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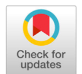
Short Communication

Principles and legal aspects of patients medical records management

Eben Jeya Roy[1,2,3,4]*

[1]*Dept. of Medical Records, Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry, India*
[2]*American Health Information Management Association, USA*
[3]*IFHRIM, USA*
[4]*International Association for Human Resource Information Management, UK*



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1. Medical Record Documentation

1. Medical Records are legal records that must be maintained in a very careful and legal manner. They must also be used in a legal way. They:
2. Tell us and all the other members of the health care team about the patient, his/her care and treatment;
3. Tell us fact about the patient or resident;
4. Help people, like the doctor and nurse, to make good decisions about the patient and his/her care; and
5. Help us to find out how well the care that is being given is helping the patient.

Documentation in these records must be:

1. Complete
2. Correct
3. Timely
4. Legal; and Professional
5. Hospitals use many kind of forms and ways to document the care the patient is given. Daily care and hygiene is some places is written on a flow sheet form. In other places this care is written in a progress noted or entered into a computer. Most hospitals are now using computers and eliminating paper documentation format.

* *Corresponding author*.
E-mail address: ebenjeyaroy@yahoo.co.in (E. J. Roy).

2. Complete Documentation

Documentation must be complete. You must record everything that you DO and everything that you OBSERVE. All care and all treatments must be recorded. You must record everything that is observed; things that you see, feel and hear, especially of they are not normal/or not normal for the patient that your are taking care of, "If you didn't document it, you didn't do it". These findings should be reported immediately and recorded in the persons medical records.

3. Timely Documentation

1. Documentation must be competed timely. This is because the documentation is used to communicate about the patient. It must ready to see and be used to make decisions. DO NOT wait until the end of a shift to complete documentation. It is a vital part of patient care and needs to be completed timely. If documentation is not completed appropriately and timely, it is difficult to determine if symptoms have improved or worsened over time. Any sudden change in behavior would not have been noted, documented and therefore NOT communicated to the Doctor. This may prevent necessary medications or other treatment being adminsiteered to the patient in a

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timely manner. Timely reporting and documentation can prevent serious injuries and further complications.
2. Always record and orally report any finding that DO NOT seem normal
3. Immediately report and document any sudden changes in behavior
4. Always records your findings in a complete and precise manner
5. Never wait until the end of a shift to report finding and observations or to complete documentation

4. Legal Documentation

Medical records are legal documents. They must be used and stored according to all governing laws and also to the policies of the hospital. In order to treat records as legal documents: [1]

1. Use blue or black ink unless you are using a computer or your hospital uses a special ink color for different shift;
2. Do NOT use pencil or ink that can be erased;
3. Write so that if can be read clearly, sloppy writing causes errors;
4. Date all of your notes;

4.1. *Write the time that you look your notes*

1. Sign your full name and title;
2. Do not scribble out things if you make a mistake;
3. Write only the facts; be professional and never add personal comments or feelings;
4. Do not chart before the facts. Follow the flow sheet according to the next incremental step;
5. Do not use abbreviation unless they are accepted for use by your hospital;
6. Do not allow anyone to touch or look at your medical records unless they are a healthcare worker assigned to take care to the patient;
7. Keep all medical records in a safe and secure place;
8. Medical Records are Confidential. Do not disclose any facts of the patient or their care with anyone other than the assigned healthcare staff or the patient themselves. [2]

5. Summary

Medical records, whether computer or paper based, hold very important information about the patient's health and medical condition. This information is not only vital to their medical treatment but is also highly confidential and private. This information Can Not legally be shared with anyone other than the assigned medical staff and the actual patient. All records must be completed accurately, completely, timely, legally and in a professional manner.

6. Source of Funding

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7. Conflict of Interest

None.

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Author biography

Eben Jeya Roy, Global Medical Records Consultant

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