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A STUDY TO ASSESS THE STANDARD OPERATING PROCEDURES (S.O.P.) FOR MEDICAL RECORD KEEPING IN L.N.MEDICAL COLLEGE & J.K.HOSPITAL, BHOPAL

Dhone PG*, Mahor GR**, AwasthiPrateek***

*Associate professor, Department of Pharmacology

**Associate professor, Department of Preventive and Social Medicine, LNMC and research Centre, Bhopal

***III year medical student, LNMC and research Centre, Bhopal

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ABSTRACT

Medical Records are the documents that explain all detail about the patient's history, clinical findings, diagnostic test results, pre & post-operative care, patient's progress & medication. The terms medical record, health record, and medical chart are used somewhat interchangeably. This document is very important for doctor as well as patient. It gives the information about health status of a patient as well as various treatments to which he is subjected to. This was the cross sectional study done at JK hospital, Bhopal. In the present study, we had followed stepwise pattern to study how the medical history is recorded? First step is formation of the record, and in the next step these records are sent in the medical record section. How all these procedures are done? These are done as follows:

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1. Introduction

Medical Records are the documents that explain all detail about the patient's history, clinical findings, diagnostic test results, pre & post-operative care, patient's progress & medication. The terms medical record, health record, and medical chart are used somewhat interchangeably. This document is very important for doctor as well as patient. It gives the information about health status of a patient as well as various treatments to which he is subjected to. Thus treating doctor as well as doctor to which patient is referred will come to know about patient's health, also it plays an important role in follow up of the patient.

From the doctor point of view, it is the only document which will provide the correctness of the treatment. Now a day cases of alleged medical negligence against the doctors are on the rise. The key of dispensability of most of the medical negligence claim rests with the quality of the medical records. Thus, record maintenance is the only way for the doctor to prove that the treatment was carried out properly. Medical records are often the only source of truth there, as they are likely to be more reliable than memory (1).

Medical records have traditionally been compiled and maintained by health care providers, but advances in online data storage have led to the development of [personal health records](#) (PHR) that are maintained by patients themselves, often on third-party websites.[2] The issue of medical record keeping has been addressed in the Medical Council of India Regulations 2002 guidelines answering many questions regarding medical records. The important issues that have been addressed are maintenance of

indoor records in a standard proforma for 3 years from commencement of treatment, request for medical records by patient or authorized attendant should be acknowledged and documents issued within 72 hours, maintaining a register of certificates with the full details of medical certificates issued with at least one identification mark of the patient and his signature and efforts should be made to computerize medical records for quick retrieval. Thus MCI is also giving special importance to the medical record keeping.

In India, despite of the intensive effect at National & International Level, the fundamental Health Care needs of the population of our country is still unmet. For formulating strategy to meet health care need of the society, basic health care data should be available. Further this data may be used by clinical researcher to know the prevalent problem in the society. The lack of basic health data makes it difficult to formulate the strategy. Insurance companies, forensic / legal medicine, courts have always recommended that all medical records must be complete & accurate (3). Thus there is need for proper record keeping so that reliable health data is available.

Aim of the study was to assess the standard operating procedures for medical record keeping in JK Hospital, Bhopal. Data was collected not only from medical record department, but also from working Staffs & members. This was done separately to assess the differences in medical record collection, entry & storage pattern of trained persons & technicians to that of non-trained ones. Thus we had tried to assess various problems encountered during the data collection especially by less trained members. In primary health centres, data collection is done by less trained person, thus this study will help us to improve data recording at the grass root level and thus improve the overall data recording.

* Corresponding Author : **Dr Pravin G. Dhone**

Assistant professor,
Department of Pharmacology,
LNMC and research Centre,
Bhopal

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Subjects and Methods:

This was the cross sectional study done at JK hospital, Bhopal. In the present study, we had followed stepwise pattern to study how the medical the medical history is recorded? First step is formation of the record, and in the next step these record are sent in the medical record section. How all these procedures are done? These are done as follows:

Formation of the record: this start with the visit of the patient to the hospital. A routine patient coming for the check up or follow up, first visit to the registration counter. There he is provided with the OPD slip. "OPD slip" consists of various basic information regarding patients (name of patient; father/husband name; date on which OPD slip made; age/sex of patient; occupation of patient; residential address; a column for diagnosis; OPD slip number). Besides this, separate columns indicating date, treatment & investigation to be done which is to instructed by the physician to patient is present. All forms are kept online as well as paper-based.

During the consultation, doctors will record the history, important examination findings and treatment. Patient is told not to misplace this paper. After the consultation is over, depending on the condition of the patient, either patient is given treatment along with or without investigation or some patient are advised admissions.

If any patient is advised admission, then patient or relative of the patient will again go to the registration counter and here IPD slip of the patient will be issued. Besides the information present in OPD slip, it also contains OPD number, IPD number, unit /department. It contains date & time of admission, name & specialty of treating doctor, provisional as well as final diagnosis & complications . It also contains name of surgery performed for which patient admitted. This information will be filled at the time of admission at the registration counter who is non medical person.

Patient may undergo any emergency or elective surgery after the admission. In some patient provisional diagnosis may change, patient may suffer from any complication. Patient may be discharged, so in such cases final diagnosis with the duration of stay will be written. Patient may expire; in such case cause of death is to be written. Besides this, it also contains informed consent which is to be taken for any procedure or surgical operation. All this information is filled by paramedical or medical personnel.

It also contains ICD number markedly important, usually filled by medical-record officer & governed by WHO guidelines.

All the above procedures are given by IPD-slip, hence it is rendered as a basic legal document for the patient & for medical record department too.

IPD slips are attached with history/physical examination sheet, doctor/nurses daily record, medication/diet Plans. History and physical examination are mainly maintained by consulting doctor and junior resident. Daily record and medication plans are maintained by nurses. Diet plan is maintained by dietician.

Once the doctor is satisfied by health status of the patient or when they seek that the on-going treatment doesn't requires further more hospitalization, patient is given discharge and patient is handed over copy of discharge certificate along with the all investigation. Before handing the discharge certificate, following procedure is done.

All forms are kept online as well as paper-based thus OPD number are of great importance as if by chance OPD-slip missed or damaged then all critical information regarding that patient can be brought down from computer online assay. This hospital is also having the system which enables to search on the basis of names.

Discharged order from doctor on IPD-slip



Deposition/showing of IPD-slip on registration counter



Giving one copy discharge certificate with investigation report to patient & one kept for record



Compiling of IPD-Slip with other documents of patient (history/physical examination sheet, doctor/nurses daily record, medication/diet plans)



resending of all compiled documents to respective ward



sending of that compiled file to medical record department

Thus record is ultimately sent to medical record department.

- 'W.H.O.' suggests the completion of whole above procedures more or less on same day or day after. But lackness in Planning Takes more time & the whole Set of Documents reaches Medical Record Department far late (in 1 week usually).

Labelling of RECORDs :-

- This is the very first step operated by Medical Record Officer/ Head of Medical Record Department/ Department in-charge that they Codes the Particular Medical Record coming to their desk by filling there Appropriate ICD CODE NUMBER. This ICD CODE designated is Specific for a Particular Disease.
- This Provides a Very Basic & Emmenceful Distinguishable Feature for each Medical Record. This ICD-Code contains Alphabets & Numericals indicating Name of Disease & the Serial number of that Patient which indicate how many Patient Earlier for the Same Disease was treated in Institution.

Electronic Record FILING :-

- Medical Record Department of WORKING AREA (J.K.Hospital) has also adapted above indicating System (Computer) to maintain MASTER-PATIENT indices & for UTILIZATION, SCREENING, RECORD COMPLETION, RECORD ANALYSIS & For ABSTRACTING of Discharged Patient Record.
- Inside Medical Record Room, Four Computer Systems are assessing which are operated by Same number of Persons. Each Operator is Fully Furnished in basics Of Computer Sciences & Received basic Trainings regarding Medical

Records Keeping. Every member designated separate works. The main Records that are Maintained by Different Technicians are:-

On First Computer System →

Records related to BIRTH/DEATH (Certificate) are registered here.

Sending of those Certificates to NAGARPALIKA Office so that they can issue the Approval Letter related to that Certificate undersigned.

Also entitled Discharge Summary of Patients.

The entry of related data is done as soon as receiving of Records is accomplished.

② On Second System →

Work related to HOSPITAL STATISTICS which are thus useful for HOSPITAL PLANNING & MANAGEMENT.

Data entry of all related RESEARCHes & its Analysis related to MRD is also feeded in the System.

Documentation of all RADIOLOGICAL REPORTS (X-Ray, CT-Scan, MRI etc) is accomplished

Haematological Reports of Patients are Subtitled here.

③ On Third System →

Main work assessed here is of Assembling Files/Records in the CHRONOLOGICAL ORDER.

FILING of Medical Records is Done.

④ On Fourth System →

Numbering of Medical Records & Files are Done.

In Medico-Legal Cases issuing of Records (duplicates one/photocopy) on the Order of COURT is Done.

Rechecking of forms to Insure the Presence & Completeness of Each & Every Compiled Document.

● Each Single Set of Document is rotated On Each COMPUTER SYSTEM after being released by MEDICAL RECORD OFFICER & Ultimately, return to the Latter. The Vicious Circle Followed is:-

ICD Coding by the MRO/DEPARTMENTAL HEAD



REGISTRATION OF DOCUMENTS on COMPUTERS



NUMBERING Of REGISTERED FILES



VERIFICATION/INSURING all Documents



RETURN BACK of FILE TO Medical RECORD Officer

MANUAL Filing of RECORD :-

The Room Collaboration Services are Par-taking in MANUAL Record Keeping Procedures. J.K. Hospital basically acquiring "OPEN-SHELLS" Filing System to Keep Medical Records well efficiently in the provided spaces for Records Storage.

There are Basically 4-Steps followed in Record-keeping/ Filing process. This includes :-

The Room Collaboration Services are Par-taking in MANUAL Record Keeping Procedures. J.K. Hospital basically acquiring "OPEN-SHELLS" Filing System to Keep Medical Records well efficiently in the provided spaces for Records Storage.

There are Basically 4-Steps followed in Record-keeping/ Filing process. This includes :-

ORGANISING the Materials of & On Each PATIENT



IDENTIFYING Each & Every Record



PLACING RECORD in File (CASE-SHEET)

KEEPING the TRACT as-such WHEN file are WITHDRAWN from SHELL

As Soon as Electronic-Filing is COMPLETED, they are Redirected to the LIBRARY-INCHARGE/ OPEN-SHELL INCHARGE who is Assigned HEAD OF OPEN-SHELL ROOM where MANUAL RECORDS are PLACED.

● Those Compiled RECORDS are Then PLACED in a Paper-Card File called as "CASE-SHEET" (Photo-1) meant for keeping records, specifically.

● Case-Sheet sites a REGISTRATION NUMBER SLOT on its extreme Top Left-Corner filled By OpEn-shell incharge by a number (four-digit) in which last two numerals indicates NAME of the DEPARTMENT/ UNIT & first two indicates SERIAL NUMBER of PATIENT seeking TREATMENT in that DEPARTMENT. Just Below Registration Number, it sites NAME Of the PATIENT.

● On the TOP RIGHT CORNER a proforma column is present which will be filled by Some Particulars of that Patient (e.g. Complaints, Investigation etc)

● After placing Record in Case-Sheet these are placed in OPEN-SHELLS/ RACKS & the Registration Code Number of Case-File Sented to COMPUTER OPERATOR who will then register the same in Computer.

● In J.K. Hospital "THE TERMINAL DIGITAL FILING SYSTEM" is used in Which the OPEN-SHELLs are assigned NUMERICALS (0-99) according to convenience.

Supplementary COLLABORATION SERVICE/ OLD RECORDS KEEPING :-

4893

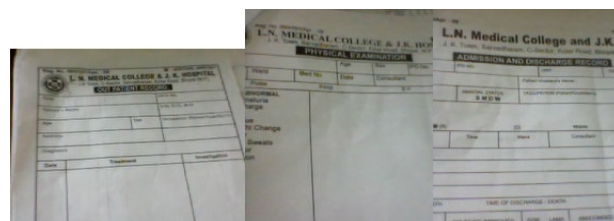
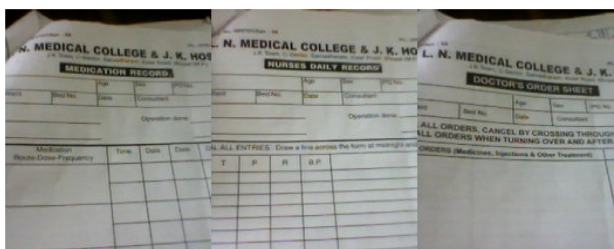
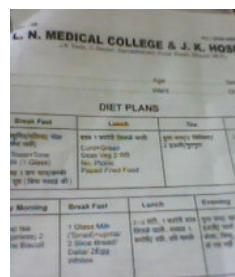
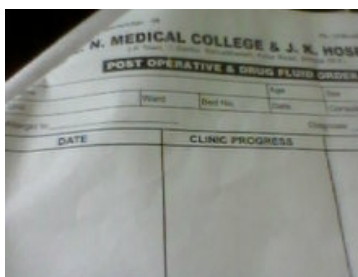
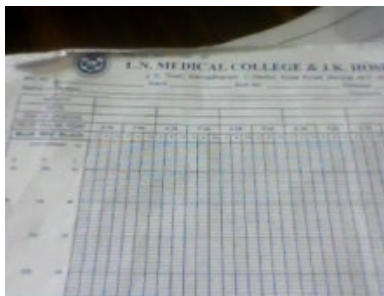
• For Conservation & Keeping of “ OLDER RECORDS ” a Transfer-procedure is applied which works under the guidelines of W.H.O. in which all older records of PAST YEARS are kept upto their assigned time-period. (MLC records upto 15yr & General upto 7yr)

• These older records are Kept in Separate Room

ISSUING & REKEEPING of ReCords :-

• Medical Records are very often used by the DOCTORS when Same Patient Re-VISITED to Him/Her. In that Cases, they use to ISSUE Medical Record File for sighting the previous diagnosis/ treatment for which a REQUISITION LETTER is being sent to the MRO By treating Doctor which then sends That Case-File (original or Zerox copy). Although, if the ORIGINAL CASE-FILE issued ARE USUALLY BROUGHTEN BACK ON SAME DAY TO MRD.

• In Medico-Legal CASES duplicate records are being issued on the REQUISITION OF POLICE OFFICER / LAWYER Under the order of COURT which beyond this must also have an APPROVAL LETTER FROM CHIEF MEDICAL OFFICER.



ObSERvaTioN&ReSULTS :-

1. OBSERVATION TABLE :- “ A ”

QUESTIONS/ Authority	INQUIRY to	V I E W s ResPonsible Authority (M.R.O.)	B y
What is front Sheet on identification & thus SUMMARY SHEET called in our HOSPITAL?	ADMISSION SHEET, also called as CASE-SHEET		
Is UNIQUE PATIENT IDENTIFIER used in HOSPITAL?	YES		
If YES, What is it? If NO, What Should or Could is Used?	For e.g. CASE-SHEET number, OPEN-SHELL & TERMINAL DIGITAL RACK number		
Do have Problem with PATIENT's IDENTIFICATION. What is Main Problem?	No, as SUCH yet no PROBLEM is ENCOUNTERED		
Do Find that a PATIENT can have more than ONE Medical RECORD due to identification problem?	DEFINITELY, in VARYING CIRCUMSTANCES a single PATIENT can have >1 medical record file		
ARE all the FORMS in MEDICAL RECORDS are of SAME SIZE?	YES		
Who design, the various FORMS in hospital & who approves introduction of a NEW FORM?	MEDICAL RECORD OFFICER (M.R.O.) designs & MANAGEMENT COMMITTEE at STATE LEVEL introduces new form if any		
ARE all RECORDS in a SINGLE FILE are held together by CLIP or FAULER?	Kept TOGETHER but not CLIPPED, instead They are STAPLED		
Do we USE ADMISSION DIVIDERS to separate each file?	NO dividers		
Are all MEDICAL RECORDS is PLACED in FOLDER after the DISCHARGE of a PATIENT?	YES, all records are recollected at MEDICAL RECORD DEPARTMENT within 1 WEEK		
WHO is RESPONSIBLE for MEDICAL RECORD Services in OUR HOSPITAL?	MEDICAL RECORD OFFICER (primarily) but too an EXTENT MRD STAFFs also		



{ PHOTO No.- 1 }

(OPEN-SHELL in which Case-Sheets are kept known as TERMINAL DIGITAL FILING)

OBSERVATION 2 :- “ How the ISSUING of VARIOUS RECORDS is ACCOMPLISHED in the HOSPITAL ????? ”

Undoubtly, each & every type Medical Record is Confidential & Privileged, but still it is much easier to obtain Medical Record in some cases as that of Comparing to other one like Record related to MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT etc. Use of Consent to Obtain Medical Records

Ans:- Discovery of Medical Records & information requires the WRITTEN PERMISSION by the PATIENT which can either be in form of 'CONSENT' or 'AUTHORIZATION'. A Consent is a document which will authorize the Use of Health Care Information for ' Treatment, Payment or Health-care Operations'. WHILE, An Authorization is a document signed by the Patient that will allow the Disclosure of Health Care Information for the Purpose stated on the release. However, Attorneys who fail to use a Valid Consent Form containing all the required elements likely to have the FORM returned to them without any RECORDS.

A Consent for RELEASE of MEDICAL RECORDS usually contains :-

A detailed description of the information to be disclosed

(b) The name or title of the person or entity authorized to release the information

(c) The name or title of the person or entity to which the records are to be disclosed

(d) A description of the reason or purpose for the requested disclosure

(e) An expiration date or event

(f) The dated signature of the individual authorizing the release, and if the individual authorizing the release is someone other than the patient a description of such representative's authority to act for the patient

(g) A statement the consent may be revoked in writing unless certain exceptions apply

(h) A statement indicating the potential for the information disclosed to be redisclosed

(i) A statement that the health care provider cannot condition treatment upon the patient signing the consent for release of information; (j) Notice that information related to communicable diseases such as HIV and AIDS can be disclosed

Use of a Court Order or Subpoena to obtain Medical Records

Ans:- A person needing Medical Records as a part of the Discovery process can obtain it with Consent of the Person whose records are to be needed. In the event the attorney cannot obtain the Consent from the patient they still have an access to it by obtaining A Court Order or Subpoena addressing Health Care Providers for releasing of the Records. But, in this case too the Health Care Providers are bound to Release only those records which are expressly indicated in the Court Order. Thus in this case Attorney need to present the order of Court as Specific & Comprehensive so that they can ensure the issuing all desired receipts from the HOSPITALS. Use of a Business Associate Agreement to Obtain Medical Records

Ans:- While not technically considered discovery, an attorney representing a health care provider are also having an assess to patient's records. Nonetheless attorney representing a health care provider cannot review the records of that provider that pertain to patients, including a patient who is the subject of litigation on which the attorney is working, unless the attorney enters into a Business Associate Agreement with the provider, or obtains consent from the patient whose records are at issue. There are many required provisions in the Business Associate Agreement that may concern attorneys, such as the requirement to destroy or return all health care records and requirements regarding accountings of disclosures of health care information and amendments to records.

OBSERVATION 3 :- “ How the MEDICAL RECORDS are Helpful for the VARIOUS WORKING PUBLIC HEALTH AUTHORITIES???? ”

By providing reliable 'MORBIDITY' & 'MORTALITY' Statistics

Ans:- Due to deliberate efforts of the government most of the Births are now taken place in Hospitals. Thus, the data regarding births can be easily accompanied. Similarly, most of the unnatural deaths are also occurring in Institutions so the rough data of that can also be achieved from Medical Records. Although, Information about Birth live issues is more satisfactory derived from these Records.

By helping the above authorities in planning 'PREVENTIVE & SOCIAL MEASURES' to meet needs of Community

Ans:- This eventually happening from last few decades. Organization of Campaigns, Awareness Programmes & much more are sighted by various Government as well as Non-Government Organisations which results in creating awareness & also for rendering effective treatment in a particular place.

By improvising the USE of Medical Records in a Condition of any Epidemic (as recently seen in Swine flu & in earlier cases also.)

Ans:- Medical Records are effective way of Surveillance of any disease which is turning or can be turned in a greater Epidemic. This is also employed in checking of turning an Endemic to Pandemic one.

OBSERVATION 4:- “ How the RECORDs being helpful in the INTEREST of the PATIENT “????

Extremely helpful in Case of REVISITS of Patient

In case of Consultancy with other Clinician

Useful in Case of prescribing Treatment

Ans:- In revisited cases the very first step taken by the Clinician is of Overviewing of last treatment given to that patient, which can only be assured by sighting previous medical records regarding that patient. It is highly effective in cases of supplementing Newer drugs if any.

OBSERVATION 5 :- “ How the MEDICAL RECORDS Are working in field of Management of J.K.HOSPITAL ????? “

In checking the availability of MEDICINES

If any especial procedures extremely required but at present not available in the HOSPITAL ??? (e.g. Venom vaccines, CT Scans etc)

Ans:- This is also a part of in case of sudden occurrence of any particular disease in an area which suggestively increases the number of patient seeking treatment for that disease in the Hospital. This is one of the positive sign in the occurrence of massive threat from that particular disease.

OBSERVATION 5 :- The medical record has four major sections:

administrative, which includes demographic and socio-economic data such as the name of the patient (identification), sex, date of birth, place of birth, patient's permanent address, and medical record number; legal data including a signed consent for treatment by appointed doctors and authorization for the release of information; financial data relating to the payment of fees for medical services and hospital accommodation; and clinical data on the patient whether admitted to the hospital or treated as an outpatient or an emergency patient.

OBSERVATION 6 :- “ How the Work of Medical Record Library is Exhibited & Maintained at J.K.Hospital “???

Ans:- The whole procedure of Record Keeping already being described. Basically, The Medical Record Library/Department is maintained & thus managed by the OUT PATIENT's & MEDICAL RECORD MANAGER & DEPUTY IN HEAD or so called MEDICAL RECORD OFFICER (M.R.O.) & The Prior maintenance of Work is Done By Day-to-Day Supervision of whole Work & Staff & thus Running of Whole Department is Exhibited

DISCUSSION :-

- As indicated in the last observation of report (obs.5) the Medical Records & all the related services accompanied to it in the working Area i.e. J.K.Hospital is quietly explored.

On one side Medical Record Collaboration Services is chiefly associated with patient's care so on next hand it also indicating the Socio-economic Status & Needs of the Community.

For e.g.- Unique identification Code Number provided to a Particular Patient will be valid not only during the course of Treatment but will also be available in The Medical record Departmental Library for a longer time eventually, in some cases Even After Death.

- The role of Medical records in the assessment of Treatment provided to the patient is clearly been stated in it. The Health Standards & the facilities provided in the the Hospital can only be assessed by the over-viewing of latest medical records & Comparing them with older records. This basically proves to be an effective way of SURVILLANCE because The ground & Criteria of Comparison is Same (6).

For e.g. If the case file of a Patient suffering from Chest-pain six months back is COMPARED with a patient complaining similar problem recently will going to reveal us THE CHANGE Of PATTERN of TREATMENT & Whether the Hospital is adopting that new change or Whether any new reforms in that field had been taken place or not.

- Its been clearly understood from this study AS MORE AS THE MEDICAL RECORD SECTION IS STRENGTHENED AS GOOD AS WILL BE THE HOSPITAL SERVICES. This is because the information in Medical records acts as a Work rEport of the HOSPITAL. Its analysis reveals the standard or quality of whole services & the services provided team too.

- Since recorded observation & case studies are basis of all clinical research, medical records become invaluable in all researches & teaching programmes. This study on “Medical Records Keeping” is not only limited to the particular field of Keeping Procedures but been also be helpful in nearly all medical researches especially those requires a larger single data at a time because most of the researches related to Medicines requires random data collection which can be easily traced using medical records which will become too easy if the keeping procedures & Manuals regarding them are fully furnished (12).

- In accessing continuity of care in event that future illness require attention in or out of hospital. In This Attention inside the Hospital simply implies services in terms of Medicines, Surgery, Nursing, & all other treatment providing team. Along with this, the Medicational facility provided by & in the Hospital to the Patient (13).

While, Attention out of the Hospital simply implies the Awareness, Campaigns, Vaccination & Some effective programmes (Shivirs, Donation Camp etc.) which are organized at very levels (14).

- Ultimately, this all will going to furnish documentary evidence for purpose of evaluation of hospital care in terms of Quality, Quantity & Adequacy. Thus, HEALTH STATUS OF COMMUNITY WILL GOING TO ATTAIN A PEAK..

- The indicated objectives are fundamentally be achievable when the KEEPING MANUALS Of the RECORDS is being updated & effective incorporation of the newer techniques & technology been inserted in to it.

- In this Study, Cross-Sectional Analyses being done as it involves the Observation & Study, of Clinical Records being formed at specific point of time. This basically being best suited as compared to other study like Case-control studies which typically involves a particular set of samples (Records in this case) with a special preference to a particular characteristic often a tiny minority as compared to rest of the

Population or FROM Cohort study which will involve only a group of Record sharing common features. { Earlier as in synopsis this study is also going to be Cohort but later on turned to Cross-section as To Study keeping Procedures all type of records are to be taken in concern which can't be accounted in cohort. }

CONCLUSIONS:-

- If the record keeping procedures are effective & are more in accordance with the W.H.O. guidelines then These MEDICAL RECORDS thus ultimately used to Furnish the Documentary Evidences which thus can be implied for the Purpose of Evaluation of Hospital Care in terms of QUALITY, QUANTITY & ADEQUACY.
- Medical Records acts as tool of Boon in assessing the Need of the Continuity of Care in terms of Treatment & otherwise, within the Hospital as well as its prevalence in the Community through various means.
- Medical Records are the ultimate way of providing a Reliable Statistics of Mortality & Morbidity Statistics which in turns will seek a source of pathway in planning & designing the proper Preventive & Social Planning & thus, its Management to meet the needs of the Community.
- All the provisions taken by HEALTH RECORD DEPARTMENT in regards to Confidentiality of Medical, Health & Treatment Records are in place to protect patient's record. Thus, only those records are being disclosed by the Health Care Provider (i.e. MRD) which are to be reasonably needed in any Civil case or in any Medico-legal Case & That too with a Consent that the PARTY to whom the records being Disclosed will treat those records with the same confidentiality as the health care provider did when the records were in its possession.
- The following is considered unacceptable practice;
 - Delete or erase notes, such that the entry is no longer legible.
 - Use "white out" correction fluids in any part of a paper clinical record.
 - Change original entries, other than as specified above.
 - Change entries made by another person.
 - Amend the record of an opinion or judgement recorded by a healthcare professional, whether accurate or not, because the recorded opinion or judgement is essential for understanding the clinical decisions that were made and to audit the quality of care.
- Clinical records have to be 'marked in error' if a mistake is made which is fully Auditable. This is the most utilised function to rectify errors with the record. There is a 'Removal of Record Function' in which requires Guardian approval or approval from authorities who will consider the justification for permanent removal. Once approval has been authorised the record can be removed with appropriate permission and access rights. For legal reasons the record will be held within a secure repository and can only be retrieved through the health care Personnel.

- Health care information starts with data and the collection of data whether maintained manually or electronically. Demographic and clinical information stored in a patient's medical record is the major source of health information and it is of no value to medical science or health care management if it is not accurate, reliable, and accessible.

- The comparison of health care data between facilities, States or Provinces, within a country or between countries is vital to the growth and dissemination of health information throughout the world. This possible sharing is meaningless, however, without the use of standardized systems for data collection, disease classification and health care statistics.

- Access to MEDICAL RECORD DEPARTMENT is restricted to authorized personnel who have received appropriate training. OUT of HOURS access requires Written Authorisation from MRD Manager/Deputy. Besides this, every new personnel are required to sign a Confidentiality Disclaimer Form. Accessing a Medical Record thus Duly Required a Form Signed by Authorising Officer (especially in case of OUT of HOURS access) specifying Name of that Person, Department, Reason of Access, Date/Time Access is authorized.

- Last but not the least, they will be very useful as they form the basis & backbone of the clinical researches that are going on in the field of Medical Sciences & thus, will also aid in methodology of various Teaching Programmes.

SUMMARY:-

- Accurate & Comprehensive information is essential for high Quality Patient care hence, Information about the clinical care of the patients is recorded in their Clinical Records which includes Presenting Symptoms, diagnosis & record of treatment documenting each episode of care for future Reference. Thus this study basically reveals All the Fundamental & Adapted Procedures which are being used for the KEEPING Of Various CLINICAL RECORDS which finally reveals clinical outcomes for the sake of benefit of the Community. The basic procedures involved is TERMINAL DIGITAL FILING of Records which is basically Keeping of Records orderly in Terminal Racks. This is not only being helpful in towards Treatment Affinity but also proves to be a milestone in Taking decisions in regards to HOSPITAL MANAGEMENT & PLANNING with too within Authority Guidelines. The main uses of the medical record are to document the course of the patient's illness and treatment to communicate between attending doctors and other health care professionals providing care to the patient; for the continuing care of the patient; for research of specific diseases and treatment; and the collection of health statistics. The basic Question which eventually a basic need aroused from this study is To create or to Make a better Synchronisation between different Units working towards Managing & Safeguarding of these records which will then eventually develop a Practice of HEALTHY RECORD KEEPING.

SUGGESTIONS:-

● This whole work basically deals with Records of patient of various department who eventually were admitted, but a larger population of patient are being simply treated in OPD thus information regarding them is not assured efficiently. So, the role of technology is highly useful here. All the Hospitals hence must employed the latest Software Technology { as J.K.Hospital acquired after continuous work of Me & My Team } which should Connect & automatically send all OPD DATA to the P.C. of MRO or in MRD.

● Secondly, It is IMPORTANT for us Attorneys to Respect the Confidentiality of Medical Record as for we too may some day be a Patient whose records need to be protected. At the same time, however, the Attorneys shouldn't use any Forgery, Unacceptable method to achieve or to legitimate discovery of relevant Medical Treatment Records.

● Lastly the appointment of Medical Record Clerks/ Officers must be through A Pre-Employment Test which can thus act as a Supervision regarding their working Skills, Knowledge & about their Working Efficacy & Adequacy too.

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