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A Study on Medical Record Sections of Dr. Bhim Rao Ambedkar Institute of Rotary Cancer Hospital (BRAIRCH) OF All India Institute of Medical Sciences, New Delhi,as Regional Cancer Centre

Dr. Suja Raj * , Dr. Imran Mohd **, Dr. Mohin Sakre***, Dr. Shreetesh Mishra ****

(Senior Medical Officer SMC , AFS Tambaram, Indian Air Force)

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ABSTRACT: Introduction: Medical / health records form an essential part of the patient's present and future health care. As a written collection of information about a patient's health and treatment, they are used essentially for the present and continuing care of the patient. Today, efficient health information systems are not only important to hospitals, but also for the government as they provide information about the health of the people on a country. The collected information is used by governments in the planning of health facilities and programs, for the management and financing of health facilities as well as medical research. Medical record beeping has evolved into a science. Medical records are an essential tool in modern medical practice. The medical record is critical for documentation and communication between healthcare professionals. A good medical record serves the interest of the medical practitioner as well as his patients. It is very important for the treating doctor to properly document the management of the patient under his care.

Aims & Objective: This study was carried out at medical record sections of Dr. Bhim Rao Ambedkar Institute of Rotary Cancer Hospital (BRAIRCH) OF All India Institute of Medical Sciences, New Delhi, which is a Regional Cancer Centre. the study has been planned to identify various documents preserved in the medial record file and to determine the necessary documents which needs to be preserved, hence efforts can be made by the institution, all clinicians and medical record officer to improve the standard of maintenance and preservation of medical records. To carry out audit of Dr. BRAIRCH patient files in terms of appropriateness of document filing and to identify the documents which needs to be retained in the IRCH patient file.

MATERIALS AND METHODS: The study design for objective 1 was descriptive, retrospective and record based study. The objective 2 was through questionnaire and unstructured interview.

RESULT: The medical record section of BRAIRCH is located in ground Floor and medical records of patients registered at this centre are stored in basement of the building. There are 26 personnel deployed in the medical record section with Junior Medical record officer-1, Medical Record Technician-6, Lower Division Clerk-1, Hospital attendants-5, Orderies from Sulabh agency-6, Data Entry operators-5 and Part time social guides-2.

The medical record files are maintained since 1984 and at present the section is holding around 1,77,596. These files are maintained for a period of minimum of ten years. The files which are more than ten years old are screened yearly and if no follow up details are found in a file for more than 5 years the files are segregated and kept as inactive file.

CONCLUSION: The average number of enclosures of medical oncology per file was 181, followed by radiation oncology-85 and surgical oncology which was 67. The documents were classified as inpatient, outpatient and miscellaneous documents in each department.

I. INTRODUCTION:

Medical / health records form an essential part of the patient's present and future health care. As a written collection of information about a patient's health and treatment, they are used essentially for the present and continuing care of the patient. Today, efficient health information systems are not only important to hospitals, but also for the government as they provide information about the health of the people on a country. The collected information is used by governments in the planning of health facilities and programs, for the management and financing of

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health facilities as well as medical research. The BRAIRCH is 182 bedded Regional Cancer Cnetre with four departments namely Medical Oncology, Surgical Oncology, Radiotherapy and Anaesthesia. Also the centre has three units supporting units for main departments for treatments planning of cancer, which are Lab Oncology, Radio diagnosis and Medical Physics. The distribution of the beds are medical oncology being 78, Surgical Oncology 61, Radiation Oncology 37, Pain and Palliative Care Unit-06. The outpatient of this centre of the last year 2014-15 was 1,38,125 which include new patients (11,000) and revisits (1,27,125). There are 32 special clinics conducted by four departments which are spread over a week. The center gets patients from main hospital land referred cases from other hospitals. Only the confirmed cases of cancer are registered and the medical record file is prepared. A file number is created on the medical record of the patient and for further visits the patient identification details are known through this file number.These documents in the file are maintained longitudinally from the time of registration at this centre till the latest treatment details. Thus, this medical record file contains the details of outpatient visits, inpatient hospitalization details of al the patients throughout the course of treatment. Adopting this system of medical record maintenance ensures that the case file has comprehensive history and treatment medical record of a patient for all the hospital visits i.e. OPD and IPD

II. OBJECTIVES:

1. To categories the documents into outpatient documents, inpatient documents and other documents of Dr. BRAIRCH medical record files from four departments namely, Medical oncology, Surgical oncology, Radiation oncology and Onco anaesthesia & palliative care.
2. To identify and recommend the documents which need to be retained in the Dr. BRAIRCH case file.

III. MATERIALS AND METHODS

METHODOLOGY

STUDY AREA: BRAIRCH Medical Record Section

Study design: The study design for objective 1 was descriptive, retrospective and record based study. The objective 2 was through questionnaire and unstructured interview.

Study period: May-Jun 2015.

Objective 1- Medical record files of BRAIRCH from 2011-2014
Objective 2- Faculty and senior residents at DR. BRAIRCH

STUDY SIZE :Simple random sampling. Medical record files from 2011 to 2014 with 3-4 files from each department during last four years were audited. A total of 45 files were audited.

STATISTICAL ANALYSIS: The data collection was tabulated,coded,and anallyzed using Microsoft word SPSS for windows version 8.1

IV. DISCUSSION:

The study was conducted at a regional cancer to streamline the medical record documentation at medical record section. the study was conducted through audit of files, distributing questionnaires followed by interview from the concerned stakeholders.

As per the questionnaire and interview, it was brought out that only selected investigation report need to be retained in the file. Rest all can be entered in the follow up notes. Also the follow up chart is not available which is not being utilized effectively. If all the investigations, reports are meticulously entered in the follow up chart then the filing of all the investigation reports can be done away with, reducing the bulk of file. Also there were several other categories of documents were recommended not for retention

Hence, the following documents are recommended not for retention as per audit and the response from the concerned specialists.

V. CONCLUSION:

This study was conducted at a regional cancer centre with the aim of streamlining the filing process of medical record files. Overall quality of medical documentation was of a reasonal standards. To improve the quality of file keeping of these records it is necessary to make utilize the tools already available in the system, which in turn, will rduce the bulk of file and space requirement at medical record section. with the digitization also being in process this will reduce the number of documents being scanned and will reduce the overall cost.

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MEDICAL ONCOLOGY	SURGICAL LONCOLOGY	RADIATION ONCOLOGY
Complete blood count, Renal function tests,, Liver function tests, Urine & Blood couture and sensitivity (to be included in protocol)	Complete blood count, Renal function tests, Liver function tests, Urine & Blood culture and sensitivity	Complete blood count, Renal function tests, Liver function tests, Urine & Blood culture and sensitivity
General history & Physical examination (MR-3)	General history & Physical examination (MR-3)	General history & Physical examination (MR-3)
Requisition form	Post op epidural catheter data	Doctor's orders (MR-3)
Application for treatment certificate	Used Troponin T kit	Nurses' daily record
Claim closure letter	Forwarding letter	Documents from outside hospital
Refund recovery performa	High dose methotrexate administration orders	HSCT progress chart
Drug product information	Post epidural cartheter data	Other OPD cards
Payment receipt	Used Troponin T kit	Dr. BRAIRCH OPD card
Appointment slip	PIC	Refund recovery performa
	Appointment for daycare	Requisition letter
		Journal article
		Referral letter

MEDICAL ONCOLOGY DOCUMENTS

OUTPATIENTS		
	Recommended for retention	**Retention not required**
1	Investigation (from AIIMS and outside hospital) – Pathological investigation Tumour Marker	Complete blood count, Renal function tests, Liver function tests, Urine & Blood culture and sensitivity (To be included in protocol)
2	Radiological investigation	
3	Outpatient follow-up notes	
4	4Daycare documents – To enter in protocol if not then retain it	
INPATIENT		
5	Investigation from AIIMS and outside hospital- Pathological investigation, Tumour Marker.	Complete blood count, Renal function test, Liver function tests, Urine & Blood culture and sensitivity (To be included in protocol
6	Discharge Summary (MR-2)	General history & physical examination (MR-3)
7	Flow sheet	
Miscellaneous		
8	Treatment regimen / protocol	RAN Sanction letter
9	Journal article – only first page to be retained	Estimate certificate
10	Consent for RCT	Requisition form
11	Haemopoetic cell co morbidity index	Treatment certificate
12	Performa for multiple myeloma	Application for treatment certificate

13		Claim closure letter
14		Refund recovery performa
15		Affidavit for address proof
16		Bank statement for address proof
17		Drug product information
18		Payment receipt
19		Appointment slip

SURGICAL LONCOLOGY DOCUMENTS

OUTPATIENTS		
	Recommended for retention	**Retention not required**
1	Investigation (from AIIMS and outside hospital) – Pathological investigation Tumour Marker, biopsy report	Complete blood count, Renal function tests, Liver function tests, Urine & Blood culture and sensitivity
2	Radiological investigation	
3	Outpatient follow-up notes	
INPATIENT		
4	Investigation from AIIMS and outside hospital- Pathological investigation, Tumour Marker, biopsy report	Complete blood count, Renal function test, Liver function tests, Urine & Blood culture and sensitivity

5	Discharge Summary (MR-2)	General history & physical examination (MR-3)
Miscellaneous		
6	Treatment regimen / protocol	Post op epidural catheter data
7	GI cancer clinic Proforma	Used Troponin T kit
8	Enquiry letter from welfare fund	Forwarding letter
9		High dose methotrexate administration orders
10		PIC
11		Appointment for day care

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RADIATION ONCOLOGY DOCUMENTS

OUTPATIENTS		
	Recommended for retention	**Retention not required**
1	Investigation (from AIIMS and outside hospital) – Pathological investigation Tumour Marker	Complete blood count, Renal function tests, Liver function tests, Urine & Blood culture and sensitivity
2	Radiological investigation	Other OPD CARDS
3	Outpatient follow-up notes	Dr. BRAIRCH OPD card
4	Flow chart	Doctor's orders (MR-5)
5	OPD file cover	REFERRAL LETTER
INPATIENT		
6	Investigation from AIIMS and outside hospital- Pathological investigation, Tumour Marker, biopsy report	Complete blood count, Renal function test, Liver function tests, Urine & Blood culture and sensitivity
7	Radiological investigation	Documents from outside hospital
8	Discharge summary (MR-2)	General history & Physical examination (MR-3)
9	Flow sheet	HSCT progress chart
10	Consultation records (MR-9)	Nurses' daily record

Miscellaneous		
11	Consent form	Identity proof document
12	Request for change of address	Refund recovery performa
13	Treatment certificate	Requisition letter
14	Chemotherapy regimen	Journal article
15	EORTC QLQ	
16	Estimate certificate	

Source of Support:Nil, Conflict of Intrest: None Declared

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