Retention & Destruction of Hospital Records

Group:7

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Types of Records in HCO

- **Medical records**

  are those stored in MRD

- **Non-Medical records**

  are those do not enter MRD

As per MCI

- Every physician shall maintain the medical records pertaining to his / her indoor patients for a period of **3 years from the date of commencement of the treatment** in a standard proforma laid down by the Medical Council of India and attached as Appendix 3.
- If any request is made for medical records either by the patients / authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be **issued within the period of 72 hours.**
- A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2.
- **Efforts shall be made to computerize medical records for quick retrieval.**

Appendix 3

FORMAT FOR MEDICAL RECORD

(see regulation 3.1)

1. Name of the patient :
2. Age :
3. Sex :
4. Address :
5. Occupation :
6. Date of 1st visit :
7. Clinical note (summary) of the case:
8. Prov. : Diagnosis :
9. Investigations advised with reports:
10. Diagnosis after investigation:
11. Advice :

Follow up

Date:

Observations:

Signature in full ....

Name of Treating Physician

FOR LEAVE OR EXTENSION OR COMMUNICATION

OF LEAVE AND FOR FITNESS

Signature of patient or

thumb impression ____

To be filled in by the applicant in the presence of the Government Medical Attendant, or Medical Practitioner.

Identification marks:-

a. ____

b. ____

I, Dr. __________________________________ after careful examination of the case certify hereby that _____________ whose signature is given above is suffering from ________________ and I consider that a period of absence from duty of __________________ with effect from ________________ is absolutely necessary for the restoration of his health.

I, Dr. ______________________ after careful examination of the case certify hereby that ____________________ on restoration of health is now fit to join service.

place____________________________

Date__________________________

Signature of Medical attendant.

Registration No. ________________

(Medical Council of India / State Medical Council of .... State)

Note: The nature and probable duration of the illness should also be specified . This certificate must be accompanied by a brief resume of the case giving the nature of the illness, its symptoms, causes and duration.

PC-PNDT

- All case related – records, forms of consent, laboratory results, microscopic pictures, sonographic plates or slides, charts, forms, reports and all the documents required to be maintained under this Act and the rules shall be preserved by the centers for a period of two years from the date of completion of counseling, pre-natal diagnostic procedure or pre-natal diagnostic test, as the case may be. In the event of any legal proceedings, the records shall be preserved till the final disposal of legal proceeding, or till the expiry of the said period of two years, whichever is later.

- In case the centers maintains records on computer or other electronic equipment, a printed copy of the record shall be taken and preserved after authentication by a person responsible for such record.

EHR 2016

- ➢ Preserve life long (Active)
- ➢ After demise wait for 3 years (Inactive)
- It is however preferred, and the HSPs are strongly encouraged to ensure, that the records are never be destroyed or removed permanently. The health of the blood relatives and natural descendants of the person can be strongly influenced by the health of the person and on-demand access to these may prove to be hugely useful in the maintenance of the health of the relations.
- Furthermore, analysis of health data of all persons is expected to greatly benefit in the understanding of health, disease processes and the amelioration thereof.
- With rapid decline in costs of data archiving coupled with the ability to store increasing amounts of data that may be readily accessible, continued maintenance of such data is not expected to lead to any major impact on the overall system maintenance and use.

CPA1986

- Dictates time for filing complaints
- 02 years for OP patients
- 03 years for IP patients

“ A problem child can get inspired by a problem child and can give you more problem exponentially”

Non Medical records

Housekeeping logs sheets

Room temperature charts

Cold chain data of temperature loggers

Equipment calibration data

Feedbacks

Complaints, Incidents and accident log forms

Training records

CQI data

Archive till next surveillance or onsite assessment