IMS

Chapter Book

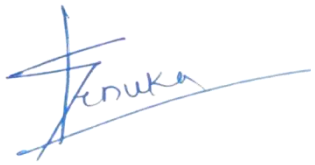
SAIDEEP
HEALTHCARE & RESEARCH PVT. LTD.

Annual Documents adequacy & Change Requirements Review

Sr. No	SOP /Doc No	Documents Name	Issue No	Rev. No	Review Date	Change	Change Rev No	Revision Date	Reason for Change	Amendment
1	SDH/IMS/1.A	The organization identifies the information needs of the patients, visitors, staff, management external agencies and community.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
2	SDH/IMS/1 .B	Identified information needs are captured and or disseminated	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
3.	SDH/IMS/2.D	The organisation stores and retrieves data according to its information needs.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
3	SDH/IMS/3.B	The contents of the medical record are identified and documented.	1	2	1-JAN-25	Amended as per 6th edition	2	1-JAN-26	No Any change review completed	No Any Amendment History
4	SDH/IMS/3.D	Authorized staff makes the entry in the medical record.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
5	SDH/IMS/5.A	The organization maintains the confidentiality of record, data and information.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
7	SDH/IMS/5.C	The organization maintains the security of records, data and	1	2	1-JAN-25	Amended as per 6th edition .	2	1-JAN-26	No Any change review	No Any Amendment History

		information.							completed	
8	SDH/IMS/5.F	Request for access to information in the medical records by patients/physicians and other public agencies are addressed consistently.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History
9	SDH/IMS/6.A	The organization has an effective process for document control.	1	2	1-JAN-25	Amended as per 6th edition .	2	1-JAN-26	No Any change review completed	No Any Amendment History
10	SDH/IMS/6.B	The organization retains patient's clinical records, data and information according to requirements.	1	2	1-JAN-25	Amended as per 6th edition .	2	1-JAN-26	No Any change review completed	No Any Amendment History
11	SDH/IMS/6D	The destruction of medical records, data and information are in accordance with the written guidance.	1	2	1-JAN-25	No Any change review completed	2	1-JAN-26	No Any change review completed	No Any Amendment History

Original Date	**Effective Date**	**Next date of revision**	**Issue NO**
01 JAN 2021	**01 JANUARY 2026**	**01 JANUARY 2027**	**1**

Reviewed & Prepared By	**Recommended By**	**Approved By**
Mrs. Renuka Sonawane	**Dr. H. Kalgaonkar**	**Dr. S. S. Deepak**
Quality Coordinator	**Quality Head**	**Chairman & Managing Director**
		

POLICY DOCUMENT
(IMS 1.a)

1. Objective

To establish a structured, systematic, and documented approach for identifying, analyzing, communicating, and periodically reviewing the information needs of all stakeholders including patients, visitors, staff, management, external agencies, and the community, ensuring transparency, compliance, and informed decision-making in alignment with NABH standards.

2. Scope

This policy applies to all departments and services of the hospital and covers:

- Clinical and non-clinical departments
- All categories of stakeholders:
  - Patients
  - Visitors
  - Staff (clinical, administrative, contractual)
  - Management
  - External agencies (regulatory, statutory, insurers, accreditation bodies)
  - Community

3. Definitions

- **Information Needs**: Specific data, knowledge, or communication required by stakeholders to make informed decisions or perform roles effectively.
- **Stakeholders**: Individuals or groups with direct or indirect interaction with the hospital.
- **Feedback Mechanism**: Structured methods to collect stakeholder inputs (e.g., forms, interviews, digital platforms).
- **Benchmarking**: Comparison with peer institutions or standards to identify best practices.
- **Notifiable Diseases**: Diseases mandated by law to be reported to public health authorities.

4. Policy Statement

The hospital shall:

1. Identify and document the information needs of all stakeholders through structured and validated mechanisms.
2. Ensure availability, accessibility, accuracy, and timeliness of information.
3. Use multi-channel communication systems (digital, physical, verbal).
4. Periodically review and update stakeholder information needs.
5. Maintain records of assessment, dissemination, and review processes.
6. Integrate the process with Quality, IT, HR, Medical Records, and Clinical Governance systems.
7. Ensure statutory and regulatory compliance in dissemination of information.

5. Procedures

5.1 Framework for Identification of Information Needs

A systematic approach shall be followed:

Step 1: Stakeholder Mapping

- Identification of all stakeholder categories by the Quality Team in consultation with department heads.

Step 2: Data Collection Mechanisms

The hospital shall utilize multiple validated mechanisms:

- Patient/Visitor feedback forms (IPD/OPD/discharge)
- Telephonic feedback and call logs
- Focus Group Discussions (FGDs)
- Structured interviews
- Suggestion boxes
- Digital platforms (website/app analytics)
- Staff surveys
- Incident/complaint analysis
- Benchmarking with peer hospitals and NABH guidelines

Step 3: Documentation of Needs

- Needs shall be categorized as:
  - Clinical
  - Administrative
  - Regulatory
  - Educational
  - Safety-related

Step 4: Validation and Prioritization

- Conducted by Quality Team and Department Heads.
- Based on:
  - Frequency
  - Risk impact
  - Regulatory requirement

Step 5: Communication Planning

- Defined mode (digital display, website, brochures, SOPs, dashboards, reports).
- Assigned responsibility and frequency.

5.2 Stakeholder-wise Information Needs

5.2.1 Patients

- OPD timings, consultant availability
- Admission, discharge procedures
- Tariffs and billing information
- Diagnostic and treatment options
- Patient rights and responsibilities
- Safety protocols and infection control practices

5.2.2 Visitors

- Visiting hours and restrictions
- Age limitations
- Infection control precautions

- Security and access guidelines
- Parking and facility navigation

5.2.3 Staff

- Standard Operating Procedures (SOPs)
- Clinical protocols and guidelines
- HR policies (leave, attendance, appraisal)
- Training schedules
- Safety policies (fire, biomedical waste, infection control)
- On call consultants
- Non availability of critical service

5.2.4 Management

- Daily census reports
- Bed occupancy rates
- Departmental performance indicators
- Financial and utilization reports
- Incident and risk management reports
- Quality indicators and audit findings

5.2.5 External Agencies

- Statutory reporting (births, deaths)
- HMIS portal data submission for National Health Mission
- ADR and MDAE reporting to PvPI and MvPI
- Notifying foreign national admission to FRO
- Notifiable diseases reporting
- Insurance/TPA documentation
- Accreditation data requirements
- Legal and compliance reports: Medicolegal case intimation/ Postmortem intimation/MPCB, AERB, FDA

5.2.6 Community

- Awareness programs and camps
- Preventive health information
- Availability of new services
- Public health alerts
- Outreach initiatives

5.3 Review and Updating of Information Needs

- Information needs shall be reviewed:
  - **Quarterly** by the Quality Team
  - **Annually** during Management Review Meetings
- Triggers for interim review:
  - Regulatory changes
  - Introduction of new services
  - Significant complaints/incidents
- Updated needs shall be documented and communicated across departments.

5.4 Departmental Linkages

Department	Role
Quality	Coordination, analysis, monitoring
IT	Digital dissemination, dashboards, data analytics
Medical Records	Data accuracy, statutory reporting
HR	Staff-related information dissemination
Clinical Departments	Clinical information validation
Administration	Public and visitor communication

6. Responsibilities

6.1 Top Management (CMD)

- Approve policy and provide resources
- Review effectiveness during management review meetings

6.2 Quality Team

- Lead stakeholder identification and need assessment
- Analyze feedback and generate reports
- Monitor compliance and indicators

6.3 Department Heads

- Identify department-specific information needs
- Ensure dissemination within departments
- Participate in review meetings

6.4 IT Department

- Maintain digital platforms (HIS, website, dashboards)
- Ensure data availability and accessibility
- Support analytics and reporting

6.5 Medical Records Department

- Ensure accuracy and confidentiality of patient data
- Manage statutory reporting

6.6 HR Department

- Disseminate staff-related information
- Conduct staff awareness and training

7. Records

The following records shall be maintained:

- Feedback Forms and Analysis Reports
- Call Logs and Patient Feedback Records
- Interview Records
- Benchmarking Reports
- Management Review Meeting Minutes

- Communication Dissemination Logs
- Revision and Review Records

Retention shall be as per hospital record retention policy.

AMENDMENT HISTORY

Sl No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	00	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.
5	01	02	1 Jan 2025	No changes.

(IMS 1.b)

1. Objective

To establish a **structured, auditable system for capturing, validating, managing, and disseminating information needs identified under IMS 1.a**, ensuring **accuracy, timeliness, security, and stakeholder-specific accessibility**.

2. Scope

This guideline applies to:

- All information needs identified through IMS 1.a processes
- All hospital departments (clinical and non-clinical)
- All data capture systems (manual and electronic)
- All dissemination platforms and stakeholders

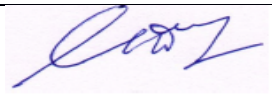
3. Definitions

- **Data Lifecycle:** Flow of data from capture → validation → storage → dissemination → review.
- **Dissemination Matrix:** Predefined mapping of *what information*, *to whom*, *how*, and *how often*.
- **Data Integrity:** Assurance that data is accurate, consistent, and unaltered.

4. Policy Statement

The hospital shall ensure that:

1. All information needs identified under IMS 1.a are **translated into measurable and traceable data elements**.
2. Data is **captured at source, validated, and owned by designated personnel**.
3. Dissemination is **structured through a defined dissemination matrix**.
4. Information shared is **approved, accurate, timely, and secure**.
5. There is **complete traceability between identified needs (IMS 1.a) and dissemination outputs (IMS 1.b)**.
6. Any data discrepancy is **promptly corrected and escalated**.
7. All processes comply with **statutory, regulatory, and confidentiality requirements**.

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

5. Procedures

A. Capturing of Information

A1. Linkage with IMS 1.a

- Each identified need shall be mapped to:
  - Data element
  - Source
  - Frequency
  - Owner

A2. Methods of Data Capture

a. Manual Systems

- Departmental registers (OPD, IPD, ICU, OT, Pharmacy, Lab)
- Statutory registers (Birth, Death, MLC, Notifiable diseases)
- Feedback and complaint forms
- Incident reporting formats

b. Electronic Systems (HIS)

- Registration and EMR modules
- LIS / RIS
- Billing system
- Quality dashboards
- HR and attendance systems

A3. Data Sources (Aligned to IMS 1.a Categories)

Category (IMS 1.a)	**Data Source**
Clinical	EMR, prescriptions, lab reports
Administrative	Admission/discharge data
Regulatory	Statutory registers, portals
Safety	Incident reporting system
Educational	Training attendance, materials

A4. Data Entry Process

- Data shall be recorded **at point of generation**.
- HIS entries shall be:
  - User-authenticated
  - Time-stamped
- Manual records shall include:
  - Date, time
  - Name, signature

A5. Validation and Accuracy Checks

Three-tier validation:

Level	Responsibility
Level 1	Data entry staff
Level 2	Department Supervisor
Level 3	Quality / IT audit

Validation includes:

- Completeness
- Logical consistency
- Cross-verification with source

A6. Frequency of Data Collection

Data Type	Frequency	Responsible
Patient census	Daily	Nursing Supervisor
Feedback data	Continuous / Weekly compilation	Quality Team
Incident data	Real-time	All staff
Regulatory data	As mandated	MRD / Dept Head
KPI data	Monthly	Quality Team

A7. Data Ownership

Data Type	Owner
Clinical data	Consultant / Nursing Head
Operational data	Department Head
Quality indicators	Quality Manager
Regulatory data	MRD
IT systems	IT Head

A8. Data Confidentiality, Integrity, and Security

- Role-based HIS access
- Password control and periodic reset
- Restricted access to sensitive data
- Backup (daily) and disaster recovery
- Compliance with legal/statutory requirements

A9. Escalation for Incorrect / Missing Data

- Step 1: Report to Department Head
- Step 2: Correction within **24–48 hours**
- Step 3: Escalation to Quality Team
- Step 4: CAPA documentation

B. Dissemination of Information

B1. Dissemination Matrix (Mandatory for NABH Readiness)

Each information need shall be mapped as:

Information	Stakeholder	Mode	Frequency	Owner

B2. Dissemination to Patients / Visitors / Staff

Channels (Aligned with IMS 1.a outputs)

- **Website:** Services, tariffs, patient rights
- **Intranet:** SOPs, protocols, HR policies
- **Information Booklets:** Discharge instructions, education
- **Display Boards / Signage:** Rights, safety, navigation
- **Social Media Platforms:** Medical information e.g. preventive healthcare

B3. Dissemination to Management

- Dashboards (real-time KPIs)
- Daily census reports
- Monthly quality reports
- Incident and risk reports

B4. Dissemination to External Agencies

(Directly aligned with your IMS 1.a list)

- Birth & Death reporting
- HMIS reporting
- PvPI / MvPI (ADR/MDAE)
- Notifiable diseases
- FRO reporting
- Insurance/TPA documentation
- Accreditation submissions
- Medicolegal and Compliance

B5. Approval Hierarchy Before Dissemination

Data Type	Approved By
Clinical	Consultant / MS
Operational	Dept Head
Quality	Quality Head
External reporting	MS / Management

B6. Timelines for Dissemination

- Daily → within 24 hours
- Monthly → within first week
- Statutory → as per law

B7. Communication and Traceability

- All dissemination must be **documented**:
  - Email logs
  - Reports shared
  - Website updates
  - Display verification

6. Responsibilities

Top Management: Approval, oversight, resource allocation

Quality Team: Monitor KPIs, Conduct audits

Department Heads: Data ownership and validation: Ensure timely reporting

IT Department: HIS functionality, dashboards, security

Medical Records Department: Clinical data integrity, Statutory compliance

HR Department: Staff communication and records

7. Records

- Data collection formats/registers
- HIS logs
- Validation/audit records
- Dissemination logs
- Communication records
- Statutory reporting records
- CAPA records

Retention: As per MRD and statutory policy.

- Dissemination Matrix existence
- Evidence of validation before sharing
- Statutory reporting compliance
- Data correction & escalation records
- KPI monitoring

AMENDMENT HISTORY

Sl No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	00	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.
5	01	02	1 JAN 2026	No changes.

Document Type: Policy
Department: Medical Records Department (MRD)
Applicability: Hospital-wide
System: Hybrid (Paper + Electronic – HIS: Mednet 2.0)

1. Purpose

To establish a **standardized, secure, and auditable framework** for the storage, preservation, and management of medical records ensuring:

- **Continuity of patient care**
- **Confidentiality and privacy of patient data**
- **Integrity and traceability of records**
- **Compliance with NABH 6th Edition (IMS), DPDP Act 2023, IT Act 2000, and EHR Standards 2016**
- **Medico-legal defensibility of records**

2. Scope

This policy applies to:

- All **medical records generated across OPD, IPD, ER, and Daycare services**
- All formats:
  - Paper-based records
  - Electronic records (HIS/EMR/PACS)
  - Hybrid records
- All departments including:
  - Clinical, Nursing, Diagnostic, Administrative, MRD, IT
- Special records:
  - Medico-Legal Cases (MLC)
  - Psychiatric records
  - Medical Termination of Pregnancy (MTP)
  - IVF / ART records
  - Paediatric and neonatal records

3. Definitions

- **UHID (Unique Health Identification Number):** Unique identifier assigned to each patient
- **MRN (Medical Record Number):** Permanent patient record number linked to UHID
- **Encounter Number:** Visit-specific identifier (OP/IP/ER)
- **EMR (Electronic Medical Record):** Digital version of patient records within the hospital
- **EHR (Electronic Health Record):** Longitudinal patient health record (as per EHR 2016 standards)
- **HIS:** Hospital Information System (Mednet 2.0)
- **Hybrid Record:** Combination of paper and electronic documentation
- **MLC:** Medico-Legal Case
- **MTP:** Medical Termination of Pregnancy
- **Data Fiduciary:** Hospital responsible for processing personal data (DPDP Act)
- **Audit Trail:** Time-stamped log of access/modification

4. Policy Statement

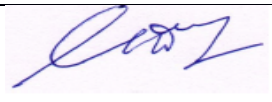
The hospital shall ensure that:

- All medical records are **securely stored, systematically organized, and easily retrievable**
- Storage systems maintain:
  - **Confidentiality**
  - **Integrity**
  - **Availability**
- Records are protected against:
  - Loss
  - Damage
  - Unauthorized access
- Storage practices are **standardized across physical and electronic systems**
- Special records are handled with **enhanced confidentiality controls**

5. Detailed Procedures

5.1 Creation and Identification

- Every patient is assigned a UHID–MRN a unique permanent number
- Each encounter (OP/IP/ER) is assigned a unique encounter number
- HIS maintains chronological linkage of all encounters

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

5.2 OPD and ER Records

- Maintained entirely in electronic format (HIS/EMR): The patients are provided with hard copies of the visit.
- Stored in secure server environment
- Accessible through role-based authentication

5.3 IPD Records Lifecycle

Step 1: Record Creation

- Paper file initiated at admission
- Parallel electronic documentation maintained

Step 2: Discharge Processing

- Record checked for completeness:
  - Clinical entries
  - Nursing notes
  - Investigation reports
  - Consents

Step 3: MRD Receipt

- File transferred to MRD for archival

Step 4: Secondary Verification

- MRD performs completeness check
- Deficiencies flagged and corrected

Step 5: Digitisation

- Entire file scanned
- Uploaded to secure HIS repository
- Verified for:
  - Completeness
  - Legibility
  - Correct mapping

Step 6: Physical Archival

- File assigned **MRD shelf and rack number**
- Stored in designated secured area

5.4 Special Handling

MTP Records

- Stored under custody of treating Obstetrician
- Maintained with **restricted access and statutory confidentiality**

MLC Records

- Stored separately under **lock and key**
- Access strictly controlled and logged

6. Roles & Responsibilities

MRD

- Custodian of physical records
- Ensures indexing, storage, and traceability
- Conducts completeness checks
- Maintains storage registers

IT Department

- Maintains electronic storage systems
- Ensures:
  - Data backup
  - Server security
  - Disaster recovery
  - Audit logs

Clinicians

- Ensure accurate and timely documentation

Nursing Staff

- Maintain clinical documentation
- Ensure completeness before discharge

Administration / Medical Superintendent

- Oversight of compliance
- Approval authority for exceptional access

7. Legal & Regulatory Compliance

This policy complies with:

- **NABH 6th Edition – IMS Standards (IMS.2, IMS.3, IMS.4)**
- **Digital Personal Data Protection Act, 2023**
- **Information Technology Act, 2000 (Sections 43A, 72A)**
- **EHR Standards for India, 2016**
- **Mental Healthcare Act, 2017 (for psychiatric records)**
- **MTP Act, 1971 (as amended)**
- **Applicable medico-legal and court requirements**

8. Confidentiality & Data Security

- Access governed by **Role-Based Access Control (RBAC)**
- Unique login credentials for all users
- Audit trails maintained for all electronic access
- Paper records accessible only to authorized personnel
- Sensitive records (MLC, MTP, Psychiatry) under restricted access

9. Record Retention & Archival Policy

- Records retained as per:
  - Medico-legal requirements
  - NABH expectations
  - Hospital retention policy
- General retention:
  - OPD: Minimum 5 years
  - IPD: Minimum 7 years
  - MLC: Permanent
  - Paediatric: Till majority + extended period
- Legal hold overrides destruction timelines

10. Storage & Preservation Standards

Physical Storage

- Secured MRD storage area
- Protection from:
  - Dust

  - Moisture
  - Pests
- Weekly cleaning and pest control
- Fire safety measures:
  - Fire extinguishers
  - Staff trained in fire drills

Electronic Storage

- Stored on:
  - Main server
  - Backup server
  - External backup devices
- Data protected through:
  - Authentication
  - Encryption (where applicable)
  - Controlled access

11 RETRIEVAL OF INFORMATION & ISSUE OF PMR COPIES

11.1 Purpose

To define lawful, transparent, and time-bound procedures for release of patient medical records and information.

11.2 General Principles

- Patients have the right to obtain copies of their medical records.
- Original medical records shall never be issued.
- Certified copies shall be provided.

11.3 Request for Records: *Saideep uses Medical Record Release Form (for patient's consent during hospitalization) and Medical Record Requisition form (for retrieving if not previously consented)*

- Requests shall be made in writing by:
  - Patient, or Authorized next-of-kin / legal guardian
  - Insurance company personnel for verification
  - Clinicians for research
  - Auditors for assessment

- Identity verification shall be performed using government-issued ID.

11.4 Approval Process

1. Request received by MRD
2. Review by Medical Superintendent
3. Consultation with treating clinician if required
4. Approval or rejection documented

11.5 Timelines

- Records shall be issued within 72 hours of approval, unless legally restricted.

11.6 Mode of Issue

- Paper copies duly stamped “Certified Copy”
- Electronic copies (where applicable) in secure format
- Every page shall bear hospital seal and authorization

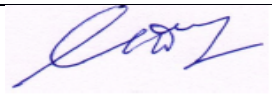
11.7 Disclosure Log

- All disclosures shall be recorded in a Release of Information Register including:
  - Recipient
  - Purpose
  - Date
  - Mode of release

11.8 Special Cases

- Death cases: Release only to authorized persons
- MLC: Only as per statutory authority orders

“The hospital may provide patients secure electronic access to their medical records through authorized mobile or web-based platforms. Access is provided only after a secure authentication. Records made available are read-only and limited to diagnostic reports, prescriptions, and discharge summaries. The electronic view is for patient reference, and the hospital medical record shall prevail in case of discrepancy.

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

11. P1 RELEASE OF PSYCHIATRIC MEDICAL RECORDS

Patient Right vs Harm Test (MHA 2017)

- While patients have the right to access their medical records, psychiatric records may be partially withheld if:
  - Disclosure is likely to cause serious harm to the patient or others
- Such decisions shall be:
  - Taken by the treating psychiatrist
  - Documented with reasons
  - Approved by Medical Superintendent

11. P2 Third-party Disclosure

- Disclosure to relatives, caregivers, police, or courts shall be:
  - Strictly as per MHA 2017 provisions
  - Limited to minimum necessary information
  - Logged in the disclosure register

12. Disaster Management & Backup

- Regular data backups maintained
- Backup stored in secure location
- Disaster recovery plan implemented for:
  - Data loss
  - System failure
  - Fire incidents
- Periodic testing of backup restoration

13. Audit & Monitoring

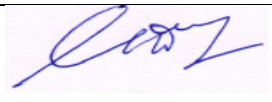
- Periodic internal audits conducted
- Indicators monitored:
  - Record completeness
  - Missing records
  - Retrieval efficiency
- Audit findings reviewed by management

14. Non-Compliance & Corrective Actions

- Non-compliance reported to MRD and Quality team
- Root cause analysis conducted
- Corrective and preventive actions implemented
- Repeated violations escalated to management

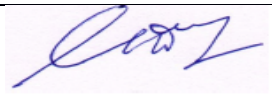
15. Documentation & Records

- MRD storage registers
- Shelf/rack indexing records
- Audit reports
- Backup logs
- Access logs (HIS)
- Incident reports

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

AMENDMENT HISTORY

Sl No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	00	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.
5	01	02	1 Jan 2026	No changes.

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/IMS /03
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Pages	1
	COMPONENTS OF THE MEDICAL RECORD		

1. PURPOSE

This Standard Operating Procedure (SOP) defines the components that constitute a complete and accurate medical record for all patients cared for by this organisation. It is aligned with NABH IMS Standard 3.b (6th Edition): **"The contents of the medical record are identified and documented."**

The purpose is to ensure that every patient's medical record is:

- Uniformly structured across all departments and care settings.
- Complete, accurate, and chronological at all times.
- Accessible to authorised personnel for clinical decision-making.
- Compliant with NABH, medico-legal, and statutory requirements.
- Supportive of patient safety, quality of care, and continuity of care.

2. SCOPE

This SOP applies to all inpatient (IP) records across all clinical units and wards. It covers both paper-based and electronic medical records. All staff — doctors, nurses, allied health professionals, and medical records personnel — authorised to make or manage entries in the medical record are bound by this SOP.

3. COMPONENTS OF THE MEDICAL RECORD

The table below lists all mandatory and standard components of the medical record, their purpose, examples of documents, and key NABH compliance requirements. **All components must carry the patient's unique Medical Record Number (MRN) and must be filed in chronological order.**

Sl. No.	Component of Medical Record	Description / Purpose	Example Documents	Key NABH Compliance Points
1	**Patient Identification Details**	Every medical record must begin with complete patient demographics. This uniquely identifies the patient and ensures all records are linked to the right individual.	Face Sheet / IP Sheet Admission Register Entry Hospital ID / MRN (Medical Record Number) Nationality, Religion, Address, Contact	• Unique identifier (MRN) on EVERY sheet (IMS.3.a) • Mandatory for all medico-legal records • Must be traceable in both paper and electronic systems • Cross-link: AAC.2.b
2	**Admission Records**	Documents the formal entry of the patient into the hospital including clinical	Admission Order Referral Letter / Transfer Note	• Reason for admission documented clearly (IMS.4.a) • Diagnosis to be coded as

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

Sl. No.	Component of Medical Record	Description / Purpose	Example Documents	Key NABH Compliance Points
		reason, referring doctor details, and initial triage/registration data.	Triage Form Mode of Arrival (Ambulance / Walk-in) Admitting Doctor Name & Department	per ICD • Treating doctor's name must be recorded • Signed and timed entry required (IMS.3.e)
3	**History & Clinical Findings**	A comprehensive account of the patient's presenting complaints, past medical/surgical/family history, allergies, and complete physical examination findings recorded by the treating doctor.	History Sheet Presenting Complaints Past Medical / Surgical History Allergy Documentation Physical Examination Findings System Review	• Entered by authorised doctor only (IMS.3.d) • Must be signed, dated, and timed (IMS.3.e) • Author identity traceable (IMS.3.f) • Filed chronologically (IMS.3.c)
4	**Investigation Reports — Laboratory**	All diagnostic test results ordered during the patient's stay, forming the evidence base for clinical decision-making.	Complete Blood Count (CBC) Blood Biochemistry (RFT, LFT, etc.) Microbiological Reports (Culture & Sensitivity) Coagulation Profile Blood Bank Reports	• Original reports to be filed in MR (IMS.3.b) • Date & time of collection / reporting mandatory • Results to be traceable to unique MRN • Ordered by authorised clinician (IMS.3.d)
5	**Investigation Reports — Radiology & Imaging**	Imaging reports and films/digital records supporting clinical diagnosis and management planning.	X-Ray Reports Ultrasonography (USG) Report CT / MRI Reports ECG Tracing with Interpretation Echocardiography Report Endoscopy Report	• Reports filed with MR; images accessible (IMS.3.b) • Radiologist's signature and date mandatory • Report must be linked to MRN • Continuity of care linkage (IMS.4)
6	**Doctor's Orders & Treatment Chart**	All therapeutic and diagnostic orders given by the treating physician form the	Doctor's Order Sheet Medication Prescription	• Only doctors may write medication orders (IMS.3.d) • Must be signed, dated, and timed (IMS.3.e)

Sl. No.	Component of Medical Record	Description / Purpose	Example Documents	Key NABH Compliance Points
		backbone of patient care management.	Diet Orders Physiotherapy / Rehabilitation Orders Investigation Orders	• No error-prone abbreviations in medication orders (IMS.3.g) • Orders must be traceable to the author (IMS.3.f)
7	**Medication Administration Record (MAR)**	Documents each dose of medication actually administered to the patient — what was given, when, by whom, and via which route.	Medication Administration Chart Intravenous Fluid Chart Antibiotic Administration Record PRN Medication Record High-Alert Drug Administration Record	• Maintained by authorised nursing staff only (IMS.3.d) • Each entry signed with name/stamp/code (IMS.3.f) • Error-prone abbreviations prohibited (IMS.3.g) • Cross-link: MOM.4.b
8	**Nursing Records & Care Plans**	Nursing assessment, care planning, implementation, and evaluation documents that record the holistic nursing care delivered to the patient.	Nursing Assessment Sheet Nursing Care Plan TPR Chart (Temperature, Pulse, Respiration) Vital Signs Chart Fluid Intake-Output Chart Fall Risk Assessment Pressure Ulcer / Skin Assessment	• Only authorised nursing staff to make entries (IMS.3.d) • Entries signed with designation (IMS.3.f) • Documents filed in chronological order (IMS.3.c) • Care plan must reflect continuity of care (IMS.4)
9	**Dietary & Nutritional Assessment**	Nutritional screening and dietary assessment conducted by a qualified dietitian, including dietary plans prescribed based on the patient's condition.	Nutritional Screening Tool (NRS 2002 / MNA) Dietitian Assessment Form Dietary Plan / Diet Chart Calorie Intake Monitoring Sheet	• Only authorised dietitians to make nutritional entries (IMS.3.d) • Must be signed with name & employee code (IMS.3.f) • Part of defined medical record contents (IMS.3.b)
10	**Physiotherapy**	Physiotherapy	Physiotherapy	• Entered only by authorised

Sl. No.	Component of Medical Record	Description / Purpose	Example Documents	Key NABH Compliance Points
	& Rehabilitation Records	assessments, goals, treatment plans, and daily session records reflecting patient rehabilitation progress.	Assessment Sheet Exercise / Rehabilitation Plan Session Notes Functional Outcome Measurement Scores	physiotherapists (IMS.3.d) • Signed and dated for each session (IMS.3.e) • Filed chronologically in MR (IMS.3.c)
11	**Consent Forms**	Legal documents recording informed consent for procedures, surgeries, anesthesia, blood transfusion, and research — obtained before performing any intervention.	General Consent Form Informed Consent for Surgical Procedure Anesthesia Consent Form Blood Transfusion Consent High-Risk Consent Consent for Sensitive Procedures	• Mandatory medico-legal document (IMS.3.c) • Must contain: patient name, procedure, doctor name, date-time, witness signature • Part of defined MR contents (IMS.3.b) • Language of patient's understanding preferred
12	**Progress Notes / Clinical Notes**	Daily and event-based notes by the treating team documenting the patient's progress, response to treatment, and changes in management.	Daily Progress Notes (SOAP format) On-Call Doctor Notes Consultant's Referral Notes Specialist Opinion Notes Pre-Operative Assessment Notes	• Filed in chronological order (IMS.3.c) • Signed, dated & timed by the author (IMS.3.e) • Author identity clearly identifiable (IMS.3.f) • Continuity and completeness of care (IMS.4)
13	**Procedure & Operation Notes**	Detailed documentation of any invasive procedure or surgery performed — including indication, technique, findings, and post-operative instructions.	Pre-Operative Check List Operation Theatre Notes / OT Record Post-Operative Instructions Anesthesia Record Procedure Notes (e.g., FNAC, LP, Biopsy) Recovery Room	• Must be completed immediately after procedure (IMS.3.e) • Signed by the operating surgeon & anaesthetist (IMS.3.f) • Diagnosis coded as per ICD (IMS.4.a) • Part of mandatory medico-legal record (IMS.3.c)

Sl. No.	Component of Medical Record	Description / Purpose	Example Documents	Key NABH Compliance Points
			Notes	
14	**Transfer Records**	Documentation for intra-hospital transfers (e.g., ward to ICU) or inter-hospital transfers, ensuring safe handover and continuity of care.	Inter-Department Transfer Form ICU Transfer Notes Referral/Transfer Summary to Another Hospital Handover Communication Record	• Reason and clinical status at time of transfer documented • Receiving unit acknowledgement required • Part of MR contents (IMS.3.b) • Supports continuity of care (IMS.4)
15	**Discharge Summary**	A comprehensive clinical summary prepared at the time of patient discharge, capturing the entire episode of care for the patient and referring physicians.	Discharge Summary (Structured) Instructions to Patient (Discharge Card) Medication on Discharge (MOD) List Follow-up Appointment Record Certificate of Fitness / Leave Certificate	• Must be complete before discharge (IMS.3.b & IMS.4) • Diagnosis coded per ICD/ (IMS.4.a) • Signed by treating doctor (IMS.3.e & IMS.3.f) • Must reflect continuity of care (IMS.4)
16	**Medico-Legal & Special Records**	Records related to cases with legal implications or special clinical situations that require additional documentation beyond the standard MR.	MLC (Medico-Legal Case) Register & Record Death Certificate / Summary Abortion / MTP Records Restraint Use Documentation Coroner / Police Case Records	• Mandatory information as per medico-legal requirements (IMS.3.c) • Missing sheet note must be recorded if any document absent • Dual oversight: legal & clinical compliance • Strict confidentiality and access control

4. GENERAL RULES FOR MEDICAL RECORD MAINTENANCE

NABH Requirement	Practical Implementation Guidance
Unique Identifier (IMS.3.a)	***Every sheet in the medical record — both paper and digital — must bear the patient's unique MRN. In electronic records, all entries must be traceable to this number.***
Chronological Filing (IMS.3.c)	All identified sheets must be filed in sequential order. Entries within each component are made in chronological order. Pages must be numbered where feasible.
Authorised Entries Only (IMS.3.d)	Written guidance exists for each category of staff authorised to make entries. For example: medication orders by doctors; medication administration by nurses; nutritional assessments by dietitians.
Signature, Date & Time (IMS.3.e)	Every entry must be documented immediately — within one hour of completion of assessment or procedure. For electronic records, automatic timestamping is preferable.
Author Identification (IMS.3.f)	The identity of the author must be traceable via full name, employee code number, or stamp. A master signature list maintained in the MR is acceptable. Electronic records must support authorised e-signatures.
Authorised Abbreviations Only (IMS.3.g)	Only standardised, approved abbreviations may be used. Error-prone abbreviations for medications are strictly prohibited. Refer to MOM.4.b for the approved abbreviation list.
Missing Sheet Protocol (IMS.3.c)	If any sheet is unavailable, a 'Missing Note' must be placed in the medical record documenting which document is missing and the reason.
Electronic Medical Records (IMS.3.b)	Organisations using EMR must define which documents are maintained in physical format. Appropriate linkages between electronic and paper records must be available.

5. SUMMARY: WHY COMPLETE MEDICAL RECORDS MATTER

5.1 Patient Safety

- A complete medical record is the primary communication tool among all members of the treating team, reducing errors, omissions, and duplication of investigations.
- Allergies, high-risk medications, fall risk scores, and surgical safety checklists — documented accurately — directly prevent adverse events.
- Continuity of care across shifts, departments, and hospitals depends entirely on the quality of documentation in the medical record (IMS.4).

5.2 Legal & Medico-Legal Protection

- The medical record is a legal document. In cases of disputes, complaints, or litigation, the medical record is the primary evidence of care provided.
- Medico-legal case records must have mandatory information — missing or incomplete records are indefensible in a court of law (IMS.3.c).
- Consent forms, operation notes, and medication records protect both the patient's rights and the clinician's accountability.
- Organisations must retain medical records as per applicable statutory and regulatory requirements.

MRD NO.	NAME OF CONSENT / FORM	AUTHORISED PERSON TO MAKE ENTRY	PAPER OR EMR	IN USE OR NOT
SD/V4/MRD/01	DOCTOR'S PROGRESS SHEET	RMO & CONSULTANT	PAPER	IN USE
SD/MRD/02	ना/हरकत प्रमाणपत्र	RELATIVE / BILLING DEPARTMENT	PAPER	NOT USE
SD/MRD/03	NURSING PROGRESS SHEET	NURSE	EMR	USE
SD/MRD/04	IPD PRESCRITION BOOK			
SD/V2/MRD/05	IPD PATIENT FEEDBACK FORM	PATIENT & RELATIVES	PAPER	USE
SD/V2/MRD/06	SERVICES BILLING SHEET	RMO & NURSE	PAPER	USE
SD/MRD/07	CONSENT FOR HIV TESTING	RMO	PAPER	USE
SD/V1/MRD / 08	INFORM CONSENT FOR ADMISSION	REGISTRATION STAFF	PAPER	USE
SD/V4/MRD / 09	EMERGENCY : INITIAL ASSESSMENT	CASUALTY RMO	EMR	USE
SD/V2/MRD/10	BLOOD TRANSFUSION RECORD	NURSE & RMO	PAPER	USE
SD/MRD/11	INFORMED CONSENT (ORTHO)	STOP		
SD/MRD/12	INFORMED CONSENT FOR JOINT REPLACEMENT (REGISTER)	STOP		
SD/V2/MRD/13	CONSENT FOR HEMODIALYSIS	RMO	PAPER	USE
SD/V2/MRD/14	REQUISITION FOR PHOTO COPIES OF IPD/OPD PAPERS	PATIENT & RELATIVES	PAPER	USE
SD/V2/MRD/15	PATIENT MONITORING & NURSING CHART	NURSE & RMO	PAPER	USE
SD/V1/MRD/16	HIGH RISK CONSENT FOR CARDIAC SURGERY	RMO & CONSULTANT	PAPER	USE
SD/MRD/17				
SD/V1/MRD/18	OPERATION THEATRE – SWAB COUNT FORM	O.T. NURSE	PAPER	USE
SD/V1/MRD/19	PERFUSION PROTOCOL	PERFUSIONIST & ANAESTHETIST SURGEON	PAPER	USE
SD/V1/MRD/20	PRE ANAESTHETIC ASSESSMENT CHART (CVST)	ANAETHESIOLOGIST	PAPER	USE
SD/V1/MRD/21	ANAESTHESIA RECORD FOR CONGENITAL HEART DISEASE (CVST)	ANAETHESIOLOGIST	PAPER	USE
SD/V2/MRD/22	PRE/OPERATIVE CHECK LIST	STAFF NURSE	PAPER	USE
SD/V2/MRD/23	SURGERY NOTES	SURGEON	EMR/ PAPER	USE
SD/V2/MRD/24	CONSENT FOR DISCHARGE AGAINST MEDICAL ADVICE (DAMA)	RMO, PATIENT & RELATIVE	PAPER	USE
SD/V3/MRD/25	CONSENT FOR REFUSAL OF TREATMENT / LAMA	RMO & RELATIVE	PAPER	USE
SD/V2/MRD/26	HAEMODIALYSIS FLOW SHEET	NEPHROLOGIST	PAPER	USE
SD/V4/MRD/27	DISCHARGE CHECKLIST	NURSE & RMO	PAPER	USE

SD/V3/MRD/28	REGULAR MEDICINES CHART	NURSE, RMO & CONSULTANT	PAPER	USE
SD/MRD/29	CONSENT FOR BLOOD TRANSFUSION	RMO, RELATIVE & PATIENT	PAPER	USE
SD/MRD/30	अपुऱ्या दिवसांनी जन्मलेल्या व कमी वजनाच्या बाळांच्या पालकांसाठी विशेष सुचना	NEONATOLOGIST PEDIATRITION	PAPER	USE
SD/MRD/ 31	NURSES DAILY ASSESMENT	NURSES	EMR	USE
SD/V2/MRD/32	SURGERY SAFETY CHECKLIST	SURGEON,ANAETHESIST & OT NURSE	PAPER	USE
SD/MRD/33	NUTRITIONAL ASSESSMENT	DIETITIAN	PAPER	USE
SD/MRD/ 34	NURSING INITIAL ASSEMENT / EMERGENCY			
SH/V2/MRD/35	NURSING INITIAL ASSESSMENT	NURSE & RMO	PAPER	NOT USE
SH/MRD/36	INTERNAL TRANSFER CHECKLIST	NURSE & RMO	PAPER	USE
SD/MRD/V3/37	INVESTIGATION SHEET	RMO	PAPER	USE
SD/MRD/38	ADVICE FOR POST/MORTEM	RELATIVES & RMO	PAPER	USE
SD/MRD/39	LETTER TO CIVIL HOSPITAL, AHMEDNAGAR	RMO	PAPER	USE
SD/MRD/40	CONSENT FOR HYSTEROSALPINGOGRAPHY	CONSULTANT, PATIENT RELATIVES	PAPER	USE
SD/MRD/41	CONSENT FOR STRESS TEST	CONSULTANT, PATIENT RELATIVES	PAPER	USE
SD/MRD/42	PRE ANAESTHESIA EVALUATION	ANESTHESIOLOGIST	PAPER	NOT USE
SD/V2/MRD/43	CONSENT FOR ANAESTHESIA	ANESTHESIOLOGIST & PATIENT	PAPER	USE
SD/V3/MRD/44	INFORMED CONSENT FOR SURGERY	SURGEON, PATIENT & RELATIVES	PAPER	USE
SD/MRD/45	FORM/ C	RMO	PAPER	USE
SD/MRD/46	CONSENT FOR NARCO	CONSULTANT, PATIENT & RELATIVES	PAPER	USE
SD/MRD/47	ADMISSION FORM	PATIENT & RELATIVES	PAPEER	USE
SD/V3/MRD/48	INITIAL ASSESSMENT & PLAN OF CARE	RMO & CONSULTANT	PAPER	USE
SD/MRD/49	APPOINTMENT SLIP (DR. RAHUL DHOOT)	RECEPTION STAFF	PAPER	NOT USE
SD/MRD/50	APPOINTMENT SLIP (DR. RAHUL DHOOT) INFORMATION	RECEPTION STAFF	PAPER	NOT USE
SD/MRD/51	CARDIAC DIET PLAN (RT FEED)	DIETITION	PAPER	USE
SD/MRD/52	RENAL DIET PLAN (RT FEED)	DIETITION	PAPER	USE
SD/MRD/53	DIABETIC DIET PLAN	DIETITION	PAPER	USE
SD/MRD/54	CARDIAC DIET PLAN	DIETITION	PAPER	USE

SD/MRD/55	RENAL DIET PLAN	DIETITION	PAPER	USE
SD/MRD/56	DIABETIC DIET PLAN	DIETITION	PAPER	USE
SD/V2/MRD/57	CONSENT FOR CORONARY ANGIOPLASTY	CARDIOLOGIST, PATIENT & RELATIVES	PAPER	USE
SD/MRD/58	CONSENT FOR ANGIOGRAPHY	CONSULTANT, PATIENT & RELATIVES	PAPER	USE
SD/MRD/59	CONSENT FOR ANAESTHESIA (CATHLAB)	ANESTHESIOLOGIST PATIENT & RELATIVES	PAPER	USE
SD/MRD/60	CONSENT FOR OPTIONS GIVEN FOR IMPLANTS /VALVES/ STENTS/ PACEMAKER	CARDIOLOGIST, PATIENT & RELATIVES	PAPER	USE
SD/V2/MRD/61	CATHLAB CHECK LIST (FOR ANGIOGRAPHY & ANGIOPLASTY)	CATHLAB NURSE & RMO	PAPER	USE
SD/V2/MRD/62	CATHLAB CHECK LIST (FOR ANGIOGRAPHY)	CATHLAB NURSE & RMO	PAPER	USE
SD/MRD/63	अनुमती पत्र	MJPJAY – DEP. STAFF	PAPER	USE
SD/MRD/64	CONSULTANT – VISIT SHEET	CONSULTANT	PAPER	USE
SD/MRD/65	CONSENT FOR OOCYTE RETRIEVALS / EMBRYO TRANSFER	CONSULTANT, PATIENT	PAPER	USE
SD/MRD/66	CONSENT FOR OOCYTE RETRIEVALS / EMBRYO TRANSFER	CONSULTANT, PATIENT	PAPER	USE
SD/MRD/67	CONSENT FOR FREEZING OF EMBRYOS	CONSULTANT, PATIENT	PAPER	NOT USE
SD/MRD/68	CONSENT FORM TO BE SIGNED BY THE COUPLE	CONSULTANT, COUPLE	PAPER	NOT USE
SD/MRD/69	CONSENT FORM FOR THE DONOR OF EGGS	CONSULTANT, DONOR	PAPER	NOT USE
SD/MRD/70	CONSENT FORM FOR THE DONOR OF SPERM	CONSULTANT, DONOR	PAPER	NOT USE
SD/MRD/71	CONSENT FOR FREEZING OF EMBRYOS	CONSULTANT, PATIENT	PAPER	NOT USE
SD/MRD/72	CONSENT OF HUSBAND	CONSULTANT, HUSBAND	PAPER	NOT USE
SD/MRD/73	OUT PATIENT FEEDBACK FORM	PATIENT OF OPD	PAPER	USE
SD/MRD/74	DAILY COUNSELLING SHEET			
SD/MRD/75	CONSENT FOR TRANSPORTATION OF CRITICALLY ILL PATIENTS FOR INVESTION	CONSULTANT, RELATIVES	PAPER	NOT USE
SD/MRD/76	CONSENT FOR EMERGENCY TRANSPORT (AMBULANCE)	RELATIVES & PATIENT	PAPER	NOT USE
SD/MRD/77	HIGH RISK CONSENT FOR TRANSPORTING PATIENT IN AMBULANCE	CONSULTANT, RELATIVES & PATIENT	PAPER	NOT USE
SD/MRD/78	PHYSICAL RESTRAINT FORM	NURSE	PAPER	USE
SD/MRD/79	CONSENT FOR PHYSICAL & CHEMICAL RESTRAINT	NURSE CONSULTANT	PAPER	USE
SD/MRD/80	DIET PLAN FOR ANAEMIA	DIETITION	PAPER	USE
SD/MRD/81	EMPLOYEE INFORMATION FORM	H.R.		
SD/MRD/82	INFECTION SURVEILLANCE DATA COLLECTION	ICN	PAPER	USE

SD/MRD/83	JOINING REPORT	H.R.		
SD/MRD/84	LOW G.C. CONSENT	CONSULTANT, RELATIVES & PATIENT	PAPER	USE
SD/MRD/85	COVID RISK CONSENT	STOP		STOP
SD/MRD/86	TRANING/ COVID RISK ASSEMENT PRIOP TO CLINIC	STOP		STOP
SD/MRD/87	COVID/19 PANDAMIC CONSENT TO START TREATMENT	STOP		STOP
SD/MRD/88	COVID/19 PANDAMIC CONSENT TO START TREATMENT/ PATIENT AGREEMENT	STOP		STOP
SD/MRD/89	FOR UNDERGOING IVF/ ICSI/ OR ET	STOP		STOP
SD/MRD/90	DIET PLAN FOR LOCTATING MOTHER	DIETITION	PAPER	USE
SD/MRD/91	MORTUARY FORM	MORTUARY ATTENDANT	PAPER	USE
SD/MRD/92	CONSENT FOR BLOOD TRANSFUSION	RMO	PAPER	USE
SD/MRD/93	COVID TREATMENT SHEET			
SD/MRD/94	COVID/19 INVESTIGATION SHEET	RMO	PAPER	STOP
SD/V2/MRD/95	NEUROSURGERY CONSENT	SURGEON, PATIENT & RELATIVES	PAPER	USE
SD/MRD/96	कोविड१९ साठी उपचारांसाठी संमती	RELATIVES & PATIENT	PAPER	STOP
SD/MRD/97	INFORMED CONSENT FOR SURGERY/ PROCEDURE	SURGEON	PAPER	USE
SD/MRD/98	CHANGE IN PAYMENT CATEGORY LETTER	BILLING I/C, CONSULTANT	PAPER	USE
SD/MRD/99	CONSENT FOR SPERM RECIPENT	RELATIVES & PATIENT	PAPER	NOT USE
SD/MRD/100	CONSENT FOR OVUM RECIPENT	RELATIVES & PATIENT	PAPER	NOT USE
SD/MRD/101	NURSING HANDLING OVER NOTES – IPD	NURSE	EMR	USE
SD/MRD/102	कोविड घोषणापत्र	RELATIVES & PATIENT	PAPER	STOP
SD/MRD/103	TRAINING CARD	H.R.	PAPER	USE
SD/MRD/104				
SD/MRD/105	MONITORING CHART (CVST)	NURSE &RMO	PAPER	USE
SD/MRD/106	PHYSICIAN FITNESS FORM	PHYSICIAN	PAPER	USE
SD/HRD/107	PRE EMPLOYEMENT PHYSICAL FORM	H.R.	PAPER	USE
SD/HRD/108	VACCINATION FORM	H.R.	PAPER	USE
SD/MRD/109	INFORMED CONSENT TO CHEMOTHERAPY	ONCOLOGIST &PATIENT&RELATIVES	PAPER	USE
SD/MRD/110	AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS	MRD I/C	PAPER	USE
SD/MRD/111	SIMPLIFIED PARTOGRAPH	NURSE &RMO	PAPER	
SD/MRD/112	HIGH RISK INFORMED CONSENT	CONSULTANT, RELATIVES & PATIENT	PAPER	USE
SD/MRD/113	URINARY CATHETER MAINTENANCE BUNDLE	NURSE	PAPER	USE

SD/MRD/141	CONSENT OF PHYSIOTHERAPY SESSION	PHYSIOTHERPIST	PAPER	USE
SD/MRD/142	OT/PROCEDURE ROOM CLEANING & DISINFECTION INSTRUCTION CHECKLIST – TERMINAL CLEANING	I/C OT NURSE	STOPPED	NOT USE
SD/MRD/143	OT/PROCEDURE ROOM CLEANING & DISINFECTION INSTRUCTION CHECKLIST – DEEP CLEANING	I/C OT NURSE	STOPPED	NOT USE
SD/MRD/144	OT/PROCEDURE ROOM CLEANING & DISINFECTION INSTRUCTION CHECKLIST – CLEANING BETWEEN PATIENTS	I/C OT NURSE	STOPPED	NOT USE
SD/MRD/145	SURGERY BUDGET CONSENT	CONSULTANT	PAPER	USE
SD/MRD/145	SURGERY BUDGET CONSENT	CONSULTANT	PAPER	
SD/MRD/146	UMBILICAL LINE	NURSE	PAPER	USE
SD/MRD/147	CONSENT FOR BLOOD DONATION	CONSULTANT /PERSON	PAPER	USE
SD/MRD/148	MOLE REMOVAL	CONSULTANT	PAPER	USE
SD/MRD/149	MICRODEMAABRESSION	DERMATOLOGIST	PAPER	USE
SD/MRD/150	रासायनिक पिलिंगसाठी (केमिकल पिलिंग) संमती फॉर्म	DERMATOLOGIST &PATIENT	PAPER	USE
SD/MRD/151	मायक्रो/निलिंग रेडिओ फ्रिक्वेन्सीसाठी लेझर आणि सौंदर्यशास्त्र संमती	DERMATOLOGIST & PATIENT	PAPER	USE
SD/MRD/152	ऑटोलॉग्स प्लेटलेट रिच प्लायमा (पीआरपी) साठी सौंदर्यशास्त्र संमती फॉर्म	DERMATOLOGIST & PATIENT	PAPER	USE
SD/MRD/153	नेल सर्जरीसाठी संमती फॉर्म	DERMATOLOGIST & PATIENT	PAPER	USE
SD/MRD/154	IADVL/ACADEMY SIG(विशेष स्वारस्य गट) लेझर आणि सौंदर्य शास्त्र लेझर केस कमी करण्यासाठी संमती	DERMATOLOGIST & PATIENT	PAPER	USE
SD/MRD/155	कार्बन डायॉक्सिइड लेझरसाठी(FRACRIONAL CO2 LASER)	DERMATOLOGIST & PATIENT	PAPER	USE
SD/MRD/156	पिगमेंटेशन लेझरसाठी संमती (LASER OF PIGMENTATION)	DERMATOLOGIST & PATIENT	PAPER	USE
SD/MRD/157	इंट्रालेशनल कार्ट्रिकोस्टिरॉईड इंजेक्शनसाठी संमती फॉर्म (KELOID ILS)	DERMATOLOGIST & PATIENT	PAPER	USE
SD/MRD/42/A	POST ANAESTHESIA EVALUATION	ANATHESIOLOGIST	PAPER	USE
SD/MRD/158	IVF FLOW SHEET	CONSULTANT	PAPER	USE
SD/MRD/159	ANC CARD	CONSULTANT	PAPER	USE
SD/MRD/160	GYNAECOLOGIC CYTOLOGY TEST REQUISITION FORM	GYNAECOLOGIST	PAPER	USE
SD/MRD/161	FOLLICULAR STUDY REPORT	GYNAECOLOGIST	PAPER	USE
SD/MRD/162	IVF PATIENT INVESTIGATION	CONSULTANT & PATIENT	PAPER	USE
SD/MRD/163/V1	DOCTOR SHIFT HANDOVER SHEET	RMO &	PAPER	USE

SD/MRD/164/VI	CENTRAL LINE INSERTION PRACTICES ADHERENCE MONITORING	RMO & CONSULTANT	PAPER	USE
SD/MRD/165/VI	URINARY CATHETER INSERTION PRACTICES ADHERENCE MONITORING	RMO & NURSE	PAPER	USE
SD/MRD/166	CONSENT FOR ENDOTRACHEAL INTUBATION / TRACHEOSTOMY AND USING VANTILATOR	CONSULTANT & RMO	PAPER	USE
SD/MRD/167	BLANK	/	/	/
SD/MRD/168/V1	CONSULTANT PROGRESS SHEET	CONSULTANT	PAPER	USE
SD/MRD/169	INFORMED CONSENT FOR FETAL REDUCTION			
SD/MRD/170	DIET PLAN FOR PREGNANCY	DIETITION	PAPER	USE
SD/MRD/171	SPIN SURGERY CONSENT	SURGEON, PATIENT & RELATIVES	PAPER	USE
SD/MRD/172/V1/E	CONSENT FORM TO BE SIGNED BY THE COUPLE OR WOMEN	PATIENT &CONSULTANT	PAPER	USE
SD/MRD/173	CONSENT FOR IUI WITH HASBANDS SEMEN/ SPERM	PATIENT N CONSULTANT	PAPER	USE
SD/MRD/174	CONSENT FOR INTRAVTERINE INSEMINATION DONER SEMEN	PATIENT N CONSULTANT	PAPER	USE
SD/MRD/175/V1/EN	CONSENT FOR FREEZING OF EMBRYOS	PATIENT &CONSULTANT	PAPER	USE
SD/MRD/176	CONSENT FOR FREEZING OF GAMATES/ SPERM/ OCYYTES	PATIENT N CONSULTANT	PAPER	USE
SD/MRD/177	BLANK	/	/	/
SD/MRD/178/V1/EN	CONSENT FOR OOCYTE RETRIEVAL	PATIENT &CONSULTANT	PAPER	USE
SD/MRD/179/V1/EN	CONSENT FORM FOR THE DONOR OF OOCYTES	PATIENT &CONSULTANT	PAPER	USE
SD/MRD/180	ECT AND ANATHESIA RECORD FORM	PSYCOLOGIST	PAPER	USE
SD/MRD/182	CARE PLAN /NEONATAL&PAEDIARIC	PEADIATRITION	PAPER	USE
SD/MRD/183	PERCUTANEOUS NEPHROLITHOTOMY			
	SURGERY CONSENT	PATIENT &SURGEON	PRINT	USE
SD/MRD/184	TRANSURETHRAL INCISION			
	SURGERY CONSENT	PATIENT &SURGEON	PRINT	USE
SD/MRD/185	CYSTOSCOPY AND OPTICAL			
	INTENALURETROTOMY CONSENT	PATIENT&SURGEON	PRINT	USE
SD/MRD/181	ROP SCREENING CONSENT	PEADIATRITION	PRINT	USE
SD/MRD/188	THROMBOLIZATION CONSENT	CONSULTANT&PATIENT	PAPER	USE
SD/MRD/186	URETEROSCOPIC STONE REMOVAL			

	SURGERY CONSENT	SURGEON&PATIENT	PAPER	USE
SD/MRD/187	DO NOT ATTEMPT RESUSCITATION	CONSULTANT&PATIENT	PAPER	USE
	DNAR CONSENT WITH ALGORITHAM	RELATIVES	PRINT	USE
SD/MRD/189	FORM / F	SONOLOGIST/PATIENT	PRINT	USE
SD/MRD/190	DELIVERY NOTES	NEONATOLOGIST	PRINT	USE
SD/MRD/191	OT PHARMACY CONSUMPTION	OT NURSE	PRINT	USE
SD/MRD/192	CT SCAN CONTRAST CONSENT	RADIOLOGIST/PATIENT	PRINT	USE
SD/MRD/193	MRI CONTRAST CONSENT	RADIOLOGIST/PATIENT	PRINT	USE
SD/MRD/194	ESWL PROCEDURE CONTRAST	UROSURGEON/PATIENT	PRINT	USE
SD/MRD/195	CONSENT FOR USE OF PATIENT	PATIENT/RELATIVES	PRINT	USE
	TESTIMONIALS,IMEGES,M.R.			
SD/MRD/196	REQUEST FOR WITHDRAWAL OF CONSENT	PATIENT/RELATIVES	PRINT	USE
SD/MRD/197	CHECKLIST FOR DE/IDENTIFICATION BEFORE PUBLICATION	PATIENT/RELATIVES	PRINT	USE
SD/MRD/198	OPD PROGRESS SHEET	CONSULTANT	PRINT	USE
SD/MRD/199	CONSENT FOR TEE	SURGEON/PATIENT	PRINT	USE

1. Purpose

This Standard Operating Procedure (SOP) defines the specific categories of staff authorized to make entries in the medical record of patients cared for at this organization. It ensures compliance with NABH Standard IMS.3 (6th Edition), specifically Measurable Element IMS.3.d, which mandates that authorized staff make entries in the medical record. This SOP serves as a binding reference for all clinical, nursing, diagnostic, and allied health personnel.

2. Scope

This SOP applies to all inpatient (IP) medical records and relevant outpatient (OP) records maintained within the organization, across all departments and units including:

- All Inpatient Wards, ICUs, and Specialty Units
- Operation Theatres and Procedure Rooms
- Diagnostic Departments (Laboratory, Radiology, Cardiology)
- Allied Health Departments (Physiotherapy, Dietary, Social Work)
- Emergency Department

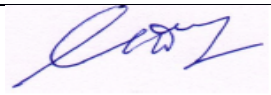
3. NABH Standard Reference

NABH Standard	IMS.3 — The patients cared for by the organisation have a complete and accurate medical record.
Measurable Element	IMS.3.d — Authorised staff make the entries in the medical record. The organisation shall have written guidance for authorising who can make entries and the content of entries. This shall be uniform across the organisation.
Classification	Commitment (Compliance mandatory for NABH accreditation)

4. General Rules for All Medical Record Entries

4.1 Mandatory Requirements for Every Entry

- Every entry in the medical record must include: Full Date (DD/MM/YYYY), Time (24-hour format recommended), Signature of the authorized staff, Name and Employee ID / Designation of the person making the entry
- Entries must be documented immediately upon completion of assessment or procedure, and no later than one hour after the event as per IMS.3.e
- All entries must be legible. Illegible entries are non-compliant and may be flagged during NABH assessment
- No erasure, overwriting, or use of correction fluid is permitted. Errors must be corrected by a single strikethrough with 'Error' written, followed by the correct entry, date, time, and signature of the original author only

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

- Abbreviations must be from the hospital's approved abbreviation list only (as per IMS.3.g). Error-prone abbreviations must never be used for medications
- No addition, deletion or change in the medical records is allowed once the patient is discharged, all the efforts must be made to ensure the correct information is entered and any correction viz. spelling mistake in name, age must be completed before the discharge process is completed.

4.2 Traceability of Author (IMS.3.f)

- The identity of every author must be traceable via: Full name written against the entry, OR Employee code/ID number, OR Authorized rubber stamp with name and designation, OR Authorized e-signature (for EMR/EHR systems, as per statutory requirements)
- A Master Signature List must be maintained in the medical records department with the name, designation, employee ID, and signature/e-signature of all staff authorized to make entries

4.3 Authentication and Countersignature

- Resident doctors' entries (medication orders, progress notes) must be countersigned by the treating consultant within the time period defined in hospital policy
- Verbal or telephonic orders must be countersigned by the ordering doctor within 24 hours (or as per policy)
- Entries made by interns or students must always be countersigned by the supervising doctor/nurse before the entry is considered valid

5. Authorization Matrix: Who Can Make Which Medical Record Entry

The following table defines, entry-by-entry, the authorized personnel, their responsibilities, and practical examples. This matrix is the primary reference for all staff and NABH assessors.

Sr.No.	Medical Record Entry Type	Authorized Personnel	Description of Responsibility
1	**Admission Orders & Admission Diagnosis**	Treating Doctor / Admitting Physician / Resident Doctor (as per hospital policy)	The treating or admitting doctor must document the provisional/working diagnosis at the time of admission. Admission orders must be written clearly with date, time, and signature. Consultant must countersign within the timeframe defined in hospital policy (e.g., within 24 hours if written by a resident).
2	**Clinical / Progress Notes**	Treating Consultant / Attending Doctor / Resident Doctor (countersigned by Consultant)	Daily progress notes must be documented by the treating team in chronological order. Residents may write notes but the consultant must countersign within the defined timeframe. Notes must include: date, time, clinical observations, assessment, and plan.
3	**Medication Orders**	Registered Medical Practitioner (Doctor / Treating Consultant / Resident with countersignature as per policy)	Only qualified and registered doctors are authorized to write medication orders. Orders must include: drug name (generic), dose, route, frequency, duration, date, time, and doctor's signature. Verbal/telephonic orders, if unavoidable, must be countersigned within the defined period (e.g., 24 hours).
4	**Nursing Assessment & Nursing Notes**	Registered Nurse / Staff Nurse (as per nursing scope of practice)	Trained and registered nurses must complete initial nursing assessment on admission. Ongoing nursing notes (shift-wise) must be documented with date, time, nurse's name, employee ID, and signature. Nursing assessments include: vital signs, pain score, fall risk, pressure ulcer risk, patient condition, and nursing interventions.
5	**Medication Administration Record**	Registered Nurse / Staff Nurse administering the medication	The nurse who actually administers the medication must document it in the `record`. Each entry must include: drug administered, dose, route, time, date, and the nurse's initials/signature/employee ID. No medication should be pre-signed in the `medication administration record`. Documentation must occur at the time of or immediately after administration.
6	**Investigation Orders (Lab, Radiology, Cardiology)**	Treating Doctor / Consultant / Resident Doctor	All investigation orders must be written by the treating doctor with a clear clinical indication. For STAT investigations, the urgency must be indicated in the order. Orders must include: date, time, investigation required, clinical indication, and doctor's signature.
7	**Investigation Reports**	Pathologist /	Lab reports must be verified and authenticated by the

Sr.No.	Medical Record Entry Type	Authorized Personnel	Description of Responsibility
	(Lab Results)	Microbiologist / Biochemist (as applicable) — Reporting Authority	qualified pathologist/biochemist/microbiologist responsible for that section. Digital reports must have authorized e-signature as per statutory requirements. Critical values must be communicated to the treating team and documentation of the same must be in the record.
8	**Radiology / Imaging Reports**	Radiologist / Radiology Consultant (qualified and credentialed)	All imaging reports (X-ray, USG, CT, MRI, etc.) must be reported and authenticated by the credentialed radiologist. Provisional verbal reports given urgently must be followed by a final signed report within the defined TAT. For digital PACS reports, e-signatures as per statutory requirements are mandatory.
9	**Cardiology Reports (ECG, 2D Echo, Holter)**	Cardiologist / Physician credentialed for cardiology interpretation	ECG interpretation and reporting must be done by a doctor credentialed for the same (cardiologist or physician). Technician records the ECG; interpretation and authentication must be by the qualified doctor. Reports must carry: date, time of procedure, time of reporting, and doctor's signature/employee ID.
10	**Consent Documentation**	Treating Doctor (obtains consent) / Witness (Nurse or family member as per policy)	The treating doctor who explains the procedure/surgery must obtain and document informed consent. The consent form must be signed by: (1) Patient or Legal Guardian, (2) Treating Doctor, (3) Witness. Date, time, name of doctor, and designation must be clearly mentioned. Consent obtained under coercion or without adequate explanation is invalid.
11	**Dietary / Nutritional Assessments and Care Plans**	Registered Dietician / Clinical Nutritionist	Nutritional screening and assessment must be documented by the hospital's registered dietician. Dietary plan/modifications must be linked to the clinical diagnosis and co-signed where required by the treating doctor. Entries must include: date, time, nutritional assessment findings, dietary plan, and dietician's name/employee ID/signature.
12	**Physiotherapy / Rehabilitation Assessments and Notes**	Registered Physiotherapist / Rehabilitation Specialist	All physiotherapy assessments and session notes must be documented by the treating physiotherapist. A referral order must be present from the treating doctor before physiotherapy documentation is initiated. Entries must include: date, time, session goals, exercises performed, patient response, and physiotherapist's name/signature.
13	**Procedure / Operation Notes**	Surgeon / Interventionist performing the procedure	The surgeon or specialist who performs the procedure must personally document the operative/procedure note. Must be completed within one hour of procedure completion. Content must include: date, time of start/end, procedure performed, findings, complications if any, anaesthesia used, post-procedure instructions, and surgeon's signature.

Sr.No.	Medical Record Entry Type	Authorized Personnel	Description of Responsibility
14	**Anaesthesia Notes (Pre, Intra, Post)**	Anaesthesiologist / Qualified Anaesthetist	All anaesthesia-related documentation (pre-anaesthesia assessment, intraoperative record, post-anaesthesia recovery notes) must be completed by the anaesthesiologist. Intraoperative monitoring entries are real-time and must be completed by the anaesthetist present in the OT.
15	**Discharge Summary**	Treating Consultant / Attending Doctor (countersignature of consultant mandatory if written by resident)	The treating consultant must ensure the discharge summary is accurate and complete. Must include: admission diagnosis, procedures done, findings, treatment given, discharge condition, follow-up instructions, and medications at discharge. Must be completed at the time of discharge (not retrospectively). The consultant's signature is mandatory.
16	**Death Summary / Certificate**	Treating Consultant / Medical Officer on duty (as per hospital policy and statutory requirements)	Death summary must be completed by the treating consultant or the most senior doctor who attended to the patient at the time of death. Must include: date and time of death, cause of death, sequence of events, and resuscitation attempts if any. Death certificate must comply with statutory regulations and be signed by a registered medical practitioner.

6. Summary: Importance of Authorization Control in Medical Records

6.1 Why Authorization Control Matters

The medical record is the single most important clinical and legal document maintained by the hospital. Uncontrolled entries — those made by untrained, unauthorized, or unidentifiable persons — can have catastrophic consequences for patient safety and institutional liability. NABH mandates authorization control under IMS.3.d specifically to:

- Ensure that only qualified, trained professionals document clinical information within their scope of practice
- Prevent transcription errors, fraudulent entries, and unauthorized modifications to the patient record
- Establish clear accountability for every clinical decision, treatment, and outcome documented
- Enable accurate clinical communication across multidisciplinary teams

6.2 Legal and Medico-Legal Implications

Hospitals in India are subject to the Clinical Establishments Act, the Indian Medical Council Act, and the IT Act (for electronic records). Medical records serve as primary evidence in:

- Consumer protection disputes and court proceedings (Consumer Protection Act, 2019)
- Insurance claims and pre-authorization documentation
- Medico-legal cases (MLC) including road traffic accidents, poisoning, assault, and suspicious deaths
- Death audits, maternal death reviews, and perinatal death inquiries

Entries made by unauthorized persons, or records that are undated, unsigned, or illegible, can be challenged in legal proceedings and may constitute negligence. The organization may be held vicariously liable for the acts of its staff in such cases.

AMENDMENT HISTORY

Sl No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	00	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.
5	01	02	1 Jan 2026	No changes.

	SAIDEEP HOSPITAL POLICIES	Doc No	SDH/IMS/05
		Issue No	01
		Rev No.	02
		Date	1JAN 2025
		Page	1
	Policy for confidentiality, integrity, and security of all records		

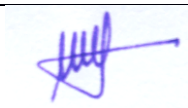
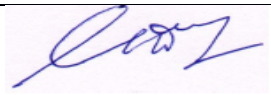
1. PURPOSE

This policy establishes the framework for maintaining the confidentiality, integrity, and security of all records, data, and information held by the hospital, and governs the lawful disclosure of privileged health information and access to medical records. It is formulated in compliance with NABH Accreditation Standards, 6th Edition, Standard IMS.5 (sub-standards a through f).

2. SCOPE

This policy applies to all departments and personnel of the hospital involved in the creation, maintenance, use, storage, or release of medical records, clinical data, and information in any form — physical or electronic. It encompasses all patient records, administrative data, laboratory results, imaging, and electronic health records managed under the Hospital Information System (HIS).

3. DefinitionsTerm	Definition
Confidentiality	Ensuring that records, data and information are accessible only to authorised persons, in accordance with applicable law.
Integrity	Ensuring that records and data are accurate, complete, and not tampered with; corrections made only as per defined procedure.
Security	Protection of records, data and information against loss, destruction, unauthorised access, and cyber threats.
Privileged Health Information	Confidential information furnished by a patient to a licensed healthcare professional to facilitate diagnosis and treatment.
Medical Record	Any document, paper, electronic data, image, or report generated during the course of patient care.
HIS	Hospital Information System — the electronic platform used for clinical and administrative data management.
MRD	Medical Records Department.
Tracer Card	A card used to track the movement of a physical medical record file in and out of the MRD.
Authorised Night Manager	Designated hospital manager authorised to make record release decisions outside normal office hours.

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

4. REGULATORY FRAMEWORK

This policy is governed by, and shall be read in conformity with, the following:

- NABH Accreditation Standards, 6th Edition – IMS.5.a through IMS.5.f
- Code of Medical Ethics, 2002 (National Medical Commission)
- Mental Healthcare Act, 2017 (MHCA 2017) – Sections 23–25
- Information Technology Act, 2000 and the IT (Amendment) Act, 2008
- Digital Personal Data Protection Act, 2023
- Right to Information Act, 2005
- Medical Termination of Pregnancy Act, 1971 (as amended)
- Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994
- Registration of Births and Deaths Act, 1969
- Applicable State Public Health Acts and Disease Notification Rules
- National Medical Commission Act, 2019
- Orders of any court of competent jurisdiction

5. CONFIDENTIALITY OF RECORDS, DATA AND INFORMATION [IMS.5.A – CORE]

5.1 General Principle

Confidentiality implies that only authorised persons shall have access to the contents of medical records and clinical data. Access shall align with applicable law and shall be limited, as far as practicable, to clinical care providers directly involved in the patient's care.

5.2 Physical Records – Access Control

- The Medical Records Department shall be a restricted area. Entry shall be permitted only to authorised MRD staff, treating physicians, and other designated personnel.
- A Tracer Card system shall be used to track the movement of all physical record files in and out of the MRD. No file shall be removed without completing the tracer card and obtaining appropriate authorisation.
- Medical records shall not be removed from designated storage areas by unauthorised personnel. Records temporarily accessed for clinical review shall be returned to the MRD promptly.
- Patient case files shall not be left unattended in open areas, nursing stations, or corridors.

5.3 Electronic Records – Access Control

- Access to the HIS and electronic medical records shall be role-based and user-specific. Each user shall be assigned a unique login credential with permissions limited to functions necessary for their role.
- Shared login credentials are strictly prohibited.
- Authentication controls, session time-outs, and automatic log-off features shall be implemented to protect data privacy and prevent unauthorised access.

- Electronic records and data shall not be copied, printed, or transmitted outside the authorised secure environment without explicit written authorisation from the Medical Superintendent or designated authority.
- Patient data transmitted electronically — including laboratory reports, imaging results, and clinical notes — shall be communicated only through a secure, encrypted messaging platform approved by the organisation.

6. INTEGRITY OF RECORDS, DATA AND INFORMATION [IMS.5.B – CORE]

6.1 General Principle

Integrity implies that entries in medical records shall not be tampered with. Records shall be accurate, complete, and free from unauthorised alteration. The organisation shall maintain a system to track changes made to records or data.

6.2 Corrections in Physical Records

- Errors in physical records shall be corrected by drawing a single horizontal line through the incorrect entry, such that the original entry remains legible.
- The correction shall be initialled, signed, dated, and timed by the person making the correction. The reason for the correction shall be noted alongside.
- Erasures, use of correction fluid (whitener), overwriting, or obliteration of any entry are strictly prohibited.
- Blank spaces in records shall not be left without being crossed or completed.

6.3 Corrections in Electronic Records

- The HIS shall provide an audit trail that automatically records the date, time, and identity of the user making any modification to an electronic entry.
- Original entries shall not be deleted; corrections shall be made as addendum entries or through the system's defined correction workflow, preserving the original entry.
- Only authorised users shall be able to make amendments to finalised electronic records, and only within the system-defined amendment period or with supervisor authorisation.

6.4 Tracking Changes

The organisation shall maintain a system — whether through the HIS audit trail or a physical log — to track all changes made to patient records and data. This log shall be available for review by the Medical Superintendent and Quality Manager.

7. SECURITY OF RECORDS, DATA AND INFORMATION [IMS.5.C – CORE]

7.1 General Principle

Security refers to the protection of records, data, and information against loss and destruction — whether from physical hazards, human error, or cyber threats.

7.2 Physical Records – Security Measures

- All physical medical records shall be stored in designated, secure storage areas within the MRD.
- Storage areas shall be equipped with adequate pest and rodent control measures to protect records from damage.
- Fire-safe cabinets or an appropriate fire suppression system shall be provided in the MRD storage area to protect records against fire. Adequate fire-fighting equipment shall be maintained and regularly inspected.
- Access to storage areas shall be restricted. The MRD shall be locked when unattended.
- Records shall be protected from water damage, excessive humidity, and direct sunlight.

7.3 Electronic Data – Security Measures

- The HIS and all electronic databases shall be protected by up-to-date anti-virus and anti-malware software.
- A robust data backup procedure shall be implemented, including regular automated backups to a secure, off-site or cloud-based location. Backup integrity shall be tested periodically.
- Preventive measures against cyber-attacks on electronic medical records data shall be implemented and shall include firewalls, intrusion detection systems, and periodic vulnerability assessments.
- USB ports on clinical workstations and medical devices shall be disabled or restricted to prevent unauthorised data copying or introduction of malware.
- Remote access to patient data shall be restricted to authorised personnel using secure, encrypted connections.
- Confidential patient data communicated electronically shall be transmitted only through a secure messaging platform.
- A documented Disaster Recovery Plan shall be in place to ensure continuity of access to critical patient data in the event of system failure.

8. USE OF TECHNOLOGY FOR IMPROVING CONFIDENTIALITY, INTEGRITY AND SECURITY [IMS.5.D – ACHIEVEMENT]

8.1 Principle

The organisation shall periodically review and update its technological features to improve the confidentiality, integrity, and security of records, data, and information. Technological improvement is an ongoing process aligned with evolving standards and threats.

8.2 Technology Review and Upgrade

- The IT Department and MRD shall jointly conduct an annual review of existing technologies deployed for records management and data protection.
- The organisation shall explore and implement technology enhancements including, but not limited to: transition from physical to electronic medical records, implementation of remote data backup, role-based access controls, biometric authentication, and encrypted data communication channels.
- USB ports on medical devices and clinical workstations shall be disabled or managed to prevent unauthorised data extraction.

- Remote access and downloading of patient data from the HIS shall be restricted and logged.
- Anti-virus software and operating systems shall be kept updated at all times.
- Patient data generated by medical equipment (e.g., patient monitors, ECG machines, imaging systems) shall be accessible only to authorised clinical personnel. Mechanisms to safeguard such data shall be reviewed periodically.

8.3 Documentation

All technology upgrades relevant to records security and confidentiality shall be documented, and the outcomes shall be reviewed by the Quality Manager and reported to the hospital management annually.

9. DISCLOSURE OF PRIVILEGED HEALTH INFORMATION [IMS.5.E – COMMITMENT]

9.1 Definition

Privileged health information is the confidential information furnished by a patient to a licensed healthcare professional authorised by law to provide care and treatment, for the purpose of facilitating diagnosis and treatment. The organisation shall disclose such information only as authorised by the patient in writing, or as required by law.

9.2 Patient Authorisation

- Any disclosure of privileged health information to a third party — including family members, employers, insurance companies, or other healthcare providers — shall require the prior written authorisation of the patient.
- Written authorisation shall be obtained on the prescribed Patient Consent for Disclosure of Privileged Health Information Form [MRD 135] which shall be available in English and Marathi.
- The authorisation shall specify: the nature of information to be disclosed, the identity of the recipient, the purpose of disclosure, and the period for which the authorisation is valid.
- Authorisation by the patient shall be obtained before any disclosure; retrospective authorisation is not acceptable except in emergency situations where the patient was incapacitated, in which case the authorisation shall be obtained as soon as practicable.
- The completed authorisation form shall be filed in the patient's medical record.

9.3 Disclosure as Required by Law

Disclosure of privileged health information without patient authorisation shall be permitted only in the following circumstances, as required by applicable law:

- Notification of notifiable diseases to the designated public health authority;
- Reporting of Medico-Legal Cases (MLC) to law enforcement and government agencies;
- Reporting of infant, child, and maternal deaths to the Registration Authority;
- Reporting under the Medical Termination of Pregnancy Act, 1971;
- Submission of Form F under the PCPNDT Act, 1994;
- Compliance with orders of a court of competent jurisdiction;
- Disclosure permitted under the Mental Healthcare Act, 2017; and

- Any other disclosure mandated by applicable Central or State legislation.

All mandatory disclosures shall be documented in the Statutory Reporting Register, referencing the specific legal provision that mandates the disclosure.

9.4 Special Care – Medico-Legal and Sensitive Cases

Special care shall be taken in medico-legal cases and other sensitive situations identified by the Government or the organisation (including cases of sexual assault, substance abuse, HIV status, psychiatric conditions, and child abuse). Disclosure in such cases shall be authorised by the Medical Superintendent or designated authority and shall strictly comply with applicable statutory provisions.

10. ACCESS TO MEDICAL RECORDS [IMS.5.F – COMMITMENT]

The detailed procedures governing requests for access to medical records by patients, next of kin, treating physicians, insurance agencies, government agencies, and courts of law — including provisions for psychiatric patients under MHCA 2017, after-hours release, denial of information, and mandatory reporting — are contained in the Standalone Policy on Access to Medical Records, reference number IMS/POL/[XXX-F].

The following is a summary of the key provisions:

Requester	Summary Requirement
Patient	Written requisition form or registered e-mail + valid photo ID.
Next of Kin (living patient)	Requisition + photo ID + authorisation letter signed by patient + relationship proof.
Deceased patient	Requisition + photo ID + death certificate + relationship/legal heir proof.
Treating Physician	Written request with clinical purpose + hospital ID / NMC registration.
Insurance Agency	Formal request on company letterhead + patient authorisation letter + investigator ID.
Government Agency	As mandated by applicable law; no patient authorisation required for mandatory disclosures.
Court of Law	Valid court order; certified copies released; originals retained unless court directs otherwise.
Psychiatric Patient (MHCA 2017)	Access per Section 24 of MHCA; withholding only on written clinical grounds by psychiatrist.
After-hours	Via Authorised Night Manager; After-Hours Release Register to be maintained.

Release of information to patients shall be in accordance with the Code of Medical Ethics, 2002. RTI grievances shall be addressed by government and other applicable bodies as per written guidance. Denial of information shall be permitted only where, in the opinion of a licensed healthcare professional, disclosure would endanger the life or safety of the patient or others.

11. STAFF TRAINING AND AWARENESS

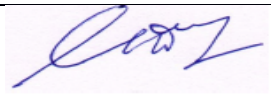
The hospital shall ensure that all staff are trained on this policy at the time of induction and at least once annually thereafter. Training shall cover confidentiality obligations, correct documentation practices, electronic data security, incident reporting, and the procedure for responding to record access requests. Training records shall be maintained by the Human Resources Department and shall be available for review during NABH assessments.

12. BREACH AND INCIDENT REPORTING

Any actual or suspected breach of confidentiality, integrity, or security of medical records or patient data shall be reported immediately to the Head of MRD and the Medical Superintendent. The incident shall be recorded in the hospital's Incident Reporting System. The Medical Superintendent shall investigate the breach, initiate corrective action, and report to the Management Committee as appropriate. Where the breach involves electronic data and may constitute an offence under the Information Technology Act, 2000, or the Digital Personal Data Protection Act, 2023, legal counsel shall be consulted.

13. NABH IMS.5 COMPLIANCE MATRIX

Standard	Requirement	Policy Section Reference
IMS.5.a	Confidentiality of records, data and information	Section 5
IMS.5.b	Integrity of records, data and information	Section 6
IMS.5.c	Security of records, data and information	Section 7
IMS.5.d	Technology for improving CIS	Section 8
IMS.5.e	Disclosure of privileged health information	Section 9

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

IMS.5.f	Access to medical records by patients, physicians, agencies	Section 10 & Standalone Policy IMS/POL/[XXX-F]

14. RESPONSIBILITIES

Designation / Department	Responsibility
Medical Records Officer / Head – MRD	Overall custody, access control, release of records, maintenance of registers, staff training.
Medical Superintendent	Final authority on complex, disputed, or court-ordered releases; oversight of all MRD operations.
IT Department / HIS Administrator	User access management, system security, anti-virus, backup, audit trails, firewall maintenance.
Treating Physicians / Clinical Staff	Correct, timely, and complete documentation; adherence to correction procedures; privileged information disclosures.
Nursing In-charge	Ensure ward-level record confidentiality; report breaches; control tracer card usage.
Quality Manager	Policy review, audit compliance, liaison with NABH assessors, document control oversight.
Authorised Night Manager	After-hours record release decisions; maintenance of After-Hours Release Register.
All Staff	Maintain confidentiality; direct all record requests to MRD; not to access, share, or copy records without authorisation.

15. RELATED DOCUMENTS AND REFERENCES

- NABH Accreditation Standards, 6th Edition – IMS.5.a through IMS.5.f
- Standalone Policy on Access to Medical Records – IMS/POL/[XXX-F]
- Patient Consent for Disclosure of Privileged Health Information Form – MRD/FORM/002 (English & Marathi)
- Medical Records Requisition Form – MRD/FORM/001
- After-Hours Record Release Register – MRD/REG/002
- Record Release Log – MRD/REG/003
- Statutory Reporting Register – MRD/REG/004
- Audit Trail Log / HIS Access Log – IT/LOG/001
- Tracer Card Register – MRD/REG/005

- Code of Medical Ethics, 2002 (National Medical Commission)
- Mental Healthcare Act, 2017
- Information Technology Act, 2000 and Amendment 2008
- Digital Personal Data Protection Act, 2023
- Right to Information Act, 2005

AMENDMENT HISTORY

Sl No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	00	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.
5	01	02	1 JAN 2026	No changes.

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/IMS /05
		Issue No	01
		Rev No.	02
		Date	1JAN 2026
		Page	1
	Policy to address requests for access to information contained in medical records		

1. PURPOSE

This policy establishes a consistent, lawful, and ethical framework for managing requests for access to information contained in medical records by patients, their authorised representatives, treating physicians, insurance agencies, government authorities, and the court of law. The policy is formulated in compliance with NABH Accreditation Standards, 6th Edition, IMS.5.f.

2. SCOPE

This policy applies to all departments and personnel of the hospital involved in the maintenance, custody, and release of medical records, including the Medical Records Department (MRD), treating physicians, nursing staff, administrative staff, and the authorised Night Manager.

3. DEFINITIONS

Term	Definition
Medical Record	Any document, paper, electronic data, image, or report generated during the course of patient care in this organisation.
Authorised Requester	The patient, legally authorised next of kin, treating physician, insurance agency investigator, government authority, or court of law.
Next of Kin	Spouse, parent, adult child, or sibling recognised as the closest living relative.
Night Manager	A designated, authorised hospital manager responsible for record release decisions during non-office hours.
MRD	Medical Records Department.

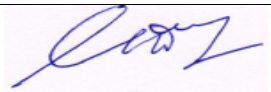
4. POLICY STATEMENT

The hospital shall ensure that all requests for access to or release of information in medical records are handled consistently, transparently, and in accordance with applicable law. Medical records are the property of the hospital; however, patients and their authorised representatives are entitled to access the information contained therein as per the provisions of this policy, the Code of Medical Ethics 2002, and all relevant statutory requirements.

5. REGULATORY FRAMEWORK

This policy is governed by, and shall be interpreted in conformity with, the following legislation and standards:

- NABH Accreditation Standards, 6th Edition – IMS.5.f

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.D1epak	
Quality Head		Chairman & Managing Director	

- Code of Medical Ethics, 2002 (Medical Council of India / National Medical Commission)
- Mental Healthcare Act, 2017 (MHCA 2017) – particularly Sections 23–25 governing confidentiality and information rights of persons with mental illness
- Right to Information Act, 2005 (RTI Act)
- Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994
- Applicable State and Central Government regulations governing notifiable diseases, MLC, and vital event reporting
- Orders of any court of competent jurisdiction

6. MODE OF REQUEST

All requests for access to or copies of medical records shall be submitted through one of the following authorised channels:

6.1 Written Requisition Form

The requester shall complete the prescribed Medical Records Requisition Form available at the Medical Records Department. The duly completed form shall be submitted in person at the MRD counter during office hours, or to the authorised Night Manager after office hours.

6.2 Registered E-mail

Requests may also be submitted via e-mail from the requester's registered e-mail address to the official hospital MRD e-mail address. The subject line shall clearly state: "REQUEST FOR MEDICAL RECORDS – [Patient Name] – [UHID/MRD No.]". E-mail requests shall carry the same evidentiary weight as written requests and shall be acknowledged within one working day.

6.3 Proof of Identity – Mandatory

Proof of identity is mandatory for all requesters regardless of the mode of request. Acceptable documents include a government-issued photo identity card (Aadhaar, Passport, PAN Card, Driving Licence, or Voter ID). Copies of the identity document shall be retained on file by the MRD as part of the record release documentation.

7. ACCESS BY PATIENTS

A patient who is an adult (18 years or above) and is of sound mind shall be entitled to access and receive copies of their own medical records upon:

- Submission of a duly completed Medical Records Requisition Form or a request via registered e-mail; and
- Production and submission of a copy of valid government-issued photo identity proof.

The hospital shall endeavour to provide the requested records or certified copies thereof within three (3) working days of receipt of the complete request.

8. ACCESS BY NEXT OF KIN – LIVING PATIENT

The next of kin of a living patient may access the patient's medical records only upon:

- Submission of a duly completed Medical Records Requisition Form or a request via registered e-mail;
- Production and submission of a copy of valid government-issued photo identity proof of the next of kin;
- Submission of a duly signed and notarised Authorisation Letter from the patient specifically authorising the named next of kin to access the records; and
- Documentation establishing the relationship with the patient (e.g., marriage certificate, birth certificate, or affidavit).

Authorisation by the patient shall be the primary prerequisite. Records shall not be released to the next of kin without such authorisation, except where the patient is a minor, incapacitated, or is a person admitted under the provisions of the Mental Healthcare Act, 2017 (see Section 11).

9. ACCESS IN CASE OF DECEASED PATIENT

In the event of the death of a patient, the medical record shall be released only to the lawful next of kin, upon:

- Submission of a duly completed Medical Records Requisition Form or a request via registered e-mail;
- Production and submission of a copy of valid government-issued photo identity proof;
- Submission of a certified copy of the Death Certificate; and
- Submission of documentation establishing the lawful relationship of the requester to the deceased (e.g., marriage certificate, birth certificate, legal heir certificate, or succession certificate as applicable).

Where multiple individuals claim to be the lawful next of kin and a dispute exists, the records shall be withheld pending production of a court order or legal heir certificate issued by a competent authority.

10. ACCESS BY TREATING PHYSICIANS

A treating physician who has provided care to the patient shall be provided access to the patient's medical records for the purpose of clinical review, continuity of care, or medico-legal purposes, upon:

- Submission of a request in writing (Requisition Form or registered e-mail) specifying the clinical purpose;
- Production of valid hospital identity credentials or registration number (MCI / NMC registration); and
- Countersignature of the Head of Department or Medical Superintendent where records are required for purposes beyond direct clinical care.

Access shall be granted as per the written guidance of the organisation. Physicians shall not remove original records from the MRD. Certified copies or electronic access shall be provided as appropriate.

11. PSYCHIATRIC PATIENTS – WITHHOLDING OF INFORMATION UNDER MHCA 2017

In accordance with the Mental Healthcare Act, 2017, the following specific provisions shall apply to persons receiving care for mental illness:

11.1 Right to Access

A person with mental illness has the right to access their medical records in accordance with Section 24 of the MHCA 2017. The hospital shall not unreasonably deny a person with mental illness access to information about their own condition and treatment.

11.2 Withholding of Information – Grounds

In accordance with IMS.5.f and MHCA 2017, the release or disclosure of information from the medical records of a psychiatric patient may be withheld, in whole or in part, only when a licensed healthcare professional (psychiatrist or qualified mental health professional) determines in writing that:

- Disclosure of the information would endanger the life or safety of the patient or any other person; or
- Disclosure would be seriously detrimental to the mental health of the patient; or
- The patient lacks the mental capacity to make an informed request for the information.

11.3 Documentation of Withholding Decision

Any decision to withhold information from a psychiatric patient shall be:

- Documented in writing by the responsible psychiatrist, clearly stating the clinical grounds for withholding;
- Recorded in the patient's medical record; and
- Communicated to the patient's nominated representative or legal guardian as applicable.

11.4 Nominated Representative

A nominated representative designated under the MHCA 2017 shall be entitled to access information in the psychiatric patient's record in accordance with the Act, subject to the withholding provisions described above.

12. RELEASE OF RECORDS TO INSURANCE AGENCIES

Medical records may be released to investigators from health insurance or life insurance companies for the purpose of claims verification, upon:

- Submission of a formal written request on the letterhead of the insurance company, specifying the claim reference number, name of insured, and purpose of the request;
- Submission of a duly signed Authorisation Letter from the patient or lawful next of kin (in case of a deceased patient) authorising release of records to the specified insurance agency;
- Production and submission of a copy of valid government-issued photo identity proof of the insurance investigator/representative; and
- Verification of the investigator's credentials and official authorisation from the insurance company.

Release shall be restricted to records directly relevant to the claim. The MRD shall maintain a log of all records released to insurance agencies.

13. RELEASE OF RECORDS TO GOVERNMENT AGENCIES AND STATUTORY REPORTING

13.1 General Disclosure to Government Agencies

Medical records shall be released to government and statutory agencies as mandated by applicable law. Such release shall not require patient authorisation where disclosure is compelled by statute. The MRD shall document all such disclosures with reference to the specific legal provision requiring disclosure.

13.2 Mandatory Reporting Requirements

The hospital shall ensure timely and accurate reporting to the designated government agencies in respect of the following, as required by law:

- Infant, child, and maternal deaths – to be reported as per the Registration of Births and Deaths Act and applicable State health authority requirements;
- Medical Termination of Pregnancy (MTP) records – to be reported to the appropriate authority as per the Medical Termination of Pregnancy Act, 1971 (as amended), and related rules;
- Form F under the PCPNDT Act, 1994 – to be submitted to the Appropriate Authority at prescribed intervals as required under the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act;
- Notifiable diseases – to be reported to the Chief Medical Officer / District Health Officer / State Disease Surveillance Unit as per the applicable State Public Health Act and National Health Policy;
- Medico-Legal Cases (MLC) – to be reported to the police authorities and relevant government agencies as per law, including the Code of Criminal Procedure.

14. RELEASE OF RECORDS ON ORDER OF COURT OF LAW

Medical records shall be released on receipt of a valid Order or Summons issued by a court of competent jurisdiction. The following procedure shall be followed:

- The original court order shall be received and verified by the Medical Superintendent or their designated representative;
- Certified true copies of the relevant records shall be prepared by the MRD;
- Records shall be released only to the court or to the party specifically named in the order, duly acknowledged by a signature and official seal or stamp;
- Original records shall not be released unless specifically directed by the court; certified copies shall be released in the first instance; and
- All releases pursuant to court orders shall be documented with a copy of the order retained in the hospital's records.

15. RELEASE OF RECORDS AFTER OFFICE HOURS

Release of medical records after standard office hours shall be governed by the following procedure:

15.1 Authorised Night Manager

A designated, authorised Night Manager shall be responsible for all decisions relating to the release of medical records outside of normal MRD operating hours. The Night Manager shall have completed the prescribed training on the medical records release policy and shall have the necessary access authority.

15.2 Process

- All after-hours requests shall be submitted via written requisition or registered e-mail in accordance with Section 6;
- The Night Manager shall verify the identity of the requester and the validity of the request against the criteria established in this policy;
- In clinical emergencies requiring immediate access to records for direct patient care, the treating physician may request access from the Night Manager verbally, with written documentation to be completed by the next working day;
- The Night Manager shall maintain a written After-Hours Record Release Register, recording: date and time of request, name and designation of requester, nature of records released, grounds for release, and the Night Manager's signature; and
- All after-hours releases shall be reviewed by the MRD Head on the next working day and countersigned in the register.

15.3 Limitations

The Night Manager shall not release records in circumstances where there is doubt as to the legitimacy of the request, the identity of the requester, or the existence of valid authorisation. In such cases, the request shall be deferred to the next working day and the requester so informed.

16. DENIAL OF ACCESS TO INFORMATION

Denial of access to information from medical records shall be permitted only when, in the professional opinion of a licensed healthcare professional, the release of the information would endanger the life or safety of the patient or others (refer Section 11 for psychiatric patients). Any denial shall be:

- Documented in writing with clear clinical justification;
- Communicated to the requester in writing; and
- Subject to the grievance redressal mechanism of the organisation.

Grievances relating to denial of information and RTI matters shall be addressed by the government and other applicable bodies as per the applicable written guidance and the Right to Information Act, 2005.

17. DOCUMENTATION AND RECORD-KEEPING

The MRD shall maintain the following registers and records in relation to this policy:

- Medical Records Requisition Register (maintained by MRD);
- Record Release Log (patient name, UHID, date, nature of request, requester, documents verified, records released, authorisation reference);

- After-Hours Record Release Register (maintained by the Night Manager);
- Statutory Reporting Register (for all mandatory government disclosures); and
- Copies of all authorisation letters, identity proofs, court orders, and insurance authorisations.

All documentation shall be retained in accordance with the medical records retention policy of the organisation and applicable regulatory requirements.

18. RESPONSIBILITIES

Designation	Responsibility
Medical Records Officer / Head – MRD	Overall implementation, maintenance of registers, staff training, day-to-day record release.
Medical Superintendent	Final authority for complex or disputed release requests; oversight of court order compliance.
Treating Physician / Psychiatrist	Clinical decision on withholding records for patient safety; countersigning physician requests.
Authorised Night Manager	After-hours record release decisions; maintenance of After-Hours Register.
Quality Manager	Policy review, audit compliance, and coordination with NABH standards.
All Staff	Maintain confidentiality; direct all requests to MRD; do not release records without authorisation.

19. RELATED DOCUMENTS AND REFERENCES

- NABH Accreditation Standards, 6th Edition – IMS.5, IMS.5.f
- Code of Medical Ethics, 2002 (National Medical Commission)
- Mental Healthcare Act, 2017 (MHCA 2017)
- Right to Information Act, 2005
- Medical Termination of Pregnancy Act, 1971 (as amended)
- Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994
- Registration of Births and Deaths Act, 1969
- National Medical Commission Act, 2019
- Applicable State Public Health Act and Disease Notification Rules
- Medical Records Requisition Form [MRD/FORM/001]
- After-Hours Record Release Register [MRD/REG/002]
- Record Release Log [MRD/REG/003]

AMENDMENT HISTORY

SINo	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	00	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.
5	01	02	1 JAN 2026	No changes.

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/IMS/06
		Issue No	01
		Rev No.	02
		Date	1 Jan 2026
		Pages	1
	Document Control Policy		

1. Purpose

To establish an effective, standardised process for the creation, review, approval, distribution, control, and archival of all hospital documents, ensuring that only current, authorised versions are available for use across all departments, in compliance with NABH IMS 6th Edition Standard IMS.6.A.

2. Scope

This policy applies to all controlled documents in use across the hospital, including:

- Policies and procedures (clinical and administrative)
- Protocols, guidelines, and clinical pathways
- Forms, formats, checklists, and registers
- Standard Operating Procedures (SOPs)
- Job descriptions, manuals, and reference documents

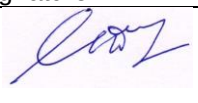
It applies to all staff involved in document creation, review, approval, or use across all departments.

3. Definitions

- Controlled Document: Any document subject to version control, formal review, and approval before use.
- Master Document List (MDL): A comprehensive register of all active controlled documents maintained by the Quality team.
- Obsolete Document: A superseded version no longer in active use but retained for reference.
- Document Custodian: The designated individual responsible for maintaining and updating a specific document.
- Approved Document: A document reviewed and authorised by the designated approving authority.
-

4. Policy Statement

The hospital shall ensure that all documents including forms, formats, policies, and procedures in use are current and relevant. They shall be created, reviewed for adequacy, authorised, and released by designated individuals. Only the latest authorised versions shall be available for use. Obsolete documents shall be removed from the site of use and archived as per a planned retention period, based on the organisation's policy.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

5. Document Lifecycle

5.1 Document Creation

Every new document shall use the hospital's standard template and shall be assigned: a unique document number (e.g., MRD-POL-001), a clear title, a version number starting at 1.0, creation and effective dates, and the author's name and designation.

5.2 Review for Adequacy

Before approval, every document shall be reviewed for accuracy, compliance with applicable legal and NABH requirements, clarity, completeness, and internal consistency with related documents. Documents shall be reviewed as per a planned schedule (minimum once every three years, or sooner upon a regulatory update, incident, or operational change).

5.3 Approval and Release

All documents shall be approved by designated authorities as per the matrix below:

Document Type	Reviewed By	Approved By
Hospital-wide Policy	Quality Manager	Medical Superintendent / CEO
Departmental Policy / SOP	HOD + Quality	Medical Superintendent
Clinical Guideline / Protocol	Clinical Lead + Quality	Medical Director
Form / Format / Register	Department HOD	Quality Manager

5.4 Identification and Numbering

All approved documents shall be uniquely identified by: Document Code ([Dept]-[Type]-[Serial], e.g., MRD-POL-001), Version Number (major revisions increment the whole number; minor edits increment the decimal), Date of Issue and Effective Date, and page count (e.g., Page 1 of 4).

5.5 Distribution and Availability

- Only the current approved version shall be available at the point of use.
- Controlled hard copies shall bear a CONTROLLED COPY stamp with copy number.
- Electronic documents shall be maintained in the hospital's Document Management System (DMS) with access controls.
- Staff shall be informed and trained whenever a new or revised document is released.

5.6 Revision and Update

- Documents shall be reviewed at planned intervals (minimum every 3 years) or upon: change in law or NABH standards, significant incident, operational change, or audit recommendation.
- Revised documents shall follow the full creation-review-approval cycle.
- A version history log shall be maintained at the end of each document.

5.7 Obsolete Document Management

- Superseded documents shall be removed from all points of use upon release of the revised version.
- One copy of each obsolete document shall be archived in the Quality Department master file for a minimum of 5 years, clearly stamped OBSOLETE — NOT FOR USE.
- Electronic obsolete documents shall be moved to a restricted archive folder in the DMS.

6. Master Document List

The Quality Department shall maintain a Master Document List containing all controlled documents, including: document code, title, version, effective date, document owner, and review due date. The MDL shall be reviewed and updated quarterly.

7. External Documents

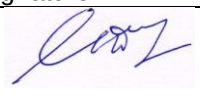
Externally originating documents relevant to hospital operations (e.g., NMC guidelines, NABH standards, Acts and Regulations) shall be listed in the MDL with source and version/date, and periodically reviewed to ensure the most current edition is in use.

8. Roles and Responsibilities

- Quality Department: Maintains the MDL; coordinates document control; facilitates review schedules.
- Department HODs: Initiate, review, and ensure departmental compliance; communicate updates to staff.
- Document Custodians: Maintain assigned documents; initiate revision requests.
- All Staff: Use only current approved versions; report outdated documents to HOD or Quality team.
- Medical Superintendent / CEO: Final approval authority for hospital-wide policies.

9. Audit and Monitoring

Compliance shall be audited annually by the Quality team. Audit indicators include: percentage of documents reviewed on schedule, proportion of controlled documents that are current, and staff awareness of document access. Findings shall be reported to the Quality Committee.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

10. Non-Compliance

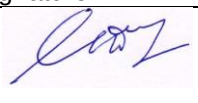
Use of unauthorised or outdated documents is a non-compliance event. Instances shall be reported to the HOD and Quality team, subjected to root cause analysis, and corrective actions implemented. Repeat violations shall be escalated to management.

11. Legal and Regulatory Compliance

- NABH 6th Edition IMS Standards — IMS.6.A (CORE)
- National Medical Commission (NMC) guidelines
- Digital Personal Data Protection Act, 2023
- Information Technology Act, 2000

AMENDMENT HISTORY

Sl. No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	01	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.
5	01	02	1 Jan 2026	No changes.

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Quality Head		Dr. S.S. Deepak Chairman & Managing Director	

	SAIDEEP HOSPITAL HOSPITAL POLICIES	Doc No	SDH/IMS /06
		Issue No	01
		Rev No.	02
		Date	1JAN 2026
		Page	1
	Retention of Patient Clinical Records, Data and Information Policy		

1. Purpose

To define the retention period for each category of patient clinical records, data, and information; to ensure retention is in consonance with rules laid down by the National Medical Commission (NMC) and the respective state authority; and to ensure that the retention process provides expected confidentiality and security, in compliance with NABH IMS 6th Edition Standards IMS.6.B (CORE) and IMS.6.C (Commitment).

2. Scope

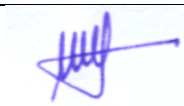
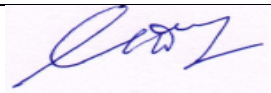
This policy applies to all patient clinical records generated and maintained by the hospital, including:

- Outpatient (OPD), Inpatient (IPD), Emergency (ER), and Day Care records
- Medico-Legal Case (MLC) records
- Speciality records: Psychiatric, MTP, IVF/ART, Paediatric/Neonatal
- Diagnostic records: Laboratory, Radiology/PACS, Pathology
- Registers, forms, and formats used to capture clinical data
- Electronic records in HIS/EMR (Mednet 2.0), PACS, LIS

It applies to all formats: paper-based, electronic, hybrid, and digitised records.

3. Definitions

- Retention Period: Minimum period for which a record must be preserved before it may be considered for destruction.
- UHID: Unique Health Identification Number assigned to each patient.
- Active Records: Records of patients currently under care or within the standard access period.
- Archival: Transfer of records from active storage to secure long-term storage after the active period.
- Legal Hold: Instruction to preserve specific records beyond the standard retention period due to litigation or regulatory inquiry.
- NMC: National Medical Commission of India — sets minimum retention standards for medical records.

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

4. Policy Statement

The hospital shall define and implement a retention period for each category of medical records, data, and formats used to capture clinical data. Retention periods shall be in consonance with rules laid down by the National Medical Commission and the respective state authority. The retention process shall provide expected confidentiality and security for both manual and electronic records.

5. Retention Schedule

The following minimum retention periods shall apply. Where state regulations or the NMC specify longer periods, the more conservative (longer) period shall apply. Retention periods are measured from the date of last active encounter or discharge unless stated otherwise.

OPD Medical Records	5 years from last visit	Paediatric: till majority + 3 yrs	Extend as directed
IPD Medical Records	7 years from discharge	Paediatric: till majority + 3 yrs	Extend as directed
Medico-Legal Case (MLC)	Permanent — never destroyed	Lock & key; restricted access	Permanent hold
Psychiatric Records	7 years min; per MHA 2017	Special access controls apply	Extend per MHA 2017
MTP Records	5 years per MTP Act 1971	Restricted; under OBG custody	As per statute
IVF / ART Records	10 years from last treatment	Per ICMR Guidelines 2021	Extend as directed
Laboratory / Pathology	5 years	Critical results: 7 years min	Extend as directed
Radiology / PACS (digital)	7 years	Mammography: 10 years	Extend as directed
Consent Forms	Coterminous with parent record	Retained as part of IPD file	With parent record
ICU / HDU Records	7 years from discharge	Ventilator & drug charts included	Extend as directed
Death Records / PMRs	10 years minimum	MLC deaths: Permanent	Permanent if MLC
Electronic HIS / EMR Data	Per applicable category above	Applies to all digitised records	Extend as directed

Note: Paediatric is defined as any patient under 18 years of age at the time of care. Majority is defined as 18 years of age.

6. Retention of Formats and Registers

Retention periods apply to clinical registers and formats used for capturing clinical data (e.g., admission registers, discharge registers, OT registers, drug administration records). Minimum retention is 5 years from the date of the last entry, or coterminous with the associated patient records, whichever is longer.

7. Confidentiality and Security During Retention (IMS.6.C)

The retention process shall ensure expected confidentiality and security for both manual and electronic records throughout the retention period.

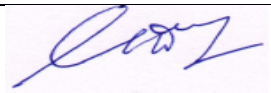
7.1 Physical Records

- Stored in the designated, secured MRD storage area accessible only to authorised staff.
- Protected against dust, moisture, pests, rodents, and fire through regular maintenance, pest control, fire-safe cabinets, and fire-fighting equipment.
- Special records (MLC, Psychiatric, MTP) stored under lock and key with strictly controlled, logged access.
- A tracer card system shall track movement of physical files in and out of the MRD.

7.2 Electronic Records

- Stored on the primary server with redundant backup on a secondary server and external backup media.
- Access governed by Role-Based Access Control (RBAC) with unique login credentials for each user.
- Automatic log-off features enabled on all HIS terminals.
- Audit trails maintained for all access and modifications.
- Protection against viruses and cyber-attacks through updated antivirus software and security patches.
- Daily incremental and weekly full backups; backup media stored in a separate secure location.
- Disaster recovery plan tested at minimum annually.

7.3 Special Access Controls

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

- Psychiatric records: Access limited to treating psychiatrist and authorised clinical staff; disclosure governed by the Mental Healthcare Act, 2017.
- MTP records: Maintained under custody of the treating Obstetrician; statutory confidentiality per MTP Act, 1971.
- MLC records: Under lock and key; access logged; disclosure only on statutory authority orders.

8. Storage Tiers

- Active Storage: Records of patients with visits within the last 2 years maintained in the active MRD area for immediate retrieval.
- Near-Archive Storage: Records from 2 to 5 years maintained in a near-archive section of the MRD.
- Deep Archive: Records beyond 5 years transferred to deep archive storage (secure physical store or off-site digital archive).
- Electronic records are stored in tiered storage within the HIS with automated archiving processes.

9. Legal Hold

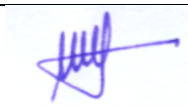
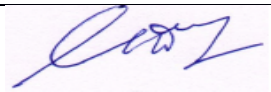
Records involved in litigation, court orders, RTI applications, police or NHRC inquiries, insurance disputes, or regulatory audits shall NOT be destroyed regardless of whether the standard retention period has elapsed. Legal holds shall be:

- Recorded in the Legal Hold Register maintained by the Medical Superintendent's office.
- Flagged in the HIS/MRD system to prevent inadvertent destruction.
- Released only upon written confirmation from the Medical Superintendent and/or legal counsel that the matter is resolved.

10. Record Retrieval During Retention Period

- Active records (within 2 years): within 30 minutes for clinical care; within 72 hours for certified copy requests.
- Near-archive records (2–5 years): within 24 hours for clinical care; within 72 hours for other requests.
- Deep archive records (beyond 5 years): within 48 hours.

All retrievals shall be documented in the MRD Retrieval Register capturing: requestor identity, purpose, date, records provided, and return date for physical records.

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar		Dr.S.S.Deepak	
Quality Head		Chairman & Managing Director	

11. Roles and Responsibilities

- MRD In-charge: Custodian of physical records; ensures compliance with retention schedules; maintains Retention Register.
- IT Department: Maintains electronic storage; ensures backup, disaster recovery, security, and tiered archiving.
- Quality Manager: Audits retention compliance; reviews policy; reports to management.
- Medical Superintendent: Authorises retention schedule; approves legal holds and extensions.
- All Clinical Staff: Ensure records are complete before submission to MRD.
- Legal Advisor: Advises on legal holds and statutory retention requirements.

12. Legal and Regulatory Compliance

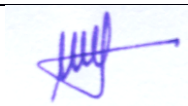
- NABH 6th Edition IMS Standards — IMS.6.B (CORE) and IMS.6.C (Commitment)
- National Medical Commission (NMC) guidelines on medical record retention
- Digital Personal Data Protection Act, 2023
- Information Technology Act, 2000 (Sections 43A, 72A)
- EHR Standards for India, 2016
- Mental Healthcare Act, 2017
- MTP Act, 1971 as amended
- Applicable state health regulations and medico-legal requirements

13. Audit and Monitoring

The Quality team shall conduct at least one internal audit per year to verify: adherence to retention periods, physical and electronic storage conditions, RBAC and access log review, backup and recovery testing, and legal hold register accuracy. Findings shall be presented to the Quality Committee with corrective action plans.

AMENDMENT HISTORY

Sl No	Current Revision			Nature of Change
	Edition No	Revision No.	Date	
1	01	00	1 Oct 2019	First issue as per NABH Hospital Accreditation Standards – 4th Edition
2	01	00	1 Nov 2020	Minor Revisions, updating Doc No. and updating for compliance as per NABH Hospital Standards 5th Edition
3	01	01	1 Jan 2022	No changes.
4	01	02	1 Jan 2025	Amended as per the 6th Edition.

Recommended By	Signature	Approved By	Signature
Dr.Hrishikesh kalgaonkar Quality Head		Dr.S.S.Deepak Chairman & Managing Director