DISCUSSION DOCUMENT

Policy Guidelines on Development and Maintenance of Medical Records in Hospitals.

GUIDELINE 1. AN ADEQUATE MEDICAL RECORD SHOULD BE MAINTAINED FOR EVERY PATIENT WHETHER THEY BE INPATIENT, OUTPATIENT OR CASUALTY ATTENDER.

The purposes of the medical record are:

- to serve as a basis for planning and continuity of patient care;
- to provide a means of communication between all those contributing to the patient's care;
- to furnish documentary evidence of the course of the patient's illnesses and treatments;
- to serve as a basis for review, study and evaluation of the care rendered to the patient;
- to assist in protecting the legal interests of the patient, hospital and medical staff and
- to provide data for use in research, education and planning.

All significant clinical information pertaining to a patient should be incorporated in the patient's medical record. The record should be sufficiently detailed to enable doctors to give effective continuing care to the patient or to assume the care of the patient at any time as well as to enable them to determine, at a future date, what the patient's condition was at a specific time and what procedures were performed.

All entries in the record should be dated and signed. Symbols and abbreviations may be used only when they have been approved by the medical staff, and when there is a legend. Diagnoses and titles of operations should be recorded in full, and without the use of either symbols or abbreviations.

GUIDELINE 2: THE MEDICAL RECORD SHOULD CONTAIN SUFFICIENT INFORMATION TO IDENTIFY THE PATIENT CLEARLY, TO EXPLAIN THE DIAGNOSES AND TREATMENTS AND TO DOCUMENT THE RESULTS ACCURATELY.

All medical records should contain:

- Identification data and consent forms;
- History of the patient;
- Report of the physical examination;
- Orders for diagnostic procedures and therapy;
- Progress notes and
- Summary

In most instances, the most detailed records pertain to inpatients. Inpatient medical records should include the following:

- Identification data and consent forms. These should include such items as the patient's name, address, age and next of kin, as well as other identifying data and consents as deemed necessary by the hospital.
- History of the patient. The record should include the patient's complaints, details of present illness, review of systems, past history, social history and family history. The history should be a record of the information provided by the patient, by his agent or his referring doctor. Opinions of the interviewer should not be recorded in the history.
- Report of the physical examination. The report on the initial examination should include all pertinent findings resulting from an assessment of all the systems of the body. Subsequent changes in the physical findings should

- <u>Orders for diagnostic procedures and therapy</u>. These should be written into the record by authorised medical staff.

- <u>Progress Notes.</u> Progress notes should incorporate observations by doctors, nurses and other authorised persons on changes in the patient's clinical picture together with results of diagnostic procedures and responses to therapy.

  The results of diagnostic procedures should be filed separately as part of the medical record.

- <u>Summary</u>: The Clinical summary should include the significant findings and events of the patient's treatment, his condition on discharge and the recommendations and arrangements for future care. Operative procedures and all relevant discharge diagnoses should be recorded using the terminology of a recognised system of disease classification.

A regular analysis of medical records should be made by a medical staff committee that includes nursing staff and the medical records officer. The Committee should review the medical records to ensure that the recorded clinical information is sufficient for the purposes of medical care. In addition it should make recommendations relative to any changes in the format of the record as well as to its proper filing, indexing, storage and availability.

GUIDELINE III: MEDICAL RECORDS SHOULD BE CONFIDENTIAL, CURRENT AND ACCURATE.

The medical record is the property of the hospital. It is the responsibility of the hospital to ensure that the information in the record is safeguarded and is made available only to authorised persons.

Entries in medical records should be made only by persons given this right under hospital policy; all entries in the record should be dated and signed. All data pertaining to the patient should be documented as soon as is reasonably possible. Records of discharged patients should be completed within a reasonable time.

GUIDELINE IV: THE MEDICAL RECORD DEPARTMENT SHOULD BE ADEQUATELY DIRECTED, STAFFED AND EQUIPPED TO FACILITATE THE ACCURATE PROCESSING, CHECKING, INDEXING AND FILING OF ALL MEDICAL RECORDS.

The hospital administrator is responsible for the adequacy and efficiency of the hospital's medical records. Where the level of activity and complexity of the hospital so justifies the hospital administrator should designate a particular officer who would be reasponsible to him for the day to day running of all medical records services and the supervision of all personnel engaged on medical records work. Medical record personnel should be afforded every reasonable opportunity to engage in education and training programmes which are relevant to their activities. These programmes would include orientation, on-the-job training, in-service education programmes together with courses and study days held outside the hospital.

The medical record department should have sufficient accommodation and equipment to enable its personnel to function effectively and efficiently and to maintain medical records so that they are readily accessible but in a manner which safeguards confidentiality. Indexes should be maintained, as necessary, to facilitate the acquisition of statistical information.

The type and amount of basic statistical information which should be maintained will depend on the needs of the hospital/health board medical and administrative staff, the Department of Health and other organisations which request information. Typical of the

- Number of hospital admissions, discharges and deaths by ward or by major clinical services;
- Number of available and occupied beds by ward or by major clinical services;
- Discharge diagnoses, by clinical services;
- Types and numbers of operative procedures performed;
- Age distribution of the patients; and
- Length of stay by diagnosis.

GUIDELINE V: THE MEDICAL RECORD DEPARTMENT SHOULD MAINTAIN A SYSTEM OF IDENTIFICATION AND FILING TO FACILITATE THE PROMPT LOCATION OF A PATIENT'S MEDICAL RECORD.

Each hospital should have a workable system for identifying and filing medical records. Because all hospital-generated medical data, both inpatient and outpatient, must be easily retrievable whenever a patient receives subsequent hospital care, it is desirable that the unit record system be used i.e. each patient should be assigned a number for use throughout his lifetime. Tracer systems should be taken to ensure against misfiling of index cards and medical records.

The length of time that records are to be kept is dependent upon the length of time that they may be needed for continuing patient care, and for legal, research or educational purposes. As a general rule it is felt that records should be stored in a readily accessible location for a minimum period of six years. An additional function of the medical record department is the preparation of reports required to meet the needs of hospital staff. The selection of a disease and operative classification system for coding hospital records should be based upon the needs of the individual hospital to retrieve records for individual study and to prepare statistical compilations of disease data, related conditions and treatments. The latest editions of International Classification of Diseases (WHO Geneva) and Classification of Surgical Operations (Office of Population Censuses and Surveys, Somerset House, London W.C.2),