STANDARD OPERATING PROCEDURES INFORMATION MANAGEMENT SYSTEM (IMS)

PROJECT MANAGEMENT UNIT
Primary & Secondary Healthcare Department

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REVISION SHEET

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Please note that this is a first draft, and may be subject to revisions. All information and content in this Material is provided in good faith by Project Management Unit, Primary & Secondary Healthcare Department and is based on sources believed to be reliable and accurate at the time of development.

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TABLE OF CONTENTS

1 ABBREVIATIONS

1	CNIC	Computerized National Identity Card
2	CPA	Corrective Preventive Action
3	CQI	Continuous Quality Improvement
4	DHQ	District Headquarter
5	DOB	Date Of Birth
6	HCE	Healthcare Establishments
7	HOD	Head Of Department
8	HMIS	Hospital Management and Information System
9	ICU	Intensive Care Unit
10	ID Card	Identity Card
11	IMS	Information Management System
12	MSDS	Minimum Service Delivery Standards
13	NICOP	National Identity Card for Overseas Pakistanis
14	OPD	Outdoor Patient Department
15	OT	Operation Theater
16	P&SHD	Primary and Secondary Health Care Department
17	PHC	Punjab Healthcare Commission
18	PMU	Project Management Unit
19	SH&ME	Specialized Healthcare and Medical Education Departments
20	SOP	Standard Operating Procedures
21	THQ	Tehsil Headquarter

2 IMS Scope

2.1 IMS OVERVIEW

The Government of Punjab is committed to improve the Healthcare Services and to bring an end to the rampant quackery. Punjab Healthcare Commission (PHC) ACT was therefore enacted in 2010 which mandated the PHC to prepare and prescribe Minimum Service Delivery Standards (MSDS) for various categories of healthcare service providers, and to get the same implemented in all public & private Healthcare Establishments (HCE) in Punjab including allopathic, homoeopathic and tibb systems, for grant of license without which no HCE can function.

Government of Punjab has taken another revolutionary step to bifurcate the responsibilities of Health Department into Primary and Secondary Health Care Department (P&SHD) and the Specialized Healthcare and Medical Education Departments (SH&ME) for improvement of healthcare services at all levels. P&SHD is implementing multiple initiatives to improve the healthcare standards and to comply with MSDS through revamping program.

MSDS for Hospitals prescribed by PHC and approved by the Government of Punjab are the minimum set of standards that a hospital must comply with while providing the healthcare services. The standards can only be complied with, if the HCEs have the proper infrastructure, material and human resources to provide the required care. Accordingly, the Project Management Unit (PMU) is currently reviewing and improving the facilities, material and human resources for betterment of the Health services. Development of Information Management System (IMS) Manual is a component of the larger effort in this regard.

IMS department serves an important role in patient care, facilitation to physician and hospital staff through timely provision of Medical Records of patient, history, medical equipment and medicine inventory related information. This will act as an integrated tool between different systems of the hospital and keep the centralized repository for addition and retrieval of patients and HCE related record. This system also ensures the safe custody and security of the record so that only authorized entry, update and retrieval can be processed on the stored record / date with proper authorization and logging of each actions through timestamp.

Medical Records serve as pivotal role in provision of patient care. Although, Computerized Management Information System have been used for safe keeping, faster retrieval of medical records but establishing the integrated structured records, Standard Operating Procedures (SOP) and record keeping formats are mandatory before moving towards the computerized system. Moreover, established manual security protocol in terms of entry and retrieval of medical records are also important before transforming them to computerized system. These Structured Records, SOP and formats related to IMS, which this manual will elaborate, then can be transformed to computerized system. All Hospitals are required to establish/revamp their respective IMS accordingly as delineated in the subject manual.

2.2 IMS OBJECTIVES

IMS Implementation major objectives are given below:

1) Each DHQ/THQ should have a complete and accurate medical record for every patient.
2) Every medical record will have a unique identifier.
3) DHQ/THQ policy will identify those authorized to make entries in the medical record who will follow the SOPs for Identification of Medical Record Entries.
4) Every medical record entry should be dated and timed as per SOPs for Time Lining the Documentation.
5) The author of the entry shall be identified according to the Identification of the Author of Data/Record Entries.
6) The record will provide an up to date and chronological account of patient care as per Up-to-date Chronological Record and Minimum Requirements for Patients' Medical Records.
7) The medical record should reflect continuity of care.
8) The medical record will contain information regarding reasons for admission, diagnosis and plan of care.
9) Operative and other procedures performed will be incorporated in the medical record along with the operative and procedure notes.
10) When a patient is transferred to another hospital, the medical record should contain the date of transfer, the reason for the transfer and the name of the receiving hospital and SOPs for Transfer of Patients will be followed.
11) The medical record shall contain a copy of the discharge note duly signed by appropriate and qualified personnel along with the Discharge Summary Record.
12) In case of death, the medical record shall contain a copy of the death certificate indicating the cause, date and time of death by an authorized officer.
13) Whenever a clinical autopsy will be carried out the medical record shall contain a copy of the report of the autopsy report.
14) Care providers will have access to current and past medical records.
15) The DHQ/THQ will regularly carry out review of medical records
16) The Medical Records should be reviewed periodically (open & Close inpatient files).
17) The medical record review committee will review 5% of the medical record of each department by random sampling.
18) The review will be conducted by identified care providers and health professionals.
19) The review will focus on the timeliness legibility and completeness of the medical records
20) The review identifies and documents any deficiencies in the record
21) Appropriate corrective and preventive measures undertaken will be documented.

3 TARGETS

3.1 TARGETS / TASK TO ACCOMPLISH

As delineated in the aforementioned IMS objectives, DHQ/THQ needs to have proper interlinked record of patient with unique identifier to track, retrieve and update the patient record on each visit to the hospital and there will be a consolidated file comprising of complete history of patient for intelligent decision making from the doctor that will lead to better patient care.

To achieve these objective targets needs to be defined along with standard operating procedure. Accomplishing the targets and following the SOP will ultimately lead to achieve the objectives and to conformance of IMS standards and regulations.

3.2 GENERATION OF UNIQUE IDENTIFIER

Patient record enables the health service provide in better patient care, any review and track of medicine, treatment and history. Therefore, need of unique identifier is eminent from the fact that during multiple visit of one patient his one file have to be maintained, retrieved and updated to establish his comprehensive medical record. It will also help in audit of any mishandling, medicine record and medical test conducted from the DHQ/THQ.

Although, patient name, father, mother name, DOB, Gender, CNIC are type of information that can never be changed. However, there is always a chance of duplication in most of the cases of these information and CNIC is not available with each person especially females and kids. Therefore, unique number needs to be generated that have to be an alphanumeric number for patients. Patient Record needs to be M1-121217-9999 or F-010120-9999 i.e. (Gender)(ID)-Date-(Sequence of patient), in this way each patient has a unique ID and when patient visits the 2nd or 3rd time, it will be easy to retrieve the record for that patient. The sequence of upper limit has been adjusted in a manner that it can cater the load of patient to the maximum and there is not even a slight probability of repetition of unique identifier for the patient.

3.3 NOTIFICATION FOR AUTHORIZATION TO MAKE ENTRIES IN PATIENT MEDICAL RECORD

Hospital administration needs to issue Notification for authorization of specific official / officer to make entries into medical records. Each Prescription, pre/post operation notes, pre/post operation medication, Tests, treatment, visits, consultation, recommendations, Admission / discharge, death certificate, must be signed along with Designation, Name, Department, date and time and stamp. Following table or record needs to be maintained and notified for record purposes to track the sign against a specific record and its matching with the authorization list.

Sr. No	Official / Officer Name	Designation	Department	Record / Data (Authorized to sign)	Sample Signature / Initial / Stamp
1					
2					

After issuance the broad categories, each individual official / officer needs to be given the list of documents which needs to be signed by him.

3.4 ALL ENTRIES OF MEDICAL RECORD MUST HAVE DATE & TIME ALONG WITH AUTHOR OF DATA

This is the concept of logging / time stamping each and every entry in medical record. This process start from the admission of patient, either from OPD or Emergency i.e. issuance of registration slip to the patient. That registration slip needs to be entered into the register with date & time. All register of the hospital must have two columns available in them i.e. date column and time column. Time must be entered in AM/PM format. Issuance of lab results, collection of samples, issuance of medicine, prescribing a medicine, pre operation notes, post operation notes, OT list,

Following columns to be added in all tables/records/list of hospital documentation

Date	Time	Official Name	Designation	Department	Sign / initial / stamp

Aforementioned columns to be appended in each table by making rest of the columns intact.

3.5 COMPREHENSIVE PATIENT MEDICAL FILE

This target will reflect the completeness of patient medical file. Starting with the creation of file with unique identifier from the first point of contact with the hospital that is either emergency or OPD till the discharge of patient, this file needs to hold each and every record in chronological order to give the complete history of all the activities performed during the time patient was admitted in the hospital. This will further lead to the history of patient also. If the patient is getting admitted 2nd or 3rd time, then same file may be appended for his 2nd and 3rd admission details with complete history of his first admission and treatment attached in logical sequence. This will help the service provider in getting his previous diagnosis, lab results, and medication and help him in better patient care.

The chronological sequence of keeping of record into patient medical file for inpatient record and outpatient record is given below. This sequence will be followed for the patient that is coming to the hospital for the first time, if the patient already had a record with the hospital, than the existing file of medical record will be retrieved and all below mentioned entries will be appended with the admission details after the medical record already existed in the available patient file.

3.5.1 INPATIENT RECORDS:

Medical record file for inpatients must comprise of

1) A unique identifying number as per format and a patient personal information form.
2) Name, address, DOB, sex, and person to be notified in an emergency.
3) The date and time of the patient's admission.
4) The admitting diagnosis and clinical symptoms.
5) The name of the attending physician.
6) Any patient allergies.
7) Documentation regarding advanced directives.
8) The report from the history and physical examination.
9) The report of the nursing assessment performed after admission:
10) Laboratory, radiological, electrocardiogram, and other diagnostic assessment data or reports as indicated.
11) Reports from any consultations.
12) The patient's plan of care.
13) Physician's orders or orders from another practitioner authorized by law to give medical or treatment orders.
14) Progress notes from staff members involved in the patient's care, which describe the patient's response to medications, treatment, procedures, anesthesia, and Surgeries.
15) Data, or summary data where appropriate, from routine or special monitoring.
16) Medication, anesthesia, surgical, and treatment records.
17) Consent forms.
18) Date and time of discharge.
19) Description of condition, final diagnosis, and disposition on discharge or transfer.
20) Discharge summary with a summary of the hospitalization and results of treatment.
21) If applicable, the report of autopsy results.

3.5.2 OUTPATIENT RECORDS:

Medical record file for inpatients must comprise of;

1) A unique identifying number as per format and a patient personal information form.
2) Name, address, DOB, sex, and person to be notified in an emergency
3) Diagnosis of the patient's condition.
4) The name of the physician ordering treatment or procedures.
5) Patient allergies.
6) Physician's orders or orders from another practitioner authorized by law to give medical treatment orders as applicable
7) Documentation that the patient has been offered the opportunity to consent to procedures for which consent is required by law/regulations.
8) Reports from any diagnostic testing.
9) Sufficient information to justify any treatment or procedure provided, report of outcome of the treatment or procedure, progress notes and the disposition of the patient treatment.

3.6 CONTENTS OF MEDICAL FILE

Following is the list of documents / record that needs to be available in the patient medical file

1) The practitioner responsible for the patient to identify the patient, provide continuing care, determine the patient's condition at a specific time, review the diagnosis and therapeutic procedures performed and the patient's response to treatment.
2) A consultant to render an opinion after a patient examination and review of the medical record.
3) Another practitioner to assume patient care at any time.
4) Retrieval of information required for utilization review, quality review and transfer recommendations, etc.

Clinical Information that needs to be available in the file is given below

5) The reason(s) for admission for care, treatment and services.
6) The patient's initial diagnosis, diagnostic impression(s) or conditions(s).
7) Findings of assessments and reassessments.
8) Any allergies to food or latex.
9) Any allergies to medication.
10) Conclusions or impressions drawn from the patient's medical history and physical examination.
11) Diagnoses or conditions established during the patient's course of care treatment, and services.
12) Any consultations reports.
13) Any observations relevant to care, treatment and services.
14) The patient's response to care, treatment and services.
15) Any emergency care, treatment and services provided to the patient before his or her arrival.
16) Progress notes.
17) All orders.
18) Medications ordered or prescribed.
19) Medications administered, including the strength, dose, frequency and route.
20) Any access site for medication, administration devices used and rate of administration.
21) Any adverse drug reactions.
22) Readmission notes.
23) Shifting record from one department to another department.
24) Treatment goals, plan of care, and revisions to the plan of car□
25) Results of diagnostic and therapeutic tests and procedures.
26) Medications dispensed or prescribed on discharge.
27) Discharge diagnosis.
28) Discharge plan and discharge planning evaluation
29) Follow-up plans.
30) Referral letters.
31) Any advance directives (Before admission of patient).

32) Informed consent, when required by hospital policy.
33) Any records of communication with the patient, such as telephone calls or email.
34) Any patient-generated information.
35) The time and means of arrival.
36) Indication that the patient left against medical advice, when applicable.
37) Conclusions reached at the termination of care, treatment and services, including the patient's final disposition, condition and instructions given for follow-up care, treatment and services.
38) Any significant medical diagnoses and conditions.
39) Any significant operative and invasive procedures.
40) Any adverse or allergic drug reaction.
41) Any current medications, over-the-counter medications and herbal preparations.

3.7 INCORPORATION OF OPERATIVE AND PROCEDURE NOTES

Operation and other high risk procedures should be included in patient's medical record before or after patient is transferred to other level of care.

Model:

OPERATING NOTES

Name	Age	Gender	MR No.	D.O.A:..dd../..mm../..yy..
Admission Via: ☐ Emergency ☐ OPD	Ward No.	Bed No.	Operation Time	D.O.O:..dd../..mm../..yy..

Surgical Safety Checklist Before Skin Incision (Time Out)			Anticipated Critical Events
Time Started: ..... : .....AM/PM	Time End: ..... : .....AM/PM		To Surgeon
☐ Confirm all Team members have Introduced Themselves by Name and Role & Team Include			☐ What are Critical or Non-routine Steps
			☐ How long will the Case Take
☐ Surgeon	☐ Assistant Surgeon	☐ Anesthetist	☐ What is Anticipated Blood Loss?
☐ Scrub Nurse	☐ Circulating Nurse	☐ Technician	To Anesthetist:
☐ Confirm Patient Name, Procedure, Incision Site & Side			☐ Are there any Patient Specific Anesthesia Related Concerns?
☐ Antibiotic Prophylactic being given within last 60 minutes			To Nurse
☐ Is Essential Imagining Displayed?			☐ Has Sterilization of Equipment Been Confirmed
			☐ Are there any Equipment Related Issues/Concerns

Pre Op Diagnosis		**Anatomical Site Surgery Performed:**
Procedure		**Incision:**
Anaesthesia Given		**Procedure Details:**
Post-Op Diagnos is		
Surgery Elective / Planned		
Anesthetist		
Surgeon		
Assistant		
Nurse		
		Wound Closure:

Findings		Sign Out	
Disease Nature & Extent of Disease		Nurse Verbally Confirms with the Team	
		☐ The Name of the Procedure	
		☐ Completion of Instrument, Sponge and Needle Counts	
		☐ Specimen Labelling (Read Specimen Labels Aloud, Including Patient Name)	
		☐ Whether there are any Equipment Problems to be Addressed	
		Intra OP Estimated Blood Loss:	
Any Unexpected Pathology		Intra OP IV Fluid / Blood transfusion:	
		Intra OP Urine Ouput:	
Specimen Test		Surgeon, Anaesthethist and Nurse	
Condition of Patient after Operation		☐ What are key Concerns for Recovery and Mangement of this Patient?	

Sutures		Drains		Prothesis	
				Type	Serial No.

Name, Signature, Stamp & ID of Surgeon	Date & Time	Name, Signature, Stamp & ID of Scrub Nurse	Date & Time

3.8 TRANSFERRING OF PATIENT

Record of patient transfer should be maintained with full details of patient past medical record, patient's disease, current condition and reason of referring, current medication, name of hospital transferring to and date and time for referring patient.

Model:

Patient's Name					**w/o, d/o, s/o**		
Age		**Gender**	**M**	**F**	**Medical Record No.**		
Consultant					**Diagnosis**		
Date of Admission			**Date of Shifting**			**Time of Shifting**	
Address							
Nature of Referral	Emergency				Non-Emergency		

Reason for the Referral (Tick the relevant)				**Condition at Referral** (Tick the relevant)			
1	Patient's/Attendant request			Alert		Pulse	b/min
2	Clinical Assessment			Respond to Verbal command		BP	mm/Hg
3	Medico legal Case			Unconscious		R.R	Breaths/min
4	Any other reason			Other(Specify)		Temp	F

Name of receiving hospital
Brief Clinical History & Examination
Diagnostic Investigations Done at DHQ Hospital
Treatment Given at DHQ Hospital
Name & Signature of Duty Medical Officer

3.9 DISCHARGE SUMMARY/REPORT

Discharge report should contain reason for admission, diagnostic investigation result, discharge medication, and follow up instruction and signature of responsible personal.

Model:

Government of the Punjab

PRIMARY & SECONDARY HEALTHCARE DEPARTMENT

DHQ / THQ HOSPITAL

MEDICINE BEDHEAD TICKET

☐ DISCHARGE FORM ☐ REFERRAL FORM

Patient Name		Father/Husband Name		MR No	
CNIC/SNIC	☐☐☐☐☐-☐☐☐☐☐☐☐-☐	Age		Gender	☐ M ☐F ☐T
Mobile No		Address			
Date of Admission: ..dd../..mm../....yy..		Time of Admission: ..... : ..... AM/PM		MLC *(In Case of MLC, Mention DOC. No./MLC. No.):*	

Presenting Complaint

Concomitant Disease	☐ DM	☐HTN	☐ Asthma	☐IHD	☐Tuberculosis	☐Hepatits
	☐ Other					

Significant Examination Findings

Diagnostic Investigations Significant Results

Final Diagnosis | **Additional Diagnosis**

MEDICATION GIVEN

1.	2.
3.	4.

Procedure Done | Outcome

Amount of Transfused Blood

In Case of Any Complications During Hospital Stay

Outcome / Response to Treatment

DISCHARGE NOTES *(In Case of Discharge Please Fill this Section)*

☐ Discharge Advised By Dr. ☐ DOR | Date of Discharge ..... / ..... / ..... | Condition on Discharge: ☐Satisfactory ☐ Fair ☐ Poor

TREATMENT ADVISED

Sr. No	Medicine & Strength	Dose	Route	Frequency	Timing	Duration
					کھانے سے پہلے/ کھانے کے بعد	
					کھانے سے پہلے/ کھانے کے بعد	
					کھانے سے پہلے/ کھانے کے بعد	
					کھانے سے پہلے/ کھانے کے بعد	
					کھانے سے پہلے/ کھانے کے بعد	

درج ذیل تاریخ کو ہسپتال ہذا کے درج ذیل ڈیپارٹمنٹ میں معائنہ کیلئے تشریف لائیے۔ تاریخ معائنہ: _____ ڈیپارٹمنٹ: _____

ہدایات برائے خوراک _____

_____

مندرجہ ذیل علامات ظاہر ہونے کی صورت میں دوبارہ ہسپتال سے رجوع کریں _____

_____

REFERRAL ☐ Yes ☐ No *(To be filled by Referring Doctor in Case of Referral)*

Nature of Referral	☐ Emergency ☐ Non-Emergency	Referred To:	
Reason for Referral	☐ Patient / Attendant's Request	☐ Clinical Assessment	☐ MLC ☐ Other_____
Condition on Referral	☐ Alert ☐Respond to Verbal Command ☐Unconscious ☐ Other_____		

Vitals on Referral	BP:	Pulse:	R/R:	Temp:
Any Drug Allergy		Date ...../...../.....		Time: ..... : ..... AM/PM
Instructions to be Carried Out During Patient Transfer				Ambulance Call Time: ..... : ..... AM/PM
				Patient Departure Time ..... : ..... AM/PM
Discharge/Referral Prepared By (Doctor Name & Signature)				Hospital Employee ID

3.10 DEATH CERTIFICATION INFORMATION

A Death Certificate is a document issued by the Government to the nearest relatives of the deceased, stating the date, fact and cause of death. It is essential to register death to prove the time and date of death, to establish the fact of death for relieving the individual from social, legal and official obligations, to enable settlement of property inheritance, and to authorize the family to collect insurance and other benefits.

Model:

DEATH CERTIFICATE

DECEDENT

Name:	Father/Husband Name:	Age:	Gender: ☐ M ☐ F ☐ T
Address:		City	District
CNIC		Date of Birth: (……../……../……..)	Date of Death: (……../……../……..)
Religion:	Marital Status:	Surviving Family Name:	Time of Death: …… : ……. AM/PM

NEXT OF KIN

Name:	Father/Husband Name:	Age:	Gender: ☐ M ☐ F ☐ T
Address:		City	District
CNIC		Date of Birth: (……../……../……..)	
Religion:	Marital Status:	Occupation:	

ADMISSION DIAGNOSIS | FINAL DIAGNOSIS

HOSPITAL COURSE OF TREATMENT & MANAGEMENT

PROCEDURE PERFORMED

SIGNIFICANT LAB FINDINGS

BRIEF SUMMARY OF FACTS SURROUNDING DEATH

CAUSE OF DEATH

Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST**	b	DUE TO (OR AS A CONSEQUENCE OF):
	c	DUE TO (OR AS A CONSEQUENCE OF):
	d	

MANNER OF DEATH				Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death?
☐ Natural	☐ Homicide	☐ Accident	☐ Suicide	☐ Yes ☐ No	☐ Yes ☐ No
☐ Pending Investigation		☐ Could not be determined			

CERTIFIER *(Check only one box)*

☐ CERTIFYING PHYSICIAN *(Physician certifying cause of death when another physician has pronounced death)*
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ PRONOUNCING AND CERTIFYING PHYSICIAN *(Physician both pronouncing death and certifying to cause of death)*
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER/CORONER
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause (s) and manner as stated.

میں تصدیق کرتا/ کرتی ہوں کہ میں نے اپنے رشتہ دار/عزیز کی لاش ہسپتال ہذا سے وصول کر لی ہے
اور ہسپتال کی جانب سے متوفی کے تمام اثاثہ جات ایمانداری کے ساتھ میرے حوالے کر دیے گئے ہیں۔

نام رشتہ دار _____ متوفی سے رشتہ _____

شناختی کارڈ نمبر _____ فون نمبر _____

پتہ _____

Name & Signature of Certifier:	PMDC No:	Date & Time ……. / ……. / ……. ……. : ……. AM/PM
Name and Signature of Pronouncing Physician:	PMDC No:	Date & Time ……. / ……. / ……. ……. : ……. AM/PM
Medical Superintendent Signature:	PMDC No:	Date filed ……. / ……. / …….

Note: Fill-out all possible available information & kindly ensure the correct spellings of names as per passport or I.D cards, accurate dates and CNIC / NICOP numbers etc.

3.11 CLINICAL AUTOPSY REPORT

Autopsies are performed for either legal or medical purposes. For example, a forensic autopsy is carried out when the cause of death may be a criminal matter, while a clinical or academic autopsy is performed to find the medical cause of death and is used in cases of unknown or uncertain death, or for research purposes. Autopsies can be further classified into cases where external examination suffices, and those where the body is dissected and internal examination is conducted. Permission from next of kin may be required for internal autopsy in some cases. Once an internal autopsy is complete the body is reconstituted by sewing it back together.

3.12 ACCESS TO MEDICAL RECORD

Create an efficient filing system for managing health records for patients so that when a patient record is required it can be find out easily. For this follow some basic principles.

The three main components of the filing system are:

1) The Finders
2) The Keepers
3) The Storage

3.12.1 THE FINDER

One of the first decisions to make is how files will be identified. if a numeric system is appropriate using assigned patient numbers.

Whether you choose alphabetic or numeric indexing, be sure to use color-coding on your labels to help find charts more quickly, and to reduce the risk of misfiled records.

In this case we have unique identifier that is described above which should be patient ID and File Number to Identify the files.

3.12.2 THE KEEPER

Patient charts accumulate a lot of documents over time. Health care demands that doctors and care providers have immediate access to complete patient information. Most clinics use a set of chart dividers to subdivide papers inside the chart so specific medical information can be found quickly. Many times, custom dividers are used with standard forms printed on them to provide for easy documentation, or to give instructions to care givers and administrative staff.

3.12.3 THE STORAGE

Your choice of filing equipment will determine the tab placement of the Keepers, on top for drawer filing, and on the side or end for shelf filing. When deciding on the Storage for your system, consider how your situation is affected by these factors:

1) Physical storage space available

2) Number of files to be stored
3) Convenience of access by users of the system
4) Projected growth
5) Security and confidentiality issues
6) Legal requirements
7) Existing filing equipment
8) Budget for new equipment and supplies

In general, use shelf filing systems to store patient charts. Shelf systems are the easiest to use, save the most space and are the least expensive to set up and maintain.

When you maintained your record in well fashion then you can give information of each patient at any time.so your filing system should be maintained.

3.13 MEDICAL RECORDS ARE REVIEW PERIODICALLY

1) Medical records should be reviewed periodically to gauge the intensity of that disease.
2) The review uses a representative sample based on statistical principles, and done by the authorized and clinical professional only. Timelines, completeness legibility, it's only required by following the existing law and regulations as defined for that reviewer.
3) HMIS (Hospital Management and Information System).
4) HMIS Should be organized to achieve the higher standard of service delivery to the patients.

Hospital Name	Name of patient	Gender	Sampling ID	M&E	Status
01-DHQ_LGH	ABC	M	001	Done	Ok
02-DHQ_KSR	XYZ	M	002	Done	Ok

Patients currently receiving care and discharged ones, for these types of all scenarios will use STATUS Colum and mark accordingly.

Records, logs should be maintained by the concerned persons.

Medical Record Review must contain the following content:

Medical Record review checklist

Patient Name_____ MR # _____ Age _____ Gender _____ Deptt Unit _____ Ward _____ Bed_____ Date of Review_____ Name/ID_____ Case type Open ☐ Closed ☐

	Yes	No	Partial	Remarks (if any)
1. Legibility				
• Entries dated?				
• Entries dated in proper order dd/mm/yy.				
• Does entries have proper Name/signatures/stamps/ID				
2. Timeliness • Every entry is recorded with time • Does time entries a according to format (12 Hr) • Correlate the Diagnostic investigation had voiced time, conducted time & reporting time. Do they all lie in required time frame? • Correlate the medication ad voiced time & administration time. Do they all lie in required time frame? • Check in Correlate, Call request for Consultant/Department & their responding time. Do they all lie in required time frame? • Is Patient Vital Sign monitoring timely?				

3. Completeness • Is Patient file complete? • Is patient file completed in Chronological order? • Are Diagnostic test reports attached • All entries are being made by doctor's / Nurses • All adverse reaction & Blood transfusion reaction are reported completely comprising all sections (ward, lab , blood bank) • In case of discharged/Death Certificate should have whole information required • whether surgical post op care has been documented and counter sign by the clinician • Is nutritional assessment screening in Paeds Gynae dialysis burn unit, ICU, Etc Present • Documented Nursing Care Plan • Is documented nursing plan required? • procedures to prevent adverse events like wrong patient and wrong procedure have been adhered to (stamping for patient identification prior to operation)				

3.14 SAMPLING POLICY FOR RECORD REVIEW

Medical record shall be randomly selected and sample size should be based on the desired Confidence intervals, usually 95%

EASE OF RETRIEVING MEDICAL RECORDS

1) Medical records are organized and stored in a manner that allows easy retrieval and are to be made.
2) All medical records related information must be available as its required, without any hurdle or delay.
3) Backup system must be available to retrieve the data at local and head office sites
4) Data ratio sampling wise

3.15 POLICIES ON AUTHORIZATION TO REVIEW THE MEDICAL RECORD

Well documented medical records facilitate the retrieval of clinical information necessary for the delivery of quality

Providers should be in compliance with professional standards and should take steps to safeguard confidentiality when sharing medical record information with other network providers.

4 MEDICAL RECORD REVIEW COMMITTEE:

1) Check total medical record of his ward in the 1st week of every month.
2) Present record by systematic random technique (5-10%) to be analyzed in the CQI meeting.
3) Deficiency observed in the medical record will be pointed out/marked with RED BALL POINT on patient medical record.
4) Point out percentage of missing record with responsibility of concerned officer/official.
5) Point out officer/official.
6) Point out deficiency regarding missing o discharge/referral/death certificates in the medical record with responsibility of concerned officer/official. Further all columns of discharge/referral/death certificates are properly filled by duty doctor with byname stamp, signatures, date & time.
7) Check 03 times round of duty doctors, 02 times round of consultants duly documented with signatures, byname stamp, date & time.
8) All relevant registers are properly & regularly maintained.
9) Present the minutes of medical record review committee in CQI meeting.
10) Medical records are reviewed periodically.
11) The review uses a representative sample based on statistical principles.

4.1 REVIEWING OF MEDICAL RECORDS

All records should have following characteristics as mandatory.

1) Should be readable by other than the responsible person.
2) Signature, first and last name and title.
3) Date should be mentioned on each record with specific format i.e DD/MM/YYYY.
4) Handwritten records should be easily readable and readily copied, no space should be left behind as to fill in future.
5) Late entries should be explained in record with sign and date.

4.2 THE REVIEW PROCESS INCLUDE BOTH RECORDS OF ACTIVE AND CLOSED PATIENTS

In review process both active and closed records have to be included.so in review process it must be verified that patient admitted in to hospitals according to standard SOP and patient record have been maintained on admission, during stay and on Discharge. So reviewer have to check both active and closed patients files and also have to check that files have been maintained according to standard SOP.

The review on admission and discharge should be checked by MS, AMS or HOD. They must have to review that during patient stay all quality cure have been delivered to patient.

Model:

Sr. No	Item	Checklist
1	Admission report	
2	Initial assessment	
3	Initial and ongoing patient management	
4	Before discharge of confirmed	
5	After discharge	

4.3 IDENTIFICATION AND DOCUMENTATION OF DEFICIENCIES IN RECORD

1) Identify the data with errors and make a log of particular entry.
2) No information or entry may be removed from a health record or database.
3) Proper monitoring check must be available while rectifying the data and updating.
4) Documentation tools have features that are designed to increase both the quality and the utility of clinical documentation, enhancing communication between all healthcare providers. These features address traditional well known requirements for documentation principles while supporting expansive new technologies.
5) Corrected entry must be written separately and include date of entry and mark (Signatures) initials along title.
6) Patient medical Information is critical parts of the medical endeavor that should be under high protection and never authorized to anyone access that data.
7) Processes must be in place to ensure the documentation for the health information used in care, research, and health management is valid, accurate, complete, trustworthy, and timely.

4.3.1 MEDICAL RECORD REVIEW REGISTER

SR.#	Date	Sample criteria	Sample contents (dept/ any specific section)	auditors	remarks	CPA if any	target	CPA closing date	Sign/ID

4.4 CORRECTIVE AND PREVENTIVE MEASURE DOCUMENTATION

1) Error in medical records are inevitable which includes minor errors. Errors should be avoided at any cost.
2) Every prescription, test record, or any other detail enter should be mentioning its author in order to clarify the person entering the input.
3) Details of corrective and preventive measures should be recorded in change log.
4) There should be a column mentioning corrective action and its date in prescription or any

other record.

5) Error occurs should be corrected by following procedure:
   a. The person who made the incorrect error should correct it and initial the error.
   b. Person making changes should cross out the incorrect entry by single line, enter correct information, and mention date and time for changes.
   c. If the correction requires more than required space then additional supplement must be prepared with reference to its primary detail.
   d. Prohibited items includes using of pencil, using of white out, altering of past dates.
   e. If error is something which reviewer can see, then it does not need any explanation, otherwise there should be proper corrective action against it.

Sample form for corrective and Preventive Action

Institution Name	Document	CPA #	Date
Title	Managing Corrective and Preventive Action		

Name of Initiator: _____ Designation: _____ Department: _____

CPA Severity: Urgent ☐ Average ☐

CPA Related to: _____ Department

Corrective Action Preventive Action

1. Description
Description of the problem
Problem Causes / Root Cause
Person In charge / Date / Time
2. Suggested Action
1st action:
Recommended by: _____ Actin assigned to:_____ Assigned on _____ Target Date_____
Person In charge/ date: _____
Effective o Yes o No o Go on the next action Person In charge/Date: _____
2nd Action
Person In charge/Date: _____

CPA #	Date	CPA Raised by	Received by	Non-Conformance Brief	CPA Action Recommended	Target Date	Status		Remarks
							Closed	Pending	