1) PURPOSE:

a) To maintain complete and accurate medical record for every patient of the hospital related to both IP & OP services, such that the medical record accurately reflects the continuity of care. To establish standardized Policies and procedures for management of Medical Records of the patient and smooth functioning of the department of medical records without violating the basic patient's rights of confidentiality. The management of Medical Records is as per updated statutory guidelines.

2) IDENTIFICATION OF MEDICAL RECORDS

a) A unique patient identification number (Outpatient / Inpatient No.) is allotted to each patient.

3) DEFINITION:

a) Continuity of care: A process of providing care and necessary documentation such that the care provided is defined by set standards and guidelines as defined by the hospital to provide comprehensive and continuous care to the patient concerned

4) ABBREVIATIONS:

a) IP – Inpatient services
b) OP – Outpatient services

5) SCOPE:

a) Hospital wide

6) RESPONSIBILITY:

a) MRD in charge
b) Nursing In-Charge
c) Medical Superintendent
d) Nursing Staff
e) Doctors

7) DISTRIBUTION:

a) Medical Record Department

8) PROCESS DETAILS:

a) Medical Records Retention Process is as defined below:
   i) All medical records (IP & OP) should be stored in digitized form as they contain valuable information
   ii) All medical records (IP & OP) should be digitized on regular and continuous basis and kept indefinitely for future reference
   iii) All Non – MLC Case Records/Medical Records (expect Pediatric / Neonatal Records) should be retained in hardcopy form for a minimum of 7 years from the date of their

last update. It should be ensured that a digital copy of the case record is available before destruction of the original hardcopy of the Medical Records.

iv) All Pediatric Records should be maintained till 18 years from the last updated date of records

v) All Neonatal Records should be maintained till 21 years from the last updated date of records

vi) In case of Mental Retard/Illness cases – the medical records should be retained indefinitely

vii) All Medico Legal Case Registers and Records in hard copy form should be stored till the disposal/closure of all the ongoing cases respective to the Medico Legal Cases/records in any of the courts related to these said records.

viii) All Medico Legal Case registers and records should be stored in Hard copy form for a minimum period of 10 years. After which a review should be conducted regarding the MLC record for further retention based on its use for any pending court cases

ix) The management can decide on case-by-case basis of the Medical Records that needs to be retained indefinitely for future reference.

b) Medical records are the property of the hospital and the treating doctor. It is a confidential communication of the patient and cannot be released without his permission

i) All requests for Medical Records should be approved by the Medical Superintendent in writing

ii) All patients have right to access their records and obtain copy of those records. The patients should submit written request to the treating doctor/hospital Medical Superintendent to obtain the said copy of records

iii) Patient's legal representative has the right to those records as long as patient has signed a release of records to accompany any request from the legal representative

iv) Other health care providers have the right to the records of the patient, if they are directly involved in the care and treatment of the patient

v) Parents of a minor also have access to patient's medical records

c) Process for release of records:

i) Request for medical records by patient or authorized attendant should be acknowledged and documents should be issued within 72 h. A relevant register should be maintained to document the process

ii) Maintain the register of certificates with the detail of medical records issued with at least one identification mark of the patient and his signature

iii) Effort should be made to computerize the records for quick retrieval

iv) Certain document must be given to the patient as a matter of right. Discharge summary, referral notes, or death summary are important document for the patient. Therefore, these documents must be given without any charge for all including patients who discharge themselves against medical advice

v) Doctors/Hospital authorities are not under any obligation to produce or surrender their medical records to the police in the absence of valid court warrant

vi) A subpoena to produce clinical records is a form of court order. Failure to comply is in contempt of court and may be punished. Medical records which are subpoenaed are to be made over / handed over to the court and not to the solicitor who sought the subpoena

d) Process for disposal/destruction of medical records:

i) Public notice of destroying the records in English newspaper and in one vernacular paper mentioning the specific date up to which destruction will be sought

ii) Give a time limit of 1 month for taking away records for those who want the records with written consent

iii) After 1 month destroy the records up to date specified except for following

(1) Where litigation is going on

(2) Where future trouble is expected

(3) Mentally ill or retarded patient

(4) Pre-litigation process of notice exchange is going on

e) Mandatory Records that needs be maintained in Hard Copy only:

i) Consent needs to be on hard copy

ii) Referral to doctor need hard copy

iii) Police case related records needs hard copy

iv) Certificate of fitness should be on hard copy

9) RECORDS:

S No	Record	Responsibility	Retention/Review
1	Medico Legal Registers	MRD In-charge	As per MRD Policy
2	Medical Records	MRD In-charge	As per MRD Policy
3	MRD Register for MLC Cases	MRD In-charge	As per MRD Policy
4	MRD Register for Release of Case Sheets	MRD In-charge	As per MRD Policy
5	MRD Register for Disposal / Destruction of Medical Records	MRD In-charge	As per MRD Policy
6	MRD Records Movement Log Register	MRD In-charge	As per MRD Policy