RFHHA MANAGEMENT TIP OF THE DAY FOR HOSPITAL ADMINISTRATORS 1243

What all Medical Documentations required to be complete for inpatient in hospital

- **Patient's complete medical records** should be available at all the times during their stay in Hospital.
- **Every page** in the medical record should have patient name, identification number and name of the ward.
- Documentation within the medical record should follow the **logical sequence of date, time**.
- Drug prescription chart, **diagnostic results, nursing care plan** should be kept as separate sections for prompt easy access.
- Data recorded or communicated on admission, handover and discharge should **be recorded using standard format**.
- Every entry in the medical record should be dated, timed (**preferably in 24-Hour format**), legible and signed by the person making the entry.
- **Deletion and alterations should be countersigned**.
- Entries to medical records should be made as soon as possible after seeing or intervention (eg. Change in clinical state, ward round, diagnostic) and before the relevant staff members goes off duty.
- **Every entry made in medical record identifies the person who is responsible for decision making**.
- An entry should made in the medical records.

Responsibility : Doctor on Duty / Ward Nurse

Dr Madhav M Singh

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