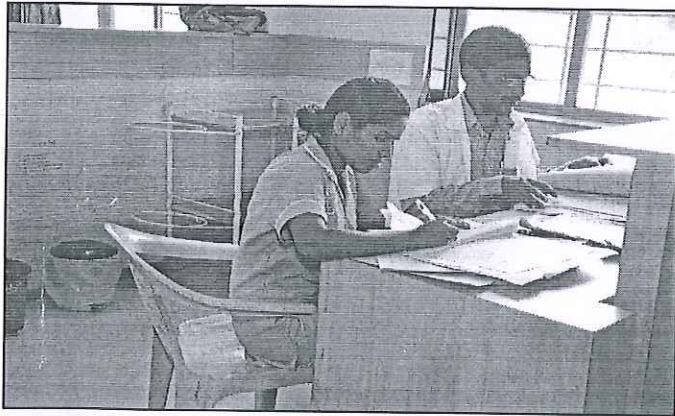


# DPU

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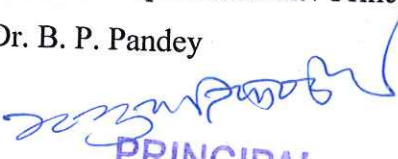

## INFORMATION MANAGEMENT SYSTEM (IMS)





# DPU

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## CONTROL OF THE MANUAL

The holder of the copy of this manual is responsible for maintaining it in good and safe condition and in a readily identifiable and retrievable.

The holder of the copy of this Manual shall maintain it in current status by inserting latest amendments as and when the amended versions are received.

Deputy Medical Superintendent is responsible for issuing the amended copies to the copyholders, the copyholder should acknowledge the same and he /she should return the obsolete copies to DMS.

The amendment sheet, to be updated (as and when amendments received) and referred for details of amendments issued.

The manual is reviewed once a year and is updated as relevant to the hospital policies and procedures. Review and amendment can happen also as corrective actions to the non-conformities raised during the self-assessment.

The authority over control of this manual is as follows:

Preparation	Approval	Issue
IMS Incharge Dr. Neeta Mahesekar	Principal /MS Prof. Dr. B. P. Pandey	Accreditation coordinator Dr. Jayashree Patil

The procedure manual with original signatures of the above on the title page is considered as 'Master Copy', and the photocopies of the master copy for the distribution are considered as 'Controlled Copy'.

### Distribution List of the Manual:

S.No.	Designation
1	Principal / Medical Superintendent
2	Deputy Medical Superintendent
3	Accreditation Coordinator

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6.0	Policy and procedures <ol style="list-style-type: none"><li>1. Policies &amp; Procedures exist to meet the information needs of the care providers, management of the hospital as well as other agencies that require data &amp; information from the hospital</li><li>2. Process of effective management of data</li><li>3. A Complete &amp; accurate medical record for every patient</li><li>4. The Medical record reflects continuity of care</li><li>5. Documented Policies &amp; procedures are in place for maintaining confidentiality, integrity &amp; security of information.</li><li>6. Retention time of Records, data &amp; Information</li><li>7. Review of Medical Records.</li></ol>	7



**1.0 INTRODUCTION:**

1.1 To meet the information needs of the care providers, management

**2.0 SCOPE:**

2.1 Hospital Management

2.2 Health Care Providers

2.3 Patients

**3.0 RESPONSIBILITY:**

3.1 Doctors

3.2 Nursing staff

3.3 IT staff

3.4 Medical records department

**4.0 ABBREVIATIONS:**

4.1 **NABH** : National Accreditation Board For Hospitals and Healthcare Providers

4.2 **IPD** : Indoor Patient Department

4.3 **OPD** : Outdoor Patient Department

4.4 **DMS** : Deputy Medical Superintendent



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SYSTEM**

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<b>Issue No.</b>	<b>01</b>
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**5.0 REFERENCE:**

**5.1 NABH :** Pre Accreditation Entry Level Standards for Hospitals, Second edition, April 2016.

**6.0 POLICY:**

**6.1 Processes for effective management of data:**

**6.1.1 Management of Data:** All the form and formats for data collection are standardized and controlled. The analyzed data is presented to the top management on a regular basis by the quality managers.

**6.1.2 Storing and retrieving data:** The records are stored in Medical Record Department and is ensured free from dust, insects and other pests/rodents. The IT department is responsible for electronic backup of data and for storing them in a secured location. Electronic data is available on the server and external hard drive .

**The assembling order for case sheet:**

1. Case sheet
2. Consent form
3. Doctors Continuation Sheet
4. Nurses Daily Record (T.P.R Chart, Intake/ Output chart , Drug Chart )
5. Investigation Reports (X-Ray, Lab.)
6. Discharge Summary



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6.1.4 Retrieval of data shall be done with the patient's OPD or IPD number.

6.1.5 Tracer are placed when the files are retrieved, which easily helps to track the record.

6.2 The organization has a Complete and accurate medical record for every patient as below:

6.2.1 Unique identifier:

6.2.1.1 Every patient is registered and assigned a Permanent Registration Number.

6.2.1.2 The patient is given a registration card which he / she have to carry every time they visit the hospital.

6.2.3 Contents of medical records reflect continuity of care:

- All entries are with O.P.D./I.P.D. Number of patient on every document page.
- No pencil entries.
- Dated and signed (include day, month, and year).
- Timing of entries is required on Medication Administration, Operation Notes, and Nursing documentation.
- Legible and include clear, concise and pertinent patient information. Authenticated. Signature. Chronological.



- 6.2.3.2** Entries written in error shall have a single line drawn through. Never erase.
- 6.2.3.3** All forms in the record must have been previously approved.
- 6.2.3.4** No part of the medical record is ever to be removed after entry.
- 6.2.3.5** Written Signatures validate written orders and written notes.
- 6.2.3.6** Inpatient Care is documented in the Medical Record and includes:
- a) Reason for admission, diagnosis and plan of care must be included in the documents.
  - b) Evidence of the initial patient assessment and all subsequent re-assessments.
  - c) Documentation of nursing care provided.
  - d) Any operation /Procedure performed in detail.
  - e) Name, signature, date, time on every entry made in the record.
  - f) The records are in a chronological order demonstrating the continuity of care.
  - g) Transfer notes should be in accordance to the policy of transfer and should include-Date, reason for discharge.
  - h) Medication administration is recorded on the Medical Administration Record.
  - i) Specific care provided is evidenced on the patient care flow sheet.
  - j) Aspects of patient care during operative or other invasive procedures, is documented on forms specific to each specialized area.
  - k) Patient discharge instructions.

- m) Discharge summary should be prepared and signed or countersigned by the doctor in charge.
- n) Death summary should include – causes of death, date, time and should bear the signature of the doctor in charge.
- o) The medical notes by the duty doctors have to be countersigned by the consultant-in charge within 24 hrs.

**6.3 The medical records provide up-to date and chronological account of patient care and are organized in the order (from admission to discharges) as below:**

**6.3.1 In patient medical records:**

S.No.	Name of the record	Authorized person for entry
1.	Admission form with Consent form	Doctors (provisional and Final diagnosis ) Medical records technicians – information related to date of discharge, mode of discharge and hospital stay.
2.	History and finding on admission	Doctor, Resident doctors and Medical officer.
3.	Initial Assessment of Nurses	Staff Nurse
4.	Dietary initial assessment form	Swasthavritta Department
5.	Laboratory Investigation Reports	Pathologist
6.	Radiology Investigation Reports	Radiology Doctor
7.	Cardiology Investigation Reports	Physician

Only controlled forms and formats, which are approved by the management, shall be used by the service providers for the medical records.



**6.3.2** The medical record contains information regarding reasons for admission, diagnosis and plan of care.

**6.3.3** Operative and other procedures performed are incorporated in the medical record.

**6.3.4** When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer.

**6.3.5** The medical record contains a copy of the discharge note duly signed by doctor.

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

**6.4 Maintaining confidentiality, integrity and security of information.**

**6.4.1 Procedure to ensure confidentiality, security and integrity of data:**

The Medical Record is a private document related to the patient history and treatment both in a physical and electronic format and should not be disclosed as it breaches the Code of Medical Ethics.

**6.4.2** No part of the information contained in the MR should be reproduced in any format by any individual who is handling the contents or details of the patient record without the consent of the management and the patient concerned unless otherwise needed for any case of subpoena or any other legal proceedings the information may be presented before the actual trial of cases without the consent of the patient.

**6.4.3** Only on written consent / authorization from the patient / legal heirs and an authorization from the management can the information be released to any external individual. The access to the Records by the visiting doctors should be provided once the doctor has been referred by the main treating doctor; the case sheets are available in the nurse's station.

**6.4.4** No record will be issued to any authority after discharge of patient after then hospital staff authorized by management, without a requisition duly signed by authority and approval from M.S. / Dy. M.S. The same is than kept with original record of the patients for future reference.





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## 6.5 Retention time of records, data and information:

### 6.5.1 Retention period of records:

- The entire Outpatient case sheets are maintained for a period of 5 years.
- All the Inpatient case sheets are maintained for a period of 5 years.
- The records which have crossed the retention period shall be selected and destroyed as per documented procedure.

### 6.5.2 Review:

- Medical records are reviewed once in a month.
- The review is done by Quality coordinators for the timeliness, legibility and completeness of the medical records in the IPD & OPD patient files.
- Deficiencies: A report is prepared for the deficiencies observed during review process; the observed deficiencies are analyzed for the root cause and corrective action and preventive action shall be identified.