4.1MEDICAL RECORDS DEPARTMENT

4.1.1Overview

The medical records department maintain records and documents relating to patient care.

Among a host of activities, its main functions are filing, indexing and retrieving medical records.

The primary purpose of establishing a medical records department is to render services to patients, medical staff and hospital administration.

The quality of care rendered depends on the accuracy of information contained in medical records, its timely availability to and the extent of utilization by the professional staff.

To achieve economy, accuracy of information and good communication which are of vital importance to the medical records system, all information should be concentrated in the original medical records of patients.

This should be indexed and filed in the department. The

three basic principles of medical records are:

- Accurately written,
- Properly filed, and
- Easily accessible.

Medical records are used as primary tools to evaluate the quality of patient care rendered by the medical staff.

To implement this effectively, the medical staff must adopt and self-enforce rules and regulation for the production of timely, accurate and complete medical records.

Medical records are widely used for teaching and research purposes.

In the context of increasing malpractice liability suits against hospitals and physicians, well-documented medical records are a good legal protection.

The physician is primarily responsible for the quality of his patient's medical records.

It is his duty to review correct and countersign records that are written by residents and junior doctors working under him.

Each entry in the medical record must be signed by the person making the entry, and the signature should be identifiable so that responsibility for accuracy and authenticity can be fixed.

The language used in writing medical records should be clear and concise and should not lend itself to misinterpretation.

Abbreviation, symbols, etc. should be of acceptable standard.

The medical records department should maintain a list of acceptable abbreviations and symbols for everyone to follow.

Every hospital should formulate policies, rules and regulations for the production, completion and maintenance of medical records.

In many hospitals, registration is an integral part of medical records.

The front office, which registers all patients, assigns each new patient a unique number, collects patient demographics and other necessary data, assigns/directs patients to physicians,and creates records.

In the case of returning patients it retrieves their records and updates them. It maintain a master patient index for all patients.

Registration is the starting point for outpatient visits and all patient-related activities.

4.1.2Functions

i) Planning, developing and directing a medical record system that includes patient's original clinical records and also the primary and secondary records and indexes. These may be in the central record room, the clinical service area, adjunct departments or the outpatient department of the hospital.

ii) Maintaining proper facilities and services for accurate and timely production, processing, checking, indexing, filing and retrieval of medical records.

iii) Developing a procedure for the proper flow of records and reports among the various services and departments including clinical services and the outpatient clinics where they are needed.

iv) Developing a statistical reporting system that includes ward census, consolidated daily census, outpatient department activities, and statistics in relation to services such as radiology, clinical laboratories and pharmacy.

v) Preparing vital records of births, deaths, reports of communicable diseases, etc. for mandatory and regulatory agencies, and statistical reports. These relate to number of admissions, discharges by major clinical services, discharge diagnoses and length of stay by diagnoses, types and number of surgeries performed, etc. for use by administration, medical staff communities and the education and research departments.

vi) Coding all diagnoses and operators according to international classification of disease for statistical purposes.

vii) Safeguarding the information in the medical records against theft, loss, defacement, tampering or use by unauthorized persons.

viii) Determining in coordination with medical staff and administration the action to be taken in medico-legal cases relating to the release of medical records in a variety of situations and determining the legality and ethical appropriateness of such actions in conformity with thelaws of the land.

To appreciate the several activities that take place during the medical record's journey after admission and after discharge of patient, see flowcharts in Fig.1.1 and Fig.1.2.

4.1.3Location

In order to provide prompt medical record service for the care of all patients at all hours and to foster a close working relationship and good communication among the related departments, the medical records department should be located close to the admitting area, outpatient department, emergency room and the business office.

It should also be close to or on the corridor leading to the doctor's lounge so that the medical staff can conveniently stop by and complete their records and study cases.

Proximity to admitting, outpatient and emergency departments eliminates delay in procuring medical records.

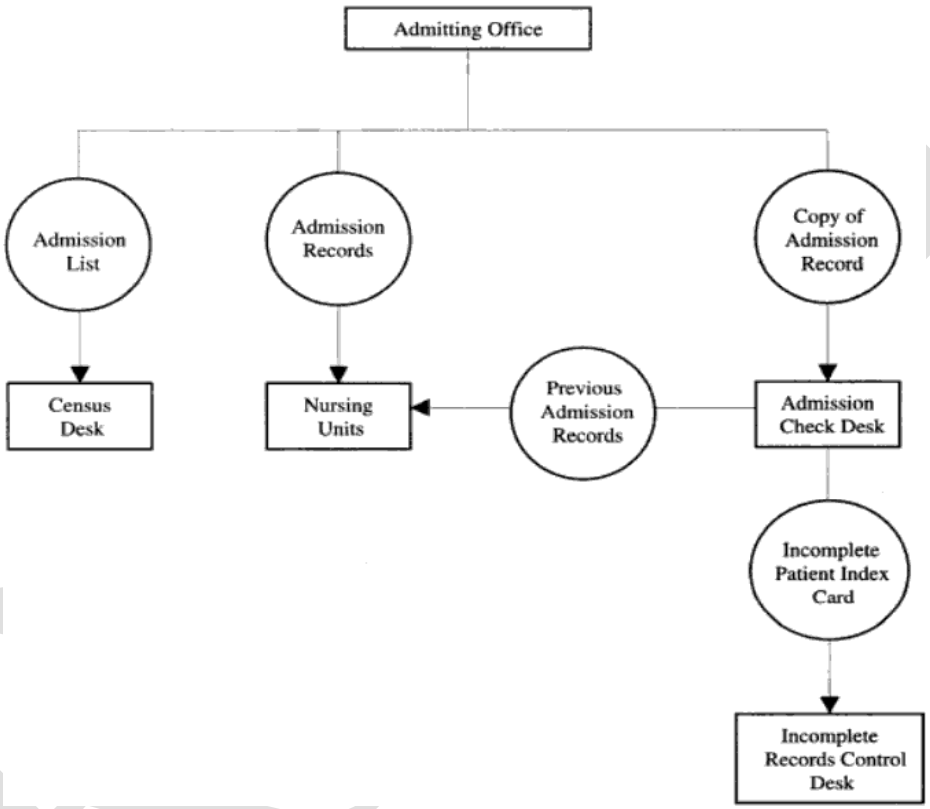

Fig. 1.1 Flowchart of Medical Records on admission of a patient

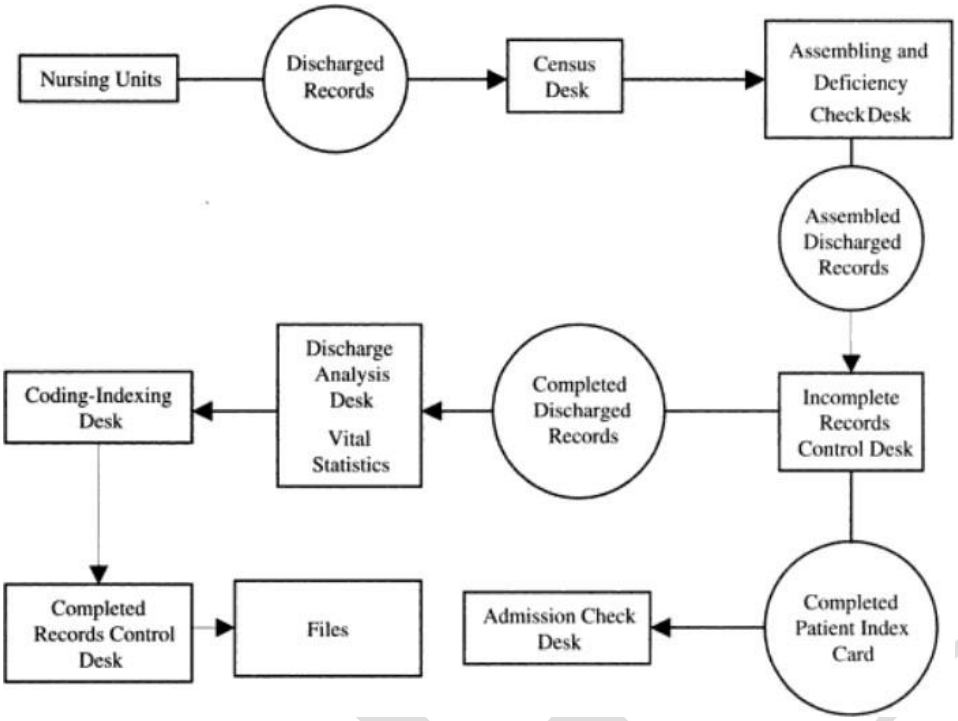

Fig. 1.2 Flowchart of Medical Records on discharge of a patient

It also permits a skeleton staff to manage the worse of the medical records department during the evening and night shifts.

While carrying on their normal duties like filing, etc. the night crew can also furnish records to the emergency department.

Location is important particularly in small hospitals where the records department usually remain closed during the night. In that case, it should be within easy walking distance

for the authorized admitting or emergency department staff to enter the department and retrieve records for emergency patients.

The need for security surveillance to safeguard medical record information also has a bearing on the location.

4.1.4Design

The front office of medical records – the registration together with the enquiry – is often the patient's first point of contact with the hospital.

It is here that public relations plays a vital role.

In addition to courteous and helpful staff, the physical design should be one that projects a warm and welcome feeling.

Good functional design, logical placement of work areas and a good system of communication

among the various sections of the department and between other departmentsare vital.

The department should also be designed with the best possible means of transportation of medical records through all stages of their use and processing.

4.1.5Organization

The medical records department may be headed by a medical record administrator or officer who reports to the director for medical or administrative services.

He should be a graduate with a degree or diploma in medical records administration.

The remaining staff in the department consists of medical records technicians and medical records clerks.

The Christian Medical Association of India and various medical colleges offer degree and diploma courses in medical administration.

In large hospitals, there may be an assistant medical record officer and supervisor for major functional areas such as filing and indexing, coding and abstracting, transcription, discharge analysis, medical audit, utilization review and registration.

4.1.6Unit Record

The unit record is a single record that documents the entire medical care provided to an individual in all the services of the hospital, namely, is the inpatient and outpatient sections and the emergency room.

The single unit consolidates and retain all the records in a chronological order, that is, in the order of occurrence of events and findings.

This way, the record provides the doctors with the necessary references to a patient's current and past conditions all tests and procedures on him and his response to therapy.

Some hospitals maintain separate records for inpatient and outpatient visits.

The disadvantage of this system is that the patient's complete history cannot be reviewed quickly and easily.

Other methods of assembling medical records are:

1. **Chronological by source** of information or section (physician's notes, nurse's notes, lab reports, etc.)
2. **Problem- oriented medical record**

4.1.7Numbering System

The most widely used method for numbering is the unit numbering, used in conjunction with the unit record system.

In this system, a single, permanent number is assigned for each patient (as against different number each time a patient is admitted).

The unit number ensures accurate identification of the patient and complete information about his

investigation, tests and the accounting records.

4.1.8Filing System

The most popular method of filing is the straight numerical filing, starting with the lowest number and ending with the highest.

Activities relating to filing and retrieving are most concentrated in the area where records with the highest numbers are stored because they are the most recent and active files.

This is the easiest method of filing as the staff is familiar and comfortable with it.

However, the chances of misfiling and not finding the misfiled charts are high in thissystem.

The other method of filing is the **terminal digital filing.**

This provides equal distribution of medical records in the storage area and therefore allows the staff to be evenly spread within the area.

The filing is based on the last two digits of the medical record number.

The entire file is divided into hundred sections from 00 to 99 and the records are storedin there sections according to their last two digits.

For example, all records ending with 14 are filed together.

In an advanced system, the terminal digits are also colour-coded.

The great advantages of this system is that the filing clerks can visualize the actual location of the records.

It also speeds up filing and retrieval of files and virtually eliminates any chance ofmisfiling.

4.1.8Dictating and Transcription System

Various dictating and transcription systems are available.

In an advanced system, doctors dictate their notes or discharge summaries from various location in the hospital – from the words, operating room, ICC & CCU complex, emergency room, etc. – using either a remote dictating equipment or the telephone which is linked to the central transcription room in the medical records department where the dictation is tape recorded.

The medical secretaries then transcribe the recorded dictation.

With the advances in telephones, doctors can now dictate their notes from anywhere from their homes or even from moving cars using car phones.

4.1.9Space requirements

The medical records department requires space and facilities for the following:

1. Reception and registration area.
2. Offices for the medical records officer and assistant medical records officer.
3. Space for sectional supervisors.

4. Work area for record processing, assembling, numbering, indexing, utilization review, discharge analysis, correspondence, work processing, quality assurance, etc.
5. Record storage for active and inactive files.
    - Active files are the files where the data of discharge or last visit is within three to five years of the current date. These files should be readily accessible.
    - Inactive record storage should also be located near the active files area as far as possible. These may be stored in a computer assisted system.
6. Space for copies that is used to a considerable degree.
7. A room for medical staff to complete records, study cases review and abstract records with tables, chairs, dictating equipment, etc.
8. An area with bookcases or shelves to temporarily house medical records pending completion or temporarily used by the medical staff.
9. Transcription area with space for the central recording equipment, tables, computers, etc. for medical secretaries to transcribe dictation.
10. Space for master patient index depending on the kind of system used, for immediate identification of current and past patients. Computer-assisted system are now widely used.
11. Storage area for medical record carts.
12. Supplies storage area for unused medical record file folders, forms, etc. 13.Staff facilities.

4.1.10Other Consideration

i) Ownership of Medical Records

Medical records are created and maintained for the benefit of patients, medical staff andthe hospital.

The hospital has the right to restrict removal of the records from the records room or from the hospital premises, determine who may have access to them, and lay down as a policy the kind of information that may be taken from them.

Except for authorized patient care purposes within the hospital, medical records may be removed from the department only on the order of a court of law and with the prior permissionof the chief executive officer.

Even when the records are given out, it is a wise policy not to part with the original records.

Only photo copies should be given except on the orders of the court.

ii) Confidentiality of Information

While the information contained in the identification section of the medical record is not confidential, the clinical data obtained professionally is confidential and it should be safeguarded.

Employees are obligated to safeguard the confidential information of patients.

Many hospitals require employees having access to patient records sign an undertaking not to divulge any patient information that may have come to their knowledge in the course oftheir work.

A great deal of harm can be alone to patients by employees divulging confidential patient information.

Confidential information may be released with appropriate authorization.

However, the information acquired by a physician in doctor-patient relationship in privileged information that the physician may not disclose even in a court of law.

iii) Record Retention

Apart from patient care, records are retained for various reasons such as for legal and research purposes.

It is not necessary to retain records permanently for any purpose, and certainly not for the purpose of proving birth, age, residence, etc.

It is generally accepted that hospitals are seldom required to produce medical records older than 10 years for clinical, research, legal or audit purposes.

iv) Computerization

Computers are widely used in the access of registration and medical records.

In registration, they are used to maintain information and patient's personal date (demographics), for assigning patient numbers, making appointments and assigning to physicians, creating records, etc.

In medical records, computers can be used for patient records and medical records administration.

For the most part, however, computers have not made much inroads into the patient records area, but in the records administration area they are used for chart abstracting, medical record indexing, diagnosis coding, chart locating, master patient index, statistics, etc.

Authorized personnel can have access to all current and historical data. On-line abstracting can be done using screens and conditional editing. All editing is done in real time.

An on-line master patient index gives immediate access to essential, episodic patientinformation.

Medical records reporting gives optional access to essential, episodic patient information.

Reports can be sorted and sequenced in a variety of ways.

They can be generated on a daily, monthly, quarterly, semi-annual and annual basis.