ Patient Information contained in Hospital Recordsmanually
- ✓ Information in Medicalrecords.
- ✓ Information kept in manual registers, forms andfiles
- ✓ Hospital Personnel's information in their personnelfiles

PROTOCOLS:

Medical records:

1. Access to be provided as per document 'Response to request for access to information in medical records'
2. Medical records are stored in medical records department after patient discharge and are kept undersecurity
3. Medical records for admitted patient are kept under custody of nursing staff and shall not be allowed for access to people not involved in direct patientcare.
4. A proper track of medical records are kept in case these records are transferred from one place toanother
5. .It are ensured by healthcare staff and medical records department that all pages and contents in the medical records and appropriately kept and are prevented from loss, tampering or destructions. No loose paper are allowed in medicalrecord
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.**RETENTION OF MEDICAL RECORDS POLICY**

1.0 POLICY:

Patient's clinical records data and information shall be retained for the time frame as per Government guidelines and regulations.

2.0 PURPOSE:

All in patient medical records will be retained as per laid down procedure.

3.0 ABBREVIATION:

MRD= Medical records Department

HOD= Head of the Department

MLC= Medico Legal Case

PNDT= Pre natal diagnostic test

ANC= Anti Natal Check Up

NABL= National Accreditation board for testing and calibration laboratories

TPA= Third party administration

4.0 SCOPE:

Hospital wide

5.0 RESPONSIBILITY:

MRD in charge

6.0 DISTRIBUTION:

Medical Record Department

7.0 PROCESS DETAILS:

DESCRIPTION OF THE PROCESS:

Retention period of In-Patient Records shall be as follows:

Opd Records :	:	Record are stored in system and not in hard copy
In Patient records	-	3 years
MLC in Patient Records	-	Not to be destroyed
Mortality register	-	Not to be destroyed
MLC registers	-	Not to be destroyed

Mortality records - Not to be destroyed

Emergency Register - 5 years

Admission, Discharge Register - 5 years

In Patient records of Pediatric cases- till the child (pediatric patients) attains 18 yrs of age

FINANCE

a. Bills 5 years

b. Charge sheets 5 years

c. Indents etc 5 years

OTHERS

a. All registers and departmental books 3 months after the register has been completely filled

b. Inventory books 1 year

MEDICAL RECORDS

1. All Medico legal patient records (electronic and manual) will be retained permanently.
2. Manual In-patient records (other than medico-legal) will be retained for 5 years.
3. Records of mortality will not be destroyed & will be retained permanently.

TPA/corporate patients' records – 1 year

Destruction of all forms shall be done as under

1. All forms / register etc shall be disposed off after a request is put up by the department head. Approval status will be as follows:

a. Medical records approved by – Chief of medical services

b. Finance related records approved by – Administrator

c. Others approved by - HOD

2. A record of all material destroyed post their retention period will be maintained in the department

Note: A press note to be given in local Medias (Regional newspapers etc) prior to destroying the Medical records.

ACTIVITY AND RESPONSIBILITY (TABULAR FORMAT):

S.No	Activity	Responsibility
1.	A policy & procedure must be laid down for retention of medical records.	Medical Record Department.
2.	All the protocols must be followed for retention of medical records and special concerned must be given to MLC cases.	Medical Record Department.
3.	Retention period of In-Patient Records shall be in accordance to the policy.	Medical Record Department.

8.0 REFERENCES: Nil

9.0 RECORDS AND FORMATS: Nil

10.0 SUPERSESSION DETAILS:

In case of new document this heading will be excluded.

This document supersedes the earlier version <Doc No…….., Revision dated………..>w.e.f. ………

IMS-5

Retention of Records

POLICY:

Medical records are stored in the Medical Record Departments for the following Retention Period

TYPESOFRECORDS	RETENTIONPERIOD
In -PatientRecord	05Years.
Out-PatientRecord	15Years.
MedicoLegalRecord	5 Years.

The process shall provide expected confidentiality and security and destruction of medical records, data and information are done only after completion of retention period and should be in accordance to standardized procedure.

IMS-6

Medical Audit

1. **PURPOSE:**

To retrospectively evaluate clinician's conformance to the norms and standards of the modern medical practice

To aid in improving quality of clinical care by highlighting opportunities forimprovement

2. **POLICY:**

   a. The medical records are reviewed and audited periodically and used as a tool for quality improvement of clinical services. A medical audit committee is composed for this who shall audit the records on quarterlybasis.
   b. Appropriate sample of the medical records are selected for audit. The sample should be based on statistical principles and representative of all records. Adequate mix of active and discharge cases are kept insample.
   c. The medical audit findings are kept confidential and circulated only to the care providers.
   d. Patients and staff anonymity are maintained in medicalaudits
   e. Based on the findings in medical audit, medical audit committee shall take appropriate corrective and preventiveactions.
   f. Medical audit are focused on timeliness, legibility and completeness of the medical records
   g. Appropriate corrective and preventive measures undertaken aredocumented.

3. **RESPONSIBILITIES**: Medical AuditCommittee

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IMS-6

Medical Audit

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e. Based on the findings in medical audit, medical audit committee shall take appropriate corrective and preventive actions.
f. Medical audit are focused on timeliness, legibility and completeness of the medical records
g. Appropriate corrective and preventive measures undertaken are documented.

3. RESPONSIBILITIES:

Medical Audit Committee

AMENDED POLICY FOR MEDICAL AUDIT

The medical audit is the systematic and objective review of healthcare through medical record analysis performed by physicians with the purpose of helping to improve the quality of healthcare.

The principal objective of medical audit is to evaluate healthcare quality but one of its consequences is the incentive towards excellence of the medical team and consequently favors the continuous education of professionals and improvement in all the activities inside hospitals which imply the correction of deficits found in the audit.

It has been demonstrated that regular audit can improve medical record quality by itself because clinicians would be more accurate when they know that their medical records will be audited. Adequate medical note keeping is critical in delivering high quality healthcare. However, there are few robust tools available for the auditing of notes.

The surgical tool for auditing records (STAR) was developed using Royal College of Surgeons (RCS) guidelines on medical record keeping.[1]

In continuation with the same, audit policy has been designed for GSR hospital .The medical record audit will be carried out once in 6 months by an appointed team of medical auditors. The team will essentially comprise a doctor and a nurse and other members as decided by the management committee.

Audit will be carried out for both active and passive records (last 6 months),5 random records from each month, for the last 6 months will be taken.

All records will be assessed through structured scoring system as adopted by the hospital which is recommended in literature.

The scoring system will be calculated by the auditor and the management committee and will be used as feeding tools for improving the documentation and record keeping.

1.Reference- Royal College of Surgeons. Guidelines for clinicians and medical records and notes. London:RCS;1994