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All India Institute of Medical Sciences, Patna

Medical Records

Standard Operating Procedure

Medical Records Department

All India Institute of Medical Sciences, Patna

29/04/25

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Medical Records Manual
(Standard Operating Procedure)

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Hospital Services: Medical Records Department

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Prof. (Dr.) Anup Kumar	:	Medical Superintendent
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Amendment Sheet
(To be updated by MRO)

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Control of Standard Operating Procedure

The authority over control of this manual is as follows:

Prepared and updated by	Edited by	Reviewed by	Overseen by	Approved by
Medical Record Officer	Faculty In Charge MRD	MRD Committee	Medical Superintendent	Director

SOP, shall be maintain by Medical Record Officer (MRO) which includes updated Amendment Sheets. This document must be kept in good condition, easily identifiable, and retrievable.

The Copies of this SOP, will be distributed to departments or individuals as needed. The MRO will be responsible for providing these controlled copies along with amendments, ensuring recipients acknowledge receipt.

Annually, the SOP will undergo review and updates according to hospital policies and procedures to remain relevant and accurate.

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MEDICAL RECORD COMMITTEE

CHAIRPERSON	: Prof. Prashant Kumar Singh, Department of General Surgery
MEMBER	: Prof. Ravikirti, Department of General Medicine
MEMBER	: Addl. Prof. Anupam Bhambhani, Department of Cardiology
MEMBER	: Asso. Prof & F/I MRD Dr. Sujeet Kr. Sinha, Department of Hospital Administration
MEMBER	: Asst. Prof. Dr Ram Krishna Mondal, Department of Hospital Administration
MEMBER	: Asso. Prof & F/I, Information Technology & Hospital Information System Dr. Abhyudaya Kumar
MEMBER	: Dr. Rathish Nair, Chief Nursing Officer
MEMBER	: CDAC Representative
MEMBER Secretary	: Ms. Rajni , Medical Record Officer
MEMBER Secretary	: Ms. Deepti Sinha , Medical Record Officer

The committee can co-opt any other members as and when required.

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1. Introduction

1.1 Purpose

The aim of this document is to outline comprehensive guidelines for the management of medical records at AIIMS, Patna. These guidelines are designed to assist all stakeholders in effectively developing, managing, and utilizing medical record services at AIIMS-PATNA. By following these guidelines, we aim to improve efficiency, enhance the quality of patient care, support medical audits, and strengthen data management through streamlined record-keeping practices.

1.2. Scope & Objectives:

This standard operating procedures related to all patient medical records at AIIMS-Patna. It aims to clear guidelines, it facilitates the seamless management of health services, enables medical research, and ensures accurate healthcare statistics for informed decision-making and planning. Maintaining accurate and organized medical records is crucial for any healthcare institution. Therefore, Medical Records Department SOP is designed to streamline and standardize the medical records processes at AIIMS-PATNA, which reflects the different stages of medical records processes, such as "Patient's file Receiving," " file Reviewing " "Filing ," ," coding" ," File Archival " and "Retrieval", by implementing standard operating procedures (SOPs) for medical records department can have numerous benefits of health care services, which consists of:

- It ensure consistency and standardization in medical record management processes at AIIMS-PATNA.
- Improve efficiency by streamlining work-flow and reducing errors in patient's medical records.
- Facilitate skill and training for new staff members and paramedical students.
- Increase data security and confidentiality of patient medical information/ records.
- Enable effective communication and collaboration between departments
- Enhance patient care by providing accurate and accessible medical records.

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1.3. A brief overview of Institute and it's Medical Records Department of AIIMS, Patna

The institute was established under Ordinance dated July 16, 2012, the Act (Amendment) 2012 on July 2, 2013, and the All India Institute of Medical Sciences (Amendment) Bill 2012 gave it a shape, and it was further supported as an autonomous body by All India Institute of Medical Sciences (Amendment) Bill, 2012. With 42 specialized departments and an array of various specialties, inpatient bed facility, and emergency and trauma services with 960 of sanctioned bed. Further the functional bed capacity has been increased as per order no. AIIMS/PAT/2025/541 by 1240 census beds, with ICU 115 beds, 30 HDU beds, 105 observaton beds. Currently it has 27 Speciality and 14 super speciality department functional. Where the medical records department (MRD) in AIIMS, Patna came into existence since 2014, which has been inducted under the control of Medical Superintendent Office and is responsible for patient registration and maintaining, storage and preservation of indoor patient records of the institution. Besides the department has been compiling, sharing, and disseminating the important healthcare information to concerned, researchers, medico-legal proceedings, and institutional stakeholders. The department has been proactive in handling in patients records and is responsible for smooth functioning.

2. Medical Records Department

2.1. Definition and Objectives

- According to *McGibbon* "A medical record is a clinical, administrative, scientific, and legal document that justifies a diagnosis and treatment plan." It provides a vital record of a patient's health status, past interventions by healthcare professionals, and current treatment plans. *Lawrence L. Weed*, The father of the modern medical record, developed a system for organizing patient data in the 1950s
- The objective of generating medical records shall include Identification information of patients, such as name, date of birth, and address, Medical history, including diseases, illnesses, medication information, including current and past medications, family history, including who to contact in an emergency, treatment history, including procedures, observations, and lab results, consent forms, admission notes, and discharge summaries, etc.
- There are four major components Additionally, medical records play a critical role in generating healthcare statistics, which are indispensable for health authorities in optimizing service delivery. Moreover, they serve as crucial evidence in legal contexts and are pivotal to the health insurance industry. For healthcare researchers, medical records

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represent a valuable source of data for advancing medical knowledge and improving patient outcomes.

2.2. Medical Records Department (AIIMS, Patna)

Inception : 2014
Controlling Authority : Medical Superintendent
AIM : **Management of Medical Records in AIIMS, Patna**
Objectives:

- Maintaining, Storage, Handling, and Preservation of Records: Ensuring proper management and safekeeping of indoor and emergency medical records.
- Sharing, and Disseminating Healthcare Information: Facilitating the timely sharing of critical healthcare data with, competent authority for medico-legal purposes, and for institutional purpose.
- Collection, Compiling, and Dissemination of Healthcare Statistics: Aggregating and reporting healthcare data to competent authority to support institutional decision-making.
- Birth & Death Registration and Certification Issuance: Managing the registration process and issuing certificates for births and deaths.
- Quality Assurance in Medical Records: Implementing measures to maintain completeness, and confidentiality of medical records.
- Capacity Building of Staff: Conducting ongoing training activities to enhance staff skills in medical record handling and management
- Currently, the MRD at AIIMS Patna does not maintain OPD records. However, if any department wishes to retain OPD records, they may do so within their own departmental space. In such cases, the MRD will provide support and guidance for proper record keeping.

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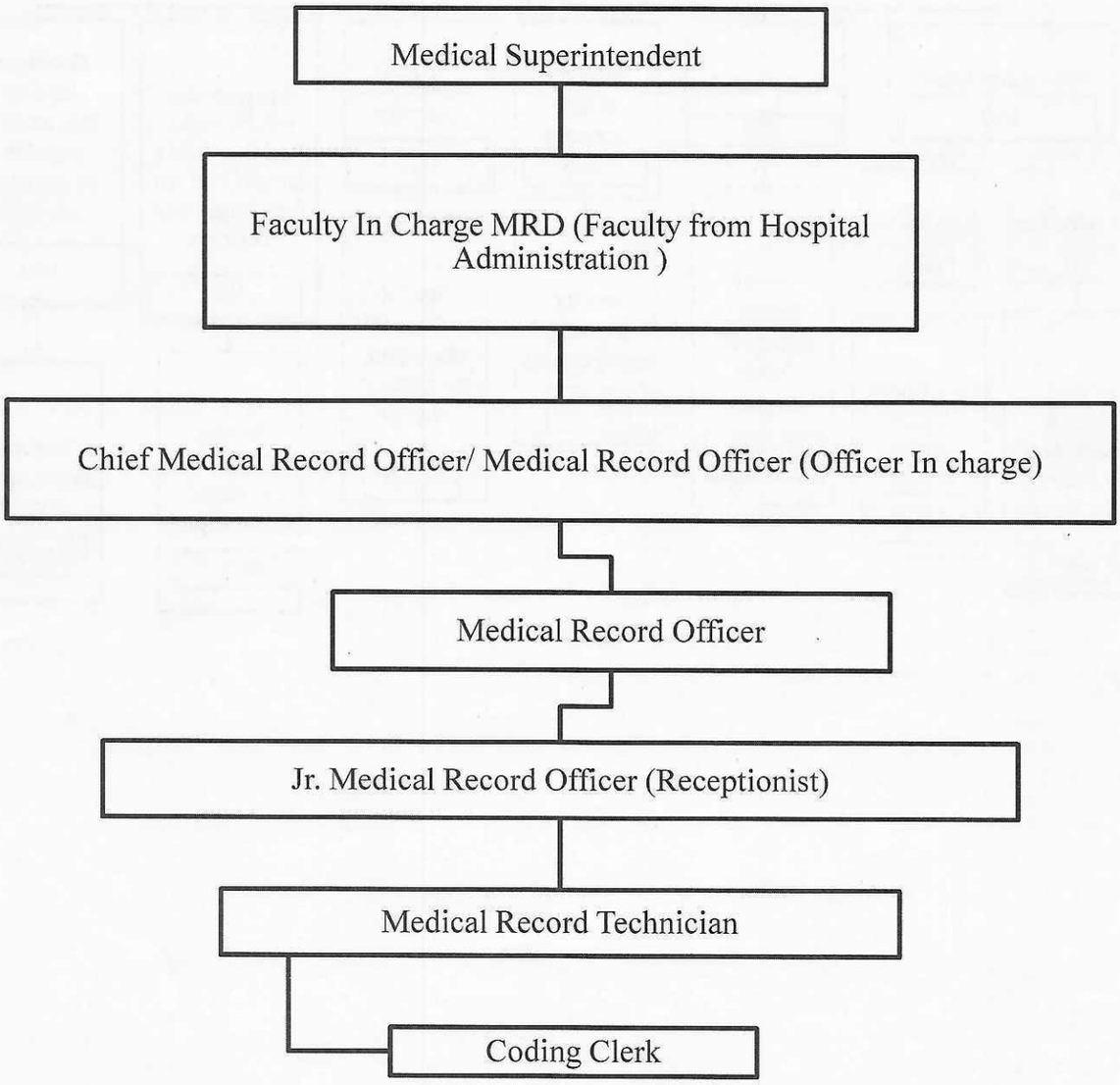
2.3. Organizational Structure



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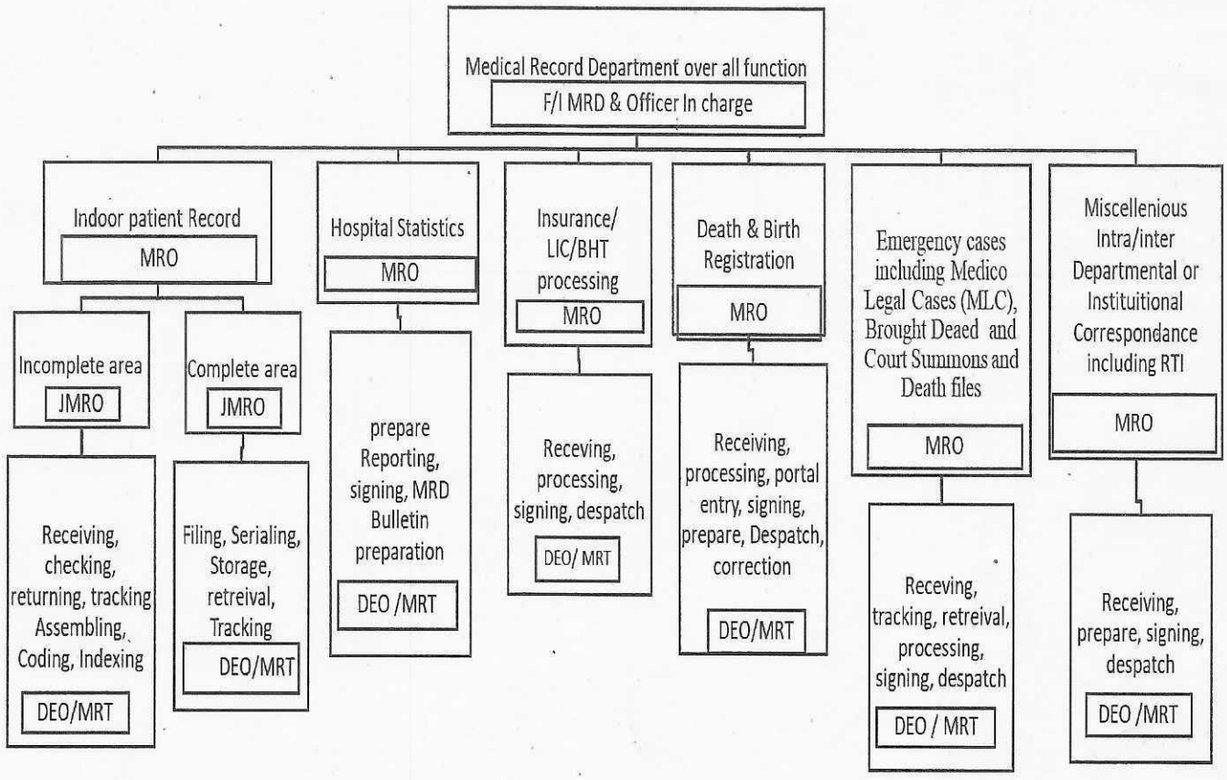
2.4. Sections & Sub-sections of Medical Records Department



2.5. Establishments and Locations

This department manage medical records of indoor patients of the institute and documents of Medico Legal Cases of casualty cases.

Area	Contact Person	Location	Timing
Indoor Patient Records	Medical Record Officer Jr. Medical Record Officer (Receptionists), MRT/ DEO	IPD Block	9am to 5 pm
Indoor Patient Records & Medico Legal Cases	Medical Record Officer	Ayush PMR	9am to 5 pm
Birth & Death Registration	Medical Record Officer Jr. Medical Record Officer (Receptionists)	IPD Block	9am to 5 pm
Reimbursement/ LIC/BHT processing	Medical Record Officer	IPD Block	9am to 5 pm
Hospital Statistics	Medical Record Officer	IPD Block	9am to 5 pm

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3. Policies and & Standard Operative Procedures of Medical Records Department of AIIMS, Patna

3.1. Patient Identification and Medical Record Numbering: Patient identification is the beginning of an efficient medical record system. Correct identification is vital to ensure that each patient has one central registration number. This helps in efficient linkage and retrieval of patient health records, to ensure unerring record management especially in case of namesakes. The responsibility for correct patient identification rests with the Medical Record Clerk/Technician/DEO at the registration counter. He/she should appropriately enter and verify the patient identity by using Unique Patient Characteristics. **WHO defines "Unique Patient Characteristic" as "something about the patient that does not change", such as father/mother's maiden name, national identification number such as Aadhaar number, date of birth (NOT age) etc.** This information along with other particulars of the patient should be recorded accurately by the clerk/self (in case of online registration) in the 'Pre registration Slip' when the patient visits the hospital for the first time.

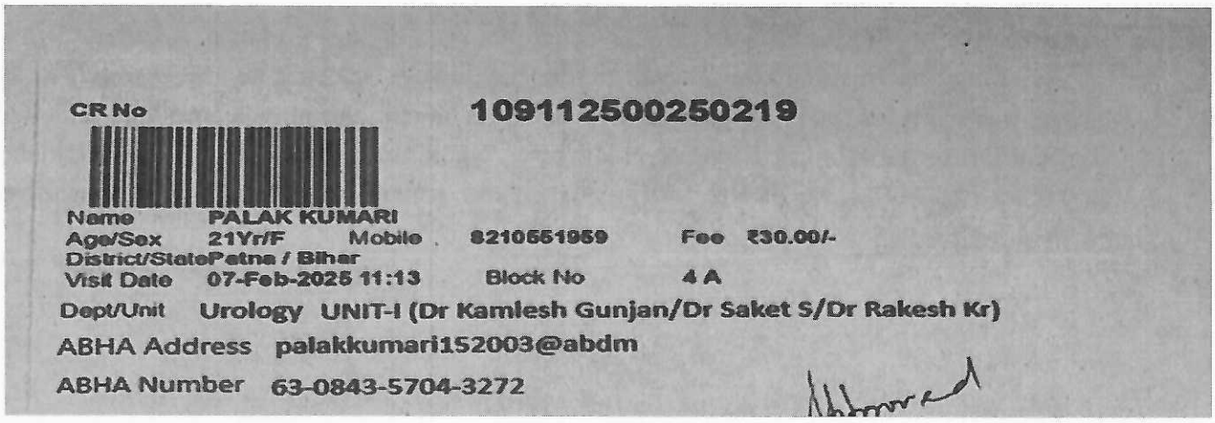
3.2. Central Registration Number (CR No.): Once a patient has been identified, the next step is to allot a unique medical record number to this patient, which is referred to as the "Central Registration Number (CR No.)" in AIIMS, Patna. The allotted CR No. is unique and permanent to every new patient, visiting the institute for the first time and the same number is used during the entire episode of outpatient consultation or hospitalization. In subsequent visits to the institute, the same number is used to identify a patient and his/her medical record. It's the duty of Medical Record Clerk/ DEO on registration counters to ensure, with careful interviewing, that an old patient visiting the facility for second or subsequent time does communicate his/her existing CR No. for linking the new record with previous ones. In case, an old patient cannot recall his/her CR No., the clerk should trace it from the Hospital Management Information System (HMIS) by using the Patient Identification information and Unique Patient Characteristics. Every effort should be made on the part of the **DEO to ensure that duplication of CR No. does not take place.** The CR No. is a unique 15 digit number assigned in a straight numerical sequence by registration module of HMIS. The CR No. is used to 'file' the medical record and thus it is important to make sure that the number is correctly recorded on all forms in the patient's medical record (Example of CR No.:- 109112500250219 in this 10911 is hospital code 25 is year, then unique series). The first five digits of this number represent the hospital code next two digit year next will be the series generated by HMIS when patient was first registered.

3.3. **Indoor Record Number (Admission No.) & Outdoor Record Number**: Along with the CR No., an alpha-numeric 'Outdoor Record Number' is also generated and printed on the OPD Card and Record. Similarly, a fifteen digit 'Indoor Record Number (Admission Number)' is generated and printed on all Inpatient Records. Both Outdoor Record No. & Admission No. are a combination of numerical series. These are used for finally 'Filing' the Medical records in MRD using Straight Numeric Filing method.

3.4. **REGISTRATION PROCEDURE & TIMINGS**: A patient visiting OPD belongs to one of the following categories:

- ❖ New Registration: against fee of Rs 30/- (for both, General or Super-speciality Clinic);
- ❖ A patient visiting Emergency needs to pay a registration fee of Rs.30 /-.

The Registration Module of HMIS is used at every registration counter, in which the patient's demographic details like name, age, sex etc. are captured through Ayushman Bharat Health Account (ABHA) and stored in 'Patient Demographic File' while fee details are stored in 'Registration Fee File' against same C.R. Number. On registration, patient is automatically allotted a ABHA Address and ABHA number by the HMIS. Registration card label displays following information:



Registration Timing:
OPD New Registration: 8 a.m. to 11:30 a.m.

3.5. **Emergency Registration in case of Unknown Patient:** Emergency patient's registration can be done without his/her name, age and other demographic details in case of unavailability. In such a case, the name of the person who brought the patient, date and time

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of patient's arrival etc. may be recorded. However, capturing such information like details of accompanying person, patient's belongings etc. which are an integral component in the HMIS must not importunately hinder the treatment process. If the patient's name is not known, patient's name field should be recorded as 'Unknown'. Provision has also been made to mention whether the patient is a Medico Legal Case (MLC) or not. Registration fee of Rs. 30/- has to be remitted to registration counter at Trauma/Emergency Department. But in urgent situation and unknown cases, patient may be allowed to register even without paying the registration fee and it should not be treated as mandatory. In case identity of an unknown person is established after admission, the following documents are required before the patient's name and demographics can be recorded in the Hospital Management Information System (HMIS):

a). NOC from police station concerned,
b). Valid government ID of patient; and
c). Approval of Medical Superintendent.

3.6. Special Clinic Registration

In case of internal departmental referral in hospital to a Special Clinic, patient may approaches the concerned Special Clinic departmental counter for registration on the specified date without any charge. In case of Patient referred from outside has to pay Rs. 30/- as registration fee only and is then registered at the Special Clinic.

3.7. Revisit

A revisiting patient should be directed to the same doctor or department that provided the initial treatment for follow-up care. However, if the patient has a new complaint, they may be referred to the relevant department. In cases where a duplicate registration booklet is issued, a registration fee of ₹30 will be charged for general patients, and ₹50 for patients with an EHS card

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3.8. Medical Record Handling and Management

A visiting patient belongs to one of the following categories:

Outdoor Patient (OPD)	
New Registration	Revisit
Indoor Patient (IPD)	
OPD	Emergency
Emergency Patient	
New Registration (First Visit)	Old Registration (Existing CR NO.)

4. Process Flow of Indoor Medical Record Handling in MRD involves:

- **Admission Process:** Patients admitted from OPD or Emergency must approach the Indoor Admission Counter with documented advice for admission and an Admission Number issued.
- **Reporting to Ward:** Upon admission, patients must report to the nursing staff in the respective ward within. Details are entered into the Admission module to accept the patient in the Hospital Information System (HIS) of respective ward.
- **Discharge and Death Recording:** Nursing staff enter details of discharged, deceased, LAMA (Leave Against Medical Advice), or absconding patients into the Discharge & Death ward registers and HMIS module and generate the case sheets.
- **Record Collection:** All ward in-charges must ensure that the MRD files of discharged, deceased, LAMA, or absconding patients are promptly sent to the Medical Records Department (MRD). They must confirm entries in the HMIS, update the MRD register, and deposit the records in the 'Incomplete Section' of the MRD within 48 hours. If any file is found to be incomplete, the MRD will return it with recommendations for correction or completion
- **Monitoring and Follow-up:** MRD checks received records against ADT module entries. Reminders are sent to In-charge Nurses and HOD's for timely submission of incomplete records.

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- **Record Assembling:** In the Incomplete Section, Medical Record Technicians (MRT) assemble records according to Source Oriented Medical Records format, ensuring completeness and marking incomplete ones for follow-up.
- **Record Completion:** Clinical departments send teams weekly to complete earmarked incomplete records at MRD (This is not existing process but it may further implement.).
- **Midnight Census and Statistics:** MRD collect daily midnight census and statistics from Hospital Management Information System (HMIS) for administrative purposes as on daily basis which shall be verified by Nursing Superintendent receives next day by 10 am.
- **Coding and Indexing:** Completed records are coded with ICD-10 codes manually on the face sheet and also entered into HMIS. Automatic indexing follows in the HMIS module before transferring records to the 'Complete Section' of MRD.
- **Digitization:** Records in the Complete Section undergo serial numbering and scanning to generate digitized copies. (yet to be implemented)
- **Filing:** Manual copies of digitized records are confidentially filed in compactors using a straight numeric filing method. Labels with file numbers on compactors aid easy retrieval.
- **Retrieval:** Records are retrieved upon requisition using prescribed forms available in MRD with the permission of Faculty In charge or by Head of the Department. Doctors must return records within 48 hours on date of issuance; reminders are issued for overdue returns, if fails to return respective department may mark as defaulter. In case of default, reminders are issued to the doctor and HOD of concerned department.

This structured process ensures efficient management, preservation, and accessibility of medical records at AIIMS, Patna, supporting optimal patient care and administrative functions.

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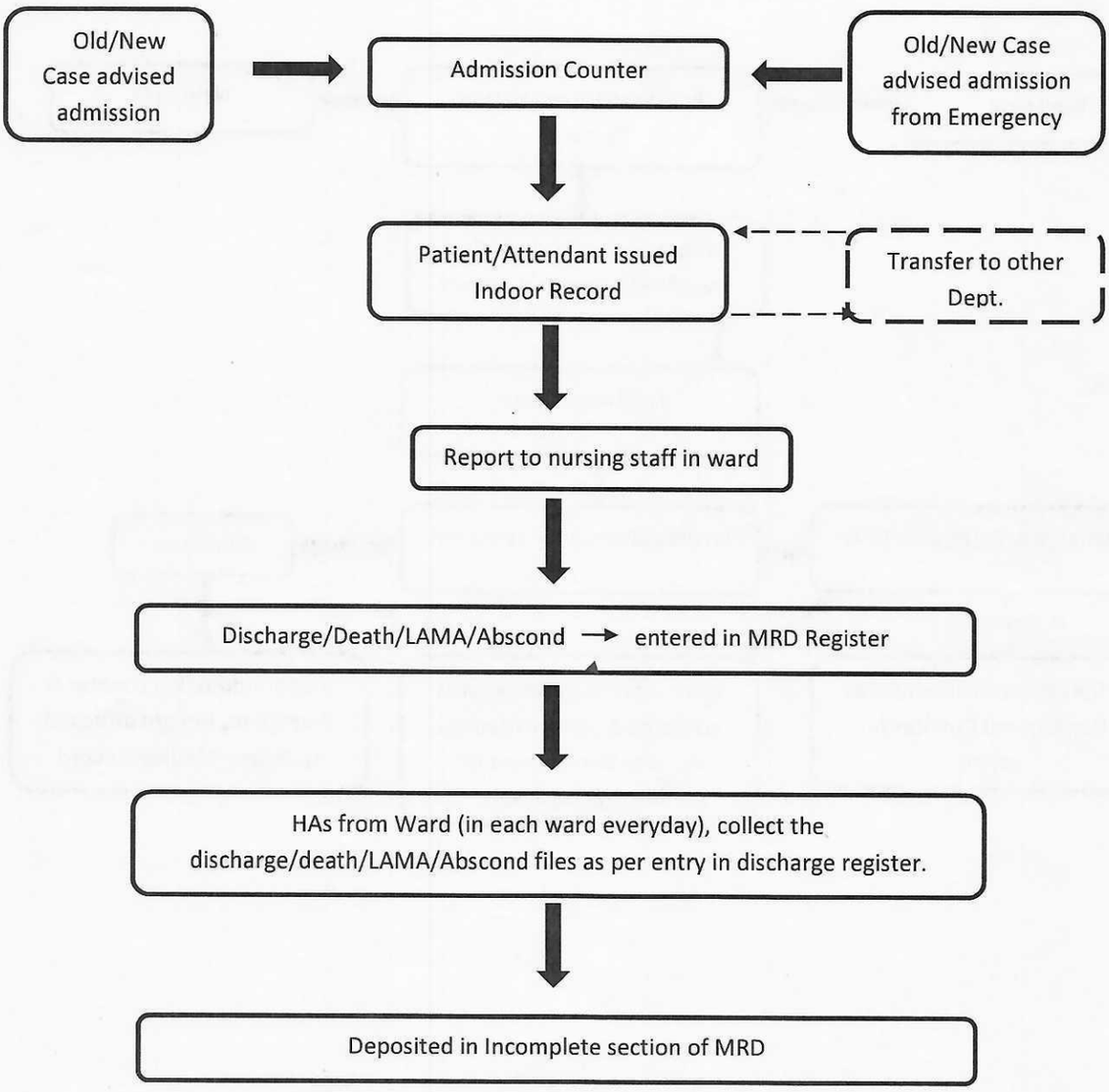
Flow Chart of Indoor Patients



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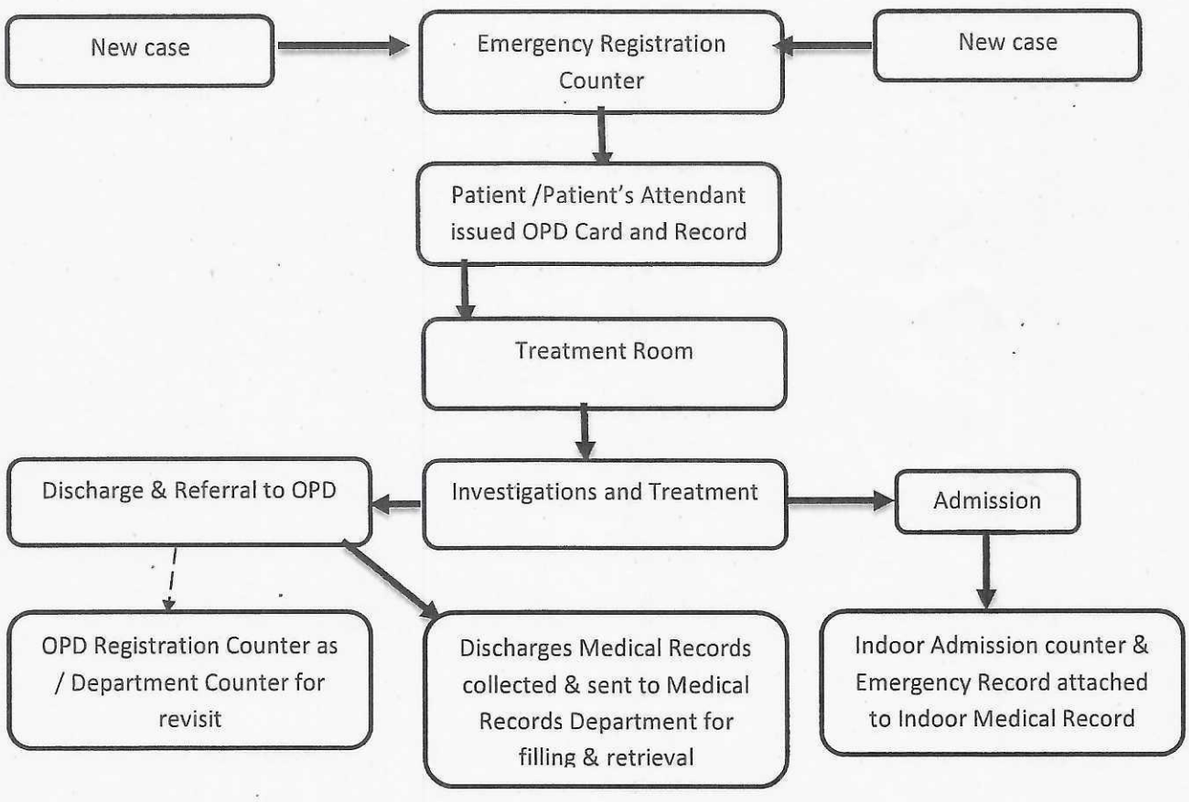
Flow Chart of Emergency Patients



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5. Process Flow for Emergency Medical Record Handling in MRD includes:

- **Registration:** Patients arriving at the emergency department are either existing beneficiaries or new to the institute's healthcare services. Dedicated registration counters issue an Emergency OPD Card, commonly referred to as Emergency Observation Card and Record/File respectively.
- **Issuance:** Upon patient identification number or Central Registration Number generation, an Emergency OPD Card cum Receipt and an Emergency OPD Record are issued upon payment of a registration fee (Rs. 30/-)
- **Consultation:** Patients, along with the Em OPD Card and Record, consult with the treating doctor in the emergency area. All medical investigations and treatments are documented in the Em OPD Record by on duty doctors.
- **Discharge or Admission:** Depending on the patient's condition, they may be discharged, advised to follow-up in the OPD, or admitted for further observation. The treating doctor updates both the OPD Card and OPD Record accordingly.
- **Discharge Process:** Discharged patients receive the OPD Card for personal information, while the OPD Record is retained by the Emergency Medical Records section. Records of discharged patients are sent Medical Records Department with 48hrs of discharge and filed in the Emergency Record Rooms for documentation and retrieval.
- **Admission:** Patients advised for admission receive an Indoor Admission Record from the Admission Counter, with the Em OPD Card and Record attached for continuity of care.
- **Revisits:** Returning patients are identified preferably by their existing CR No. and issued an updated Em OPD Card and Record. Efforts are made by medical record technicians/clerk, using HIS (Hospital Information System), to prevent duplication of CR Nos.

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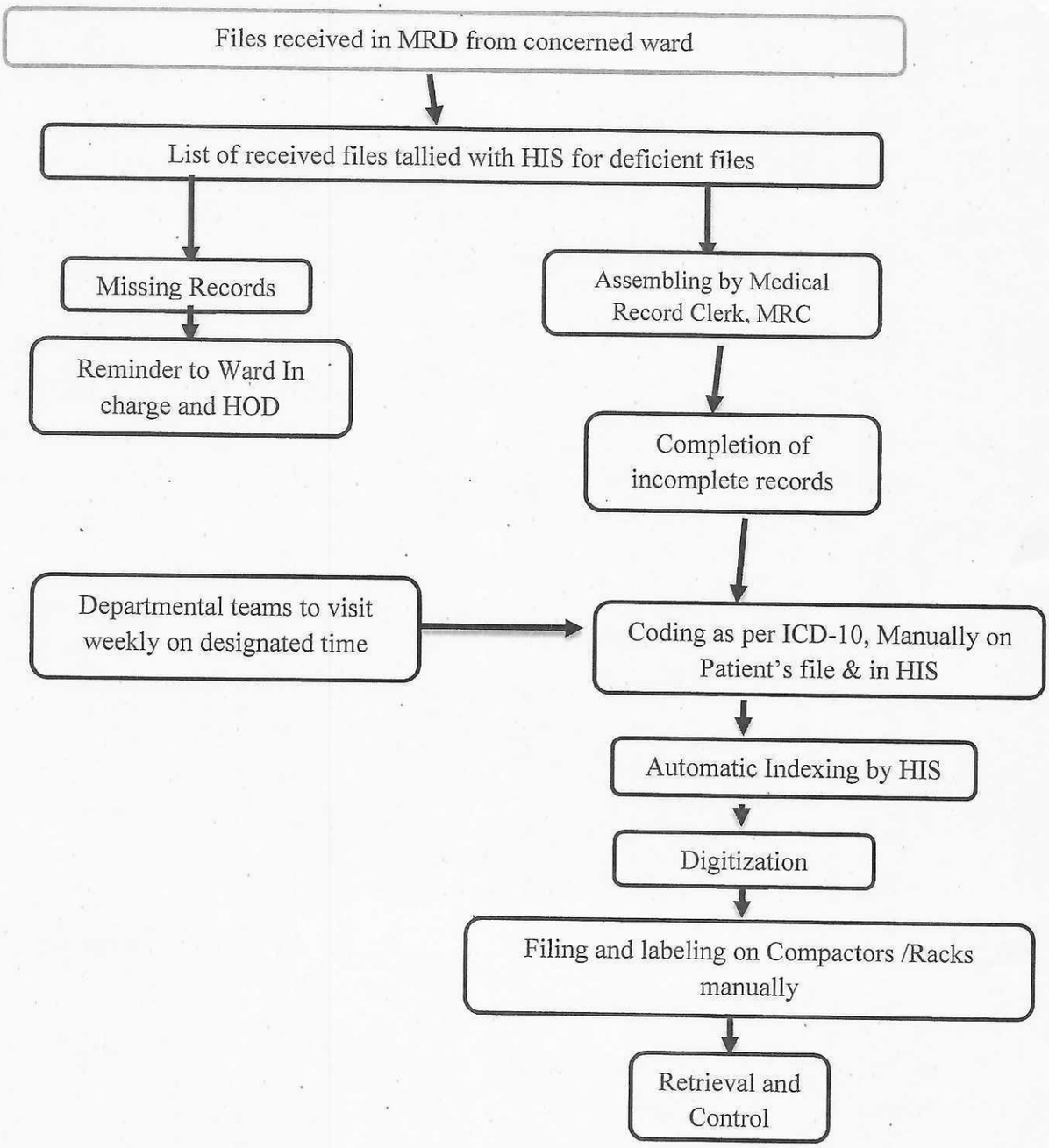
Process Flow Diagram for indoor medical record handling in MRD



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➢ **Processes in the 'Incomplete Section' of MRD includes:**

- **Assembling:** Assembling is the process of collecting all health records of a patient upon discharge and arranging them according to a standardized chart order. At AIIMS, the Source-oriented Medical Record Assembly Format is utilized, organizing patient data into sections based on its source (e.g., clinical notes, laboratory tests, nursing notes, etc.).

  Assembly Order: The medical record is structured in the following sequence:

  1. Face sheet (Includes Admission & Discharge Order/ Admission & Discharge Card with general consent and LAMA consent)
  2. Case sheet
  3. General Consent form
  4. Doctor's Continuation Sheet/Progress sheet/Clinical Notes
  5. Nurses Report/Orders/ Nursing notes
  6. Consent form for procedures
  7. Pre-Operative checklist
  8. Post-Operative checklist/OT notes
  9. T.P.R Chart (Temperature, Pulse, Respiration)/ICU Chart
  10. Intake/Output chart
  11. Drug Chart
  12. Investigation Reports (X-Ray, Lab, etc.)
  13. Referral and other communication sheets
  14. Discharge/Death/LAMA summary/report
  15. Final Bill & Provisional Bill

Benefits of Fixed Format: Adhering to a fixed assembly format ensures consistency and facilitates thorough scrutiny of all medical records. This structured approach supports efficient retrieval and review processes, enhancing overall healthcare service delivery.

Completeness Assessment: Once assembled, each record undergoes a thorough assessment to ensure all required components are included. This verification step is crucial in maintaining the integrity and utility of patient medical records. This revised version aims to clarify the processes involved in assembling and ensuring completeness of medical records in the 'Incomplete Section' of the MRD, emphasizing the systematic approach adopted at AIIMS, Patna.

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- **Completion of Records:**

After sorting forms into the correct order according to the assembly format, the Medical Record technicians undertakes a thorough 'discharge analysis' to ensure both quantity and quality aspects of the assembled medical record:

- **Requisite Forms:** The clerk verifies that all necessary forms are present, including operation reports, progress notes, pathology and x-ray reports, nursing notes, final bill and a final discharge note by the attending doctor detailing follow-up arrangements.
- **Front Sheet:** Ensures completeness of the front sheet, including the main condition/ provisional and final diagnosis, signed by the treating doctor indicating responsibility for the record's contents.
- **Discharge Summary:** Verifies the presence of a discharge/death/LAMA summary authored by the attending doctor, containing:
    - Patient identification
    - Final Diagnosis
    - Provisional Diagnosis
    - Reason/History for admission
    - Examinations and findings
    - Treatment details
    - Medications and diagnoses
    - Investigation Details
    - Proposed follow-up plans

Incomplete medical records are kept separately, and departmental teams visit weekly to complete them or may be sent back to concerned ward for completion of file. Once records are deemed complete in quality and quantity, coding of diseases, injuries, and operations listed on the front sheet is conducted.

- **Coding:**

Coding involves assigning alphanumeric codes based on ICD-10 for diseases/injuries The process ensures accuracy by:

- Verifying completeness and accuracy of the front sheet
- Cross-checking diagnoses with the discharge summary and supporting evidence in the medical record
- Reviewing progress notes for additional codes (complications, external causes, etc.)

Assigned codes are manually recorded on the front sheet and entered into the Hospital Information System (HIS).

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- **Indexing:**

Two primary types of indexes are prepared:

- **Disease Index:** This index lists diseases, conditions, and injuries, each assigned a specific code according to ICD-10.
- **Procedure Index:** This index includes operations and procedures performed at the hospital, with each operation or procedure assigned a specific code.

Both indexes are maintained based on the code numbers of diseases, conditions, or procedures, typically on index cards unless a computerized system is used. At this institute, the Hospital Information System (HIS) maintains a digital index.

Index Card Details: Each patient's CR No. is recorded on a 'Disease/Procedure Index Card' for the specific disease or procedure. For example, a card for a patient with a primary diagnosis of Coronary artery disease, would be labeled with code I 25.1 (Coronary artery disease). The card also includes:

- Patient's Medical Record Number/ In patient number
- Name of the treating doctor
- Service under which the patient was treated (e.g., medical, surgical, orthopedic)
- Patient's age and sex
- Outcome of treatment (alive or deceased)

Uses of Indexing: Indexing facilitates the retrieval of medical records and supports various functions, including:

- Reviewing records of patients with specific diseases
- Conducting research on particular diseases
- Obtaining information on hospital facilities and services
- Evaluating the quality of healthcare
- Performing medical records audits
- Supporting training and educational purposes
- Conducting epidemiological and infection-control studies
- Providing educational material for health professionals and medical staff meetings

➢ **Processes in the 'Complete Section' of MRD:**

- **Digitization:** Digitization is a key component of the Digital India initiative. Every record received in the MRD must be digitized before filing. This process ensures longer retention of medical records before physical destruction. At AIIMS, Patna digitization shall be given to outsourced.

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- **Medical Record Filing:** After assembling, coding, indexing, and collecting statistics, the final step is to file medical records securely and confidentially. Key considerations include:

  File Area: The filing area must be spacious, clean, well-lit, and equipped with desks for clerks to sort records and manage tracers. There should also be a designated space for records awaiting filing or completion.

  Filing Systems: AIIMS employs a decentralized filing system where each center has its own Medical Record Filing Area. Among the filing methods—Unit filing system, Serial filing system, and Serial Unit filing system—AIIMS uses the Serial filing system. Records are filed in compactors in numerical order, according to the Indoor Patient Number (Admission No.) and Central Registration Number (CR No.). Despite a centralized numbering system, each center's filing area may not always have a complete series of records.

- **Retrieval and Record Control:** The retrieval system is designed to facilitate access to filed medical records for follow-ups, research, insurance, planning, and statistics. Retrieval is managed through the Index, with the ADT module of the HIS system integrating with the Master Patient Index and disease systems. Requests for records are processed using printed requisition forms available in the MRD.

  Tracer System: To maintain record control, a TRACER (or OUTGUIDE) is used whenever a medical record is removed from a rack or compactor. The tracer card, which is slightly larger than the medical record, includes:

- Patient's name
- Patient's Admission number
- Destination of the medical record
- Date of removal from the compactor

The Medical Record Clerk (MRC) is responsible for entering all issued records into the 'Issue Register' and checking it daily for any missing files, known as MISFILES. Records borrowed by doctors must be returned within 48 hours. If a record is not returned on time, reminders are sent to the doctor and the Head of the Department (HOD). In cases of permanent loss, the healthcare provider must submit an affidavit assuming responsibility for any complications arising from the lost record.

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6. Management of Medical Record Components / Medical Record Forms:

Medical records are composed of various forms that capture specific patient information and data. The basic set of forms included in the inpatient medical record are:

A. Face/Front Sheet:
- Contains patient identification details, CR No., Admission number, final diagnoses, disease and procedure, and the attending doctor's signature.
- **Consent for Treatment:** Located on the back of the Front Sheet, this form includes:
  - General consent for treatment, signed by the patient at the time of admission.
  - Consent to release information to authorized persons.

B. Correspondence and Legal Documents:
- Includes any referral letters, requests for information, or other relevant legal documents received about the patient.

C. Discharge Summary or Other Summaries:
- Summarizes the patient's stay, including key diagnoses, treatments, and outcomes.

D. Admission Notes/ Case Sheet:
- Document patient's family and medical history, past medical history, presenting symptoms, results of physical examination, provisional diagnosis, and proposed investigations and treatments.

E. Clinical Progress Notes:
- Records daily treatment and patient reactions, documented by the attending doctor and other healthcare professionals.

F. Nurses' Progress Notes:
- Details daily nursing care, including charts for temperature, pulse, respiration, blood pressure, etc.

G. Operation Report:
- If an operation or procedure was performed, it includes details of the operation.

H. Other Healthcare Professional Notes:
- Includes notes from physiotherapists, social workers, and other professionals involved in patient care.

I. Pathology Reports:
- Includes reports from hematology, histology, microbiology, biochemistry, and other diagnostic tests.

J. Imaging Reports:
- Includes reports from X-rays, MRI scans, CT scans, and other imaging studies.

K. Orders for Treatment and Medication:
- Lists daily medications ordered and administered, with signatures of the prescribing doctor and the administering nurse.

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L. Special Forms:

- Includes any additional forms used for specific observations or treatments.

Order of Forms in the Medical Record:

Source-Oriented Medical Record Format: Forms are assembled according to the source of the data and placed within the medical record after discharge or death of the patient. All medical record forms or official forms approved by the administration or Medical Record Committee must be maintained and included in every medical record. Each form should clearly display the patient's name and Central Registration number/ In patient number for identification and tracking.

- **Hospital Information System (HIS): Admission, Discharge, and Transfer (ADT) Module**

The ADT module provides a comprehensive inpatient tracking service, allowing hospital staff to monitor the location and status of all currently admitted patients. Key features and functionalities of the ADT module include:

- **Patient Tracking:** Maintains real-time tracking of patient locations and identification details throughout their hospital stay.
- **Bed and Record Management:** Provides information on bed allocation, medical record status, and patient transfer and discharge details.
- **Automated Reporting:** Facilitates the automatic generation of essential reports and statistics for efficient hospital administration, including:
  - Admission lists
  - Discharge lists
  - Current inpatient lists
  - Lists of inpatients with extended lengths of stay
  - Midnight census
  - Lists of deceased patients
  - Transfer records between wards
  - Bed status reports
- **Access and Documentation:** Allows authorized users to access patient files directly and ensures that all admissions, transfers, and discharges are accurately recorded in real-time.

The ADT module enhances hospital operations by ensuring precise tracking and documentation of patient movements and statuses, supporting effective management and administration.

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- **Discharge / Death / LAMA / Absconding**

Throughout a patient's hospitalization, all clinical information, including results from investigations and special procedures, is meticulously recorded by doctors, health professionals, and nurses. This includes nursing notes and observations.

Discharge Procedures:

- Upon discharge, the complete medical record is sent to the Medical Record Department (MRD) by nursing staff. This should occur as soon as possible, ideally within 24 hours.
- The patient or their attendant is provided with a comprehensive discharge summary detailing all aspects of the hospital stay. A copy of all investigation reports done during hospital stay shall be provided. In Case of normal/death discharge (except MLC cases) all radiological reports shall be handover to the patient/ patient's attendant.

Death Procedures:

- In the event of a patient's death, a death summary or death notification form (in double) must be completed by the attending doctor. The distribution of copies is as follows:
  - One copy is given to the attendants.
  - One copy is filed with the medical record.
  - The final copy is sent to the MRD for processing the death certificate.
- The Death Register is maintained to track all inpatients who have died during their hospital stay. **Brought-in dead/ Trauma & emergency death patients are not included in this register. This information has been recorded in the ADT module of the HIS by treating doctor.** Records shall maintain separately by medical records department.

LAMA (Leave Against Medical Advice):

For patients who leave against medical advice (LAMA), the same procedures are followed as for discharge. It is essential to ensure that the patient or their attendants sign an undertaking regarding LAMA, which should be documented on the general consent form or a customized form/ Consent which is already mentioned at admission order back side.

Absconding Cases:

In cases where patients abscond, the police must be notified. If the patient has taken the medical record file with them, a recovery process is initiated through the police by the concerned Ward ANS/SNO through hospital security.

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Issuance of Death Certificate:

The Medical Record Officer (MRO) at AIIMS is responsible for issuing death certificates. Attendants must present the required documents and the death notification form at the MRD. After verifying and uploading the details into the Civil Registration System (CRS) via the National Information System Portal (NIS), the death certificate is issued to legal heir of deceased.

7. Medical Record Retention Policy & Procedure for Disposal

Retention Policy:

- **Digital Records:** All medical records of indoor patients from the past 10 years (or as available) should be stored in digital form. Moving forward, medical records of indoor patients will be continuously digitized and retained indefinitely. This practice supports future reference needs, including research and policy planning.

- **Physical Records/Hard Copies:**
  - **Inpatients:** Retained for 3 years.
  - **Medico-Legal Records:** Retained for 10 years or until the disposal of ongoing legal cases.

Disposal Procedure:

- At the end of each year, medical records that have reached the end of their retention period (3 years) are prepared for disposal according to hospital policy.
- Written permission for disposal is obtained from the Competent Authority.
- A request is then sent to the condemnation store to process the disposal following the established condemnation procedures.

8. Privacy, Confidentiality, and Release of Patient Information

Medical records are the property of the hospital and are maintained primarily for the benefit of the patient. The personal data contained within these records is confidential. Although the medical record is considered the hospital's property, it must be readily accessible to the patient upon request. Thus, medical records must be securely stored, and stringent policies regarding confidentiality and the release of patient information must be established.

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Access to Medical Records:

Unauthorized individuals must not be granted access to medical records. No information should be released without the patient's written consent, unless directed by legal authorities/ competent authority of the hospital.

Procedure for Release of Patient Information: The release of patient information can be performed through the following methods:

- **Direct Access to the Medical Record:** Allowing authorized individuals to view the medical record in person.
- **Supply of an Abstract:** Providing a summary of the information requested.
- **Verbal Release:** Giving information verbally, where applicable.
- **Photocopying:** Providing a copy of the medical record or parts of it.

Request Process:

Requests for medical information should be directed to the Medical Record Officer (MRO) and must be submitted in the prescribed format available with the Medical Record Department (MRD). The request must include:

- **Patient Details:** Admission No., full name, address, date of birth, date of admission, and date of discharge/ any valid government ID .
- **Requester Information:** Name of the person or institution requesting the information and any valid government ID.
- **Purpose and Need:** The reason for requesting the information and its intended use.
- **Extent and Nature:** Specific details of the information required, including relevant dates.
- **Authorization:** A recently dated and signed authorization from the patient or their authorized representative dully approved by faculty in charge / medical superintendent.

Whom to release: Treating doctors/ Patient/ legal heir (any valid government ID which shows the relationship with patient with proper justification)/investigating officer/order from court.

- **Right to Information Act, 2005**

Under the Right to Information (RTI) Act, 2005, requests for information must be submitted in the prescribed format available from the RTI Cell at AIIMS, Patna or on the institute's official website. The request should be addressed to the Central Public Information Officer (CPIO) or Assistant Public Information Officer (APIO) in the Medical Record Department (MRD) and must include the prescribed fee as specified by the Act.

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Exemptions and Special Conditions:

Medical records will not be provided in cases that fall under the exemption clause of Section 8(1)(e) of the RTI Act, 2005. For other cases, particularly when the patient is deceased or if the request pertains to a medico-legal case, the following conditions must be met:

- **For Deceased Patients:** An affidavit must be submitted, duly attested/verified by a First Class Judicial Magistrate or Executive Magistrate. The affidavit should include a photograph of the applicant and state their relationship with the deceased, as well as the specific purpose for which the copy of the treatment record is required.
- **For Medico-Legal Cases:** A No Objection Certificate (NOC) from the concerned investigating agency or police station must be provided. The NOC should confirm that issuing copies of the treatment record will not obstruct the ongoing investigation.

  Photo Identity Proof: A valid photo ID of the applicant (legal heir) which relates their relationship with patient/ deceased must be submitted along with the request in all the cases in RTI for providing any medical records.

Upon submission of these documents, verified photocopies of the treatment record will be issued.

9. Medico-Legal Cases

When a case is registered as or converted to a Medico-Legal Case (MLC) upon the recommendation of the treating doctor, the case file should be stamped as "M.L.C.". All MLC case should registered in the M.L.C. Category within the Hospital Information System (HIS). The Medical Officer/ treating doctor, upon receiving a request from the investigating police officer, prepares a Medico-Legal Report (M.L.R.)/Injury Reports using the prescribed format and provides it for legal purposes. Which shall be given to concerned investigative officer upon his/her written request in name Medical Superintendent. Further under approval of Medical Superintendent it shall release to concerned investigative officer.

In case a copy

Procedure for Requesting Medico-Legal Reports (M.L.R.):

- **Affidavit Submission:** An affidavit must be submitted in the name of the applicant. This affidavit should state the applicant's relationship with the patient (if the applicant is not the patient themselves), the purpose for which the M.L.R. is needed, and the number of copies required.
- **No Objection Certificate (NOC):** A No Objection Certificate (NOC) from the concerned investigating agency or police station must be provided. This NOC should

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confirm that issuing copies of the medico-legal report will not obstruct the investigation.

Issuance of Copies:

- After submitting the required documents, copies of the M.L.R. are issued, duly attested by the concerned doctor or Medical Officer (MO). Attested copies may also be issued based on special court directions.

Points to follow in MLC cases:

- Three copies of the Medico-legal report, one is kept as hospital record, other is kept in the office of Medical Superintendent or emergency department and the original is given to police after getting proper receipt.
- Hospital records or file of MLC should be kept as confidential in Medical Record Department till judgment by the court of law or lifetime (for practical purposes, no time limit).
- If Medico-legal report has already been issued, then duplicate Medico-legal report should not be issued unless specifically requested by the police in writing or by the order of the court.
- While receiving the file, confirm whether MLC has been registered in emergency or not. Should be mentioned MLC number with date and time with red Seal of MLC on each paper of MLC file.
- Completion of all the documents including discharge summary, consent forms, vital sheets and investigation reports and so on with sign, stamp and also demographic details on each document with MLC stamp.
- In all forms of investigation, MLC number should be written clearly.
- Mandatory completion of all the consent forms without fail.
- Page numbering on each document.
- If a MLC, recorded elsewhere (in other hospital) is referred, it should be treated as MLC but NO NEW MLC number should be issued. Treatment should continue in outside MLC number. Neither a new MLR (MEDICO LEGAL REPORT) should be prepared nor is it needed to inform the police.
- Discharged Inpatient physical files MLC, MLC Death, must receive from wards in 48 hrs.
- MLC register must maintained and stored permanently.
- MLC and Death cases are entered in MLC and Death register respectively.
- In case of brought in dead, the same is entered in brought dead register.
- All MLC documents are confidential and to be kept under lock & key and safe custody to avoid any tempering.

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- In case, the MLC/Death file is missing, the nearest police station should be informed for the same.

Summons or Court Orders:

All court summons related to medical records are received by the Medical Record Clerk (MRC) at the MRD receipt desk. A computerized record of relevant information—such as the date of evidence, contesting parties, court name, judge's name, district and state, particulars of documents required, doctor's name and department, date of receiving, and remarks—is maintained for future reference. The summons or court order, along with the requisite patient file, is forwarded to the concerned department's Head of Department (H.O.D.) by the Medical Record Officer (MRO) in the prescribed format. After providing evidence, the issued file must be returned to the MRD immediately, with a receipt confirming the return.

Process for Preparing a Medical Record for Court:

1. **Locating the Medical Record:**
   - The Medical Record staff should locate the medical record. If it is not on file, it should be found and kept securely awaiting preparation for court. A tracer should be made to show that the record is with the MRO for medico-legal purposes.
2. **Checking Information:**
   - Verify that all necessary information as specified in the subpoena is present in the medical record and that it is complete. Ensure all pages (forms) are numbered, and the total number of pages is recorded.
3. **Photocopying:** If a photocopy is acceptable to the court, the original medical record shall not be submitted. Before sending any documents to court, all relevant forms should be photocopied, numbered, and retained in their original place within the medical record. Additional copies should be prepared for court use. A note should be added to the medical record indicating that a copy has been made for court purposes and will be destroyed upon the return of the original record. Once the original is returned from court, the copy should be removed and securely destroyed.
4. **Receipt of Return:**
   - Obtain a receipt from the court's receiving officer. This receipt should contain information such as the number of the subpoena, date received, name of the lawyer requesting the record, name and Medical Record Number of the patient, number of pages, and the date the record was sent to court.
5. **Returning the Record:**
   - Upon return from court, check that all pages are present, return any removed correspondence to the medical record, and ensure the record is filed correctly. Remove the tracer once the record is returned.

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10. Hospital Statistics Overview:

Medical records are crucial for obtaining accurate hospital statistics. These statistics are essential for financial planning, administrative purposes, and research. The Health Statistics section of the Medical Records Department (MRD) is responsible for the collection, maintenance, and publication of these statistics. Below is an outline of the key responsibilities and tasks performed by this section:

Responsibilities of the Health Statistics Section:

- **Data Collection:**
  - Gather verified statistical information from all hospital departments, operation theatres, and centers.
  - Compile and analyze data from these sources to generate meaningful insights.
- **Manual Compilation:**
  - Manually compile statistical reports from information generated online.
- **Daily Census Preparation:**
  - Prepare and compile the daily midnight census, categorized by specialty, ward, and emergency.
- **Reminders for Data Submission:**
  - Send reminders to various departments to ensure timely submission of statistical data to the MRD Department.
- **Monthly Census Compilation:**
- **Compile daily census data into monthly reports.**
- **Monthly Hospital Statistics:**
  - Prepare monthly reports on outpatient department (OPD) statistics, operating statistics, and indoor statistics.
- **Disease Statistics:**
  - Compile disease-wise statistics on a monthly and annual basis.
- **Annual and Financial Abstracts:**
  - Prepare annual reports and financial abstracts, and publish them on the AIIMS annual reports.
- **Statistical Information Provision:**

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- Provide statistical information to administrative authorities and clinicians as needed.

❖ **Mandatory Reporting:**

- Report required data to prescribed authorities and organizations.

❖ **Birth and Death Reporting:**

- Report births and deaths to the Registrar Births & Deaths of the institute.

Importance of Accuracy

The accuracy of hospital statistics depends heavily on the precision of the original medical records from which they are derived. Accurate data is crucial for effective financial management, administrative decision-making, and research activities.

11. Medical Record Committee Overview

The Medical Record Committee (MRC) plays a critical role in overseeing and guiding the management of medical records and patient information within a hospital. This committee is responsible for setting policies, procedures, and standards related to medical records and ensuring compliance with these guidelines.

Functions and Responsibilities

1. **Review of Medical Records:**
   - Ensure medical records are accurate, clinically relevant, complete, and readily available.
   - Verify that records support continuing patient care, meet medico-legal requirements, and facilitate medical research.
2. **Completion of Medical Records:**
   - Ensure that concerned medical staff complete patient records by including a discharge diagnosis and writing a discharge summary (where required) within a specified timeframe for each discharged patient.
3. **Standards and Policies:**
   - Develop and determine standards and policies for medical records and related services.
   - Regularly review and update these standards to ensure they meet current medical, legal, and operational needs.
4. **Problem Resolution:**
   - Address and recommend solutions for issues that arise concerning medical records and the medical record services.

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5. **Form Format and Approval:**
    - Determine the format for medical records and oversee the introduction of new medical record forms.
    - Ensure all new forms are reviewed and approved by the committee before being implemented in the hospital.

The Medical Record Committee ensures that medical records are managed efficiently, adhering to high standards of accuracy and relevance, and supports the overall functionality of the hospital's record-keeping system.

12. Insurance Claim /LIC Form Processing

The process for handling insurance claim forms at the hospital involves several key steps to ensure accurate and efficient processing. Here is an overview of the procedure and required documentation:

Process for Insurance Claim Form Processing

- **Request Receipt:**
    - When a patient or nominee requests the filling out of an insurance claim form, the request is forwarded to the relevant department along with the patient's treatment file for verification and attestation.
- **Bill Verification:**
    - Once the claim request is received in the MR department it should be further forwarded to account section to verify the same. Accounts section needs verify it same-day and return back to department.
    - After bill verification, MRD will proceed the further step of attestation of claim which is verified by the treating doctor and countersigned by the Medical Superintendent.
- **Return and Issuance:**
    - The final claim form is issued to the applicant with attested required documents.

Documents Required for Insurance Claim Form Processing

- **Insurance Documents:**
    - For health insurance claims: ID of the insurer or department.
- **Patient Records:**

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- Death/discharge summary and final bill.
- Company's claim form (duly filled).
- Claimant's ID and his/her relation proof as legal heir

Steps for Filling Out the Insurance Claim Form

- **Application Submission:**
  - The patient / patient attendant should submit his / her application form
- **Document Retrieval:**
  - Upon receipt of the application and for required documents for processing the same, the patient's case file is retrieved.
- **Form Completion:**
  - The insurance claim form is attached to the case file and sent to the concerned Head of Department (H.O.D.) for completion after bill verification is done by account section.
- **Form Issuance:**
  - Once the insurance claim form is completed its all formalities, the same is handed over to the applicant (patient or next to kin). A copy of the same must be attached to his/her IPD file.

Documents Required for LIC Claims

- **Treatment Record:** Copy of the treatment record or death notification form if the patient passed away at AIIMS Patna.
- **Policy Bond:** Copy of the insurance policy showing the nominee's name.
- **Application Request:** An application request for nominee.
- Insurance Form: Blank claim form from the insurance company.
- Death Certificate: Copy of the death certificate if the patient expired outside AIIMS Patna.
- Claimant's ID and hi..s/her relation proof as legal heir
- Payment of Rs.35/-

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13. Issuance of Bed Head Ticket (BHT)/ Indoor Case Paper (ICP)

Documents required for issuance of BHT/ ICP

- Application from patient/ patient attendant/ Insurance firm/ TPI in which reasons shall clearly mention
- Consent from patient/ legal heir in case of death
- Claimant's ID and his/her relation proof as legal heir
- Payment of Rs.35/-

14. Birth and Death Certification

The MRO is responsible for registering and issuance of Birth and Death certificates. Certificates are issued free of charge, with specific procedures and documentation required.

For Birth Certificate

- Name Registration: Name Declaration Form for registration of the baby's name.
- Copy discharge Summary of baby/ mother
- ID Proof: ID proof of parents.
- ID proof of the applicant (e.g., father, mother, grandparents, or self).
- Authorisation letter if required
- No email/RTI request will be entertained.

For Death Certificate

- **Acknowledgement Slip: Issued by AIIMS, Patna at the time of death**
- **ID Proof:**
  - ID proof of the deceased.
  - ID proof of the legal heir (e.g., spouse, parent, child, or sibling) which shall be proof of legal next of kin.
  - Authorisation letter if required
  - No email/RTI request will be entertained.

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Payments for Issuing / Corrections in Certificates

- **Addition of Child's Name:**
  - Within one year:- no charges may apply
  - After one year: Charges may apply as per RBD act.
- **Any major/ minor Corrections in birth and certificate:**
  - Any corrections in details: first class magistrate affidavit is mandatory specifying the details of correction with their reasons. Which shall contain photograph of applicant and ID details and must specify the relationship with deceased.
  - In the event of the loss of a birth or death certificate, the applicant must provide a copy of the First Information Report (FIR) along with an affidavit. The affidavit should include the following details:
  - Reasons behind the Loss: A clear explanation of how the certificate was lost.
  - Request for Issuance of second copy of the birth/death certificate: Justification for the issuance of a duplicate certificate.
  - Relationship with the deceased/ newborn: A statement confirming the applicant's relationship to the child or deceased individual.

15. Reference:

1. AIIMS, Patna Website https://aiimspatna.edu.in/
2. Post Graduate Institute of Medical Education and Research , Medical Records Chandigarh https://pgimer.edu.in/PGIMER_PORTAL/AbstractFilePath?FileType=E&FileName=Medical%20Records%20Manual6919.pdf&PathKey=EDITORREPOSITORY_PATH

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