PROTOCOLS FOR MEDICAL RECORDS

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INTRODUCTION

This document is the Medical Records Protocol for and to be used by all Medical Records Staffs of the **Gilead Medical and Dental Centre.**

The medical record is a powerful tool that allows the treating physician to track the patient's medical history and identify problems or patterns that may help determine the course of health care.

In addition to telling the patient's story, complete and accurate medical records will meet all legal, regulatory and auditing requirements. Most importantly, however, they will contribute to comprehensive and high quality care for patients by optimizing the use of resources, improving efficiency and coordination in team-based and interprofessional settings, and facilitating research. This is achieved in the following ways:

- **Quality of care:** Medical records contribute to consistency and quality in patient care by providing a detailed description of patients' health status and a rationale for treatment decisions.
- **Continuity of care**: Medical records may be used by several health practitioners. The record is not just a personal memory aid for the individual physician who creates it. It allows other health care providers to access quickly and understand the patient's past and current health status.
- **Assessment of care:** Medical records are fundamental components of:
    - external reviews, such as those conducted for quality improvement purposes and investigations

  - billing reviews (records must be properly maintained in order for patients to be properly billed.
  - physician self-assessments, whereby physicians reflect on and assess the care they have provided to patients (for instance, through patterns of care recorded in the EMR).
- **Evidence of care:** Medical records are legal documents and may provide significant evidence in regulatory, civil, criminal, or administrative matters when the patient care provided by a physician is questioned.

  This document explains how medical records must be kept, outlining general requirements and considerations about the collection, use, storage, and disclosure of patients' personal health information, with respect to both paper and electronic records. It outlines requirements with regard to access and retention periods to ensure continuity of care for patients.

The primary purpose of this document is to aid free flow of patient at the OPD and various inter-related departments.

The document summarizes each page by a detailed protocol at the Medical Records of the Gilead Medical and Dental Centre.

5.0 BIODATA COLLECTION

5.1 PURPOSE: To generate an accurate patient record documentation which will be useful to foster quality and continuity of care.

5.2 POLICY: It is the policy of the medical records department to capture the biodata of every patient who access healthcare at the Gilead Medical & Dental Centre.

5.3 PROCEDURE;

5.3,1 PRIVATE

- Welcome client/ patient at the OPD and explain procedures and cost of service to the patient/client.
- Offer the client/patient a Pre-registration form to fill.
- Make sure all portions on the Pre-registration form are filled.
- Assist patients who cannot fill the Pre-registration form.
- Capture the following
    1. Name
    2. Date of birth
    3. Nationality
    4. Contact details
    5. Residential address
    6. Work address
    7. Next of kin`s name and contact
    8. Occupation

9. Religion
10. Photograph of client/patient.

- Offer the patient a seat and complete registration.
- Make sure patients are not moved unessentially.

5.3,2 INSURANCE

- Welcome client/ patient at the OPD and explain procedures to the patient/client.
- Authenticate patient`s Health Insurance Card.
- Offer the client/patient a Pre-registration form to fill.
- Make sure all portions on the Pre-registration form are filled.
- Assist patients who cannot fill the Pre-registration form.
- Capture photograph of client/patient.
- Offer the patient a seat and complete registration.
- Make sure patients are not moved unessentially.

6.1 CORPORATE

- Welcome client/ patient at the OPD and explain procedures to the patient/client.
- Authenticate patient`s Introductory letter depending on the patient's policy with the Gilead Medical & Dental Centre.
- Verify from list of staffs On the GM medical software and identify patient.
- Offer the client/patient a Pre-registration form to fill.
- Make sure all portions on the Pre-registration form are filled.

- Assist patients who cannot fill the Pre-registration form.
- Capture photograph of client/patient.
- Offer the patient a seat and complete registration.
- Make sure patients are not moved unessentially.

6.2 EMERGENCY CASES

6.2,1 PROCEDURE;

- Quickly assist to convey to the emergency unit.
- Send a pre-registration form for new patients and take the patient`s biodata immediately after the patient has been stabilized.
- Check the patient`s mode of service payment and register accordingly. Refer to paragraph 2.4, 2.5, 2.6.

7.1 STORAGE OF HEALTH INFORMATION

7.2 PURPOSE: is to provide direct, high-quality patient care and serve the interests of the patient. It is also used for analyses, decision-making and forecasting.

7.3 POLICY: It is the policy of the Gilead Medical Records Department to store and keep the biodata of a patient confidential.

7.4 PROCEDURE;

- Log in to the Gilead Medical (GM) Software with your ***username*** and ***password.***
- Key-in patient`s biodata into the GM Medical software.
- Make sure to key data accurately.
- Confirm Patients ID number on the GM Medical and make sure records are filed appropriately.
- File pre-registration forms and other related patient manual records with system generated ID numbers in one file.
- Make sure the patient`s biodata is protected und kept highly confidential to all other clients at the OPD.

8.1 RETENTION PERIODS

8.2 PURPOSE: To set a baseline of when a patient`s medical record can be discarded or destroyed.

8.3 POLICY: The medical records department keeps and maintains the medical record of a patient

Healthcare records of an adult – eight years after last treatment or death.

8.4 GUIDELINES FOR THE RETENTION PERIODS OF MEDICAL RECORDS AT GILEAD MEDICAL & DENTAL CENTRE

Category	Medical Record Retention Period
1. Computerised/ electronic 2. medical records	
	Lifetime+6 years
2. Paper Hospital / Inpatient records	

a) Adults	15 years
b) Minors	Until the patient is 24 years of age
c) Lacks Mental Capacity	Lifetime +6 years
3. Paper Intermediate & **4. Long Term Care records**	
Includes all residential ILTC institutions	15 years
4. Paper Ambulatory / Outpatient records	
a) Outpatient	6 years or longer for "high risk" patients
b) Primary health care (PHC)	
c) Dental outpatient	
5. Others	
a) Electronic Patient registers	Lifetime + 6 years
b) Diagnostic images	6 years
c) Assisted Reproduction	Child's Lifetime +6 years

9.1 RETRIEVAL OF PATIENT`S MEDICAL RECORDS

9.2 PURPOSE: Provide on timely and accurate medical records to eligible users when needed.

9.3 POLICY: The medical records staff is under strict obligation to keep patient`s medical records highly confidential.

9.4 PROCEDURE;

9.4,3 PRIVATE

- Welcome client/ patient at the OPD.
- Give the patient a sheet of paper and take details. For eg. Name, D.O.B etc,
- Offer the patient a seat and search for the patient`s records from the GM software.
- Write a bill for the patient to pay at the cashier`s unit.
- Create a visit number using the patient`s receipt number.
- Check the patient in to the appropriate department GM medical software.
- Offer the patient with a number ticket.
- Direct the patient to the appropriate department. Eg. The triage, treatment room., etc

9.4,4 INSURANCE

- Welcome client/ patient at the OPD.
- Authenticate patient`s Health Insurance Card.
- Give the patient a sheet of paper and take details. For eg. Name, D.O.B etc,
- Offer the patient a seat and search for the patient`s records from the GM software.
- Create a visit number if time is due.
- Check the patient in to the appropriate department on the GM medical software.
- Offer the patient with a number ticket
- Direct the patient to the appropriate department. eg. The triage, treatment room., etc

10.1 CORPORATE

- Welcome client/ patient at the OPD.
- Give the patient a sheet of paper and take details. eg. Name, D.O.B etc,
- Offer the patient a seat and complete retrieval of patient`s records.
- Confirm the patient`s company.
- Create a visit number if time is due.
- Check the patient in to the appropriate department GM medical software.
- Offer the patient with a number ticket
- Direct the patient to the appropriate department. eg. The triage, treatment room., etc.

10.2 PATIENT REQUEST FOR A MEDICAL RECORD

Patient seeking for their health records will do the following;

- Offer the patient a Medical History request form to fill.
- Make the patient aware of when to pick it up.
- Forward the form to the head of medical records for the necessary action to be taken.
- The Medical Director will give the final authorization concerning the release of the health record.
- Medical records may also be released by court order, subpoena, or as otherwise

required by law.

10.3 PROCESSING OF HEALTH INFORMATION

10.4 PURPOSE: To provide how data will be analyzed and interpreted into useful information.

10.5 POLICY: To provide statistical reports monthly, quarterly and annually.

10.6 PROCEDURE;

- Identify records to process for eg. Mortality and morbidity statistics, bed management statistics,etc.
- Assembly
- Quantititive analysis
- Coding
- Retrieval
- Abstracting
- Tracking records while processing

11.1 APPOINTMENTS

Patients on appointments may be consulting with specialists like the dentist, the gynaecologist, etc.

11.2 PROCEDURE;

11.2,3 BOOKING APPOINTMENTS

- Refer all appointments to the information desk for booking.
- Information desk staff will get the available appointment days from the various practitioners.
- The staff will issue appointments to a client/patient based on the available date taking conditions that demands urgent attention into consideration.
- The patient/client will be contacted through phone calls, emails, SMS, etc. to remind him/her before the appointment date.
- A list of clients/patients on appointment will be given to the Medical records team for ID card verification, payment and corporate validity.

11.2,4 RECEIVING APPOINTMENTS

- Patient will visit medical records for registration (new patients /walk-ins).
- Confirm the patient's appointment and validity.
- Create a visit number for the patient and issue a number ticket.
- Check the patient in to the appropriate department.
- Direct patient appropriately.

11.2,5 WALK-IN`S

- Patient visits the medical records for registration-for insurance and corporate clients
- Create a visit number for patient.

- Direct patient to the appropriate department.

12.1 ABOUT GHIMA

12.2 Description

The Ghana Health Information Management Association (GHIMA) is a professional group made up of all cadre of staff in all Departments under the Ministry of Health involved in Planning, Records and Health Information management.

These cadre of staff consist of

1. Statisticians
2. Biostatistics Officers
3. Technical Officers (H.I.) & (Biostatistics)
4. Biostatistics Assistants
5. Medical Records Assistants

The association was formed under the Health Professions Regulatory Bodies Act, 2013 (ACT 857). It is a member of the following Associations

1. International Federation of Health Information Management Associations (IFHIMA)
2. Allied Health Professions Council (AHPC)
3. Ghana Federation of Allied Health Professions (GFAHP).

Members of GHIMA are represented in the following departments.

1. Ghana Health Service

2. Ministry of Health Teaching Hospitals

3. Quasi-Government Hospitals

4. Private Hospitals

5. Christian Health Association of Ghana (CHAG) Hospitals

6. MoH Training schools

12.3 MISSION

To provide eminent health information / data to aid the improvement of quality in health service delivery through application of innovations and adherence to ethical standards in managing data/HealthRecords.

12.4 VISION

1. To become the beacon of hope for the health service by maintaining and promoting quality health information management

2. To properly supervise all Health Information Practitioners on adherence to ethical standards in health Information Management

3. To inspire innovations, provide forums for the exchange of ideas, education and coaching for Information Managers to ensure continuous improvement in the process of managing health data.

13.1 CORE VALUES

13.1,1 Partner Friendly

GHIMA develops and strengthens collaborative relationships with all of its partners.

13.1,2 Professionalism

GHIMA ensures that members aim for the highest professional standards through adherence to principles in Health Information Management.

13.1,3 Innovation / Excellence

GHIMA pursues excellence and innovations to continuously improve service delivery.

13.1,4 Discipline

GHIMA believes that a disciplined workforce can effectively deliver a quality service. It is committed to being guided by professional ethics and codes of conduct in Health Information Management.

13.1,5 Integrity

Integrity is paramount and GHIMA strives to maintain the highest level of integrity in its operations.

13.2 AGM

The medical records staff attends AGM organized by GHIMA annually to keep up to date information for all members of GHIMA.

13.3 The objects:

Finding remedies to conundrums to facilitate quality health care delivery and accessibility through research.

2. To exercise professional supervision over members with a view to maintaining a high standard of professional competence and conduct.

3. To promote the science and to develop the practice of Health Information Science for the benefit of mankind.

4. Promoting healthy lifestyles through analysis and interpretation of health outcomes

through health education.

5. To foster the spirit of brotherliness and unity among all Health Information Managers in Ghana and the world at large.

6. To cater for the social, economic and professional needs of the members.

7. For the purpose of carrying out the objects, the Association shall seek to have influence and secure for members such definite status and recognition as may assist members in the discharge of their duties.

8. To hold meetings for the delivery of lectures, for the reading of papers, and for the discussion of scientific and technical matters as well as other subjects of general interest.

9. To issue on request, copies of lectures and professional transactions to members and others interested in Health Information Science.

14.3 MEANING OF WORDS

Biodata; Information regarding an individual's personal information when registering a patient.eg date of birth, name, gender, etc.

New patient; A patient who visits the facility for the first time within one-year calendar.

Private; A patient who pay immediate cash to services rendered.

Medical Records;

The medical record covers all clinical encounters and original inpatient and outpatient records generated at the time of admission or outpatient attendance. Also called a medical record, It contains all of the data collected for an individual patient.

Retention Period; the end of the life cycle of a patient's Health Records

Computerized / Electronic Medical Records; Computerized and/or electronic medical records include all records produced by electronic systems and paper medical records which have been digitized into an electronic format.

Walk-Ins; a person, as a client or patient who arrives at the facility without an appointment.

15.1 SOURCES

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