



MEDICAL RECORD KEEPING; AN UPDATE

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Abstract

Now a day's Medical Profession not only deals with Medical affairs it involves various aspects of Legal Profession as well. Hence it should be re- coined as Medico Legal Profession. While providing any medical services if any issue arises then Doctors has to face the legal consequences and brought under the court jurisdiction for prosecution like other criminals. The only thing which helps in front of court is the documents produced by the treating doctor, so keeping the Medical Records in meticulous manner, maintaining it & keeping it safe is very important.

So one should be very particular while recording the details & vitals in OPD Card, Bed Head ticket, Consent Form, Admission & Discharge Ticket of the patients. Doctors should be well aware of the things to be recorded into Medical Records, as well more aware about how to keep the records & to produce them when demanded in a Legitimate manor.

Keywords: Medical Records, Record Keeping, Medico legal, Guidelines, Legitimate

One of the inspirational proverb is -"Verba volant, scripta manent"

(Spoken words fly away, written words remain)-Caius Titus

WHO Should keep the records?

Documentation should be a record of first hand (direct) knowledge, observation, actions, decisions and outcomes. Therefore it should be recorded by;

Doctors	Nurses	Midwives	Patients	Other health professionals	Other care providers
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Clinical documentation should reflect;

- use of consistent data collection form
- Properly classified documents required by Record room.
- identification of roles and responsibilities of each health care provider (ie who is responsible for review/initiation/ completion of documentation in what circumstances);
- clear process for review, storage and archiving
- clarification of access and communication processes

WHAT?

- All aspects of patient care
- It should be in a combined approach of the all Health care providers participating.
- Complete information
- Subjective and objective information

- Observation, assessment, actions, outcomes
- Variances from expected outcomes or established protocol
- Rationale for decision and actions
- Critical incidents involving the patient

WHEN?

- Each event kept with the corresponding time in sequence.
- The action or event
- Collaborations
- Variances to expected outcomes
- Critical incidents

WHY?

- Basis of communication between health professionals

- To improve the quality & the Legitimacy of the care provided.
- To show the accountability for the patient.
- Used to abstract details for coding purposes
- An important source of data for future use.

HOW?

- Concise, accurate and true record
- Clear, legible, permanent and identifiable
- Chronological, current, confidential
- Based on observations, evidence, assessment
- Consistent with guidelines, organisational policy, legislation
- Avoids abbreviations, white space, ambiguity

Guidelines for Medical Record

Medical Record and Clinical documentation

1. Confidential
2. Clear
3. Concise
4. Complete
5. Contemporary
6. Consecutive
7. Correct
8. Comprehensive
9. Collaborative
10. Patient centred

TYPES OF MEDICAL RECORDS

- PAPER RECORDS
- E-RECORDS
- IMAGES /Videos–Xrays,slides,consent videos, surgical videos etc.
- SOUND RECORDS –audio tapes

How long Medical records be kept for??

- GP Records- until 10yrs after the death of the patient or permanently left the country,they remain in European union.

E records must not be destroyed or deleted for the foreseeable future.

Children & Young People

- All types of records should be retained until the patient is of 25yrs of age(or 26 if they are 17 when treatment ends)

Or

- 8yrs after their death.

Or

- If the child's illness or death could be relevant to adult condition or have genetic implication for their family,records should be kept longer.

Maternity Records including O&G and Midwifery

- Records should be retained for 25yrs. after the birth of last child.

Mental Health Records

- Records should be kept for 20yrs after the last contact with the Health professional or 8yrs after the death of the patient if sooner.

NOTE

As per NHS Code of practice on GOV.UK.,the requirements may vary in those cases related to

- Patients under clinical trial
- Patients of mental disorder within the meaning of mental health Act 1983.
- Peoples serving in Armed forces & people serving a prison sentence.
- According to medical record manual a guide for developing countries is issued by Health World Organization,there is no general retention policy.
- It varies from country to country USA,Australia.
- In England,NHS has published a guideline covering all the existing laws binding upon all the states ,Corn(2009)in an article entitled clinical record deserve long term preservation.

MEDICAL RECORD KEEPING

- Medical record is the only proof of the medical services provided to the patients:-
 - Hence very important document
 - Must be complete in all respects
 - Incomplete records shall let you down
 - Preserve records for 3 years in India.
 - Copy of records should be provided within 72 hours on demand
 - Not providing proves.- Misconduct.

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OPD TICKET

Enter the following very clearly:

- Whether free or paid
- Complete name, address, age, sex, Mo.Number
- Drug Allergies
- Name of referral
- Immunization status of the patient
- Summary of complaints, clinical findings
- Important negative points
- History of previous treatment taken
- Instructions in Hindi
- Investigations advised
- Date of next visit
- NOTE: If patient has not following your advice
- If patient refuses admission

INDOOR TICKET

- Consent for admission
- Complete postal address of the patient with mobile number
- Time of admission in emergency
- In MLC- name of the person bringing the patient and mark of identification of the patient.
- Time when first seen by the Doctor
- Complaints, history, clinical findings
- Investigations advised and the reports
- Daily notes--
- Entry of progress and treatment advised
- Do not postpone entries
- Pre-op investigations, PAC, operative notes, post op condition.
- Indication for surgery
- Anesthetic records

INDOOR TICKET CONT....

Mode of discharge:-

- DOR(Disharge on Request)
- LAMA(Leaved against medical advice)
- Death

MUST ENTER

- If referred elsewhere and why???
- Patient not cooperating and ignoring your instructions
- Taking other remedies[Pathies]
- Taking intoxicants
- Malingering
- Fees not paid

DISCHARGE TICKET

- Never think that a Discharge ticket is a Medical paper ... It is always a Medico-legal Document.

- It is a summary of the record always put forward in front of court, Must be completed.
- Time of admission in emergency , D.O.A & D.O.D
- Condition on admission
- Investigation reports
- Summary of the treatment given, operation done, post - op condition
- Patient's condition on the time of discharge with wound status
- Further advice
- When to come for follow up

MEDICAL CERTIFICATE

- No false certificates should be given under any emotional influence.
- Properly signed by the patient
- Identification mark of the patient
- Make a register of the certificates

IMPORTANT

- Keep the records complete , legitimate and properly signed .
- No manipulation at a later date
- If record is lost must inform police

PAYMENT MADE BY THE PATIENT

- All entries to be made on a separate sheet
- Whether payment settled or not settled
- Fees can be taken in advance
- Treatment Can be refused on non -payment except in emergency
- Patient / property/ dead body cannot be detained for non-payment

SECOND OPINION [REFERRAL]

- Referring doctor should be send a Summary of the case
- Purpose of referral
- Opinion must be given in writing
- Doctor consulted should not take over the case .

INVESTIGATION REPORTS

- Should be copied on Indoor ticket and Discharge ticket and if handed over to the patient should be mentioned on discharge ticket and a sign of the patient or attended or policeman should be taken on front of Indoor ticket .

KEEP RECORD IN SAFE CUSTODY

- ***So that this important Document should not get spoiled.***

CONCLUSION:

It is very much important and essential now a days to Keep the Records in a proper manor , to be safe and answerable , for the Doctors & their staff to the court of law as you can't control how some people will treat you or what they say about you, but you can control how you react on it.

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