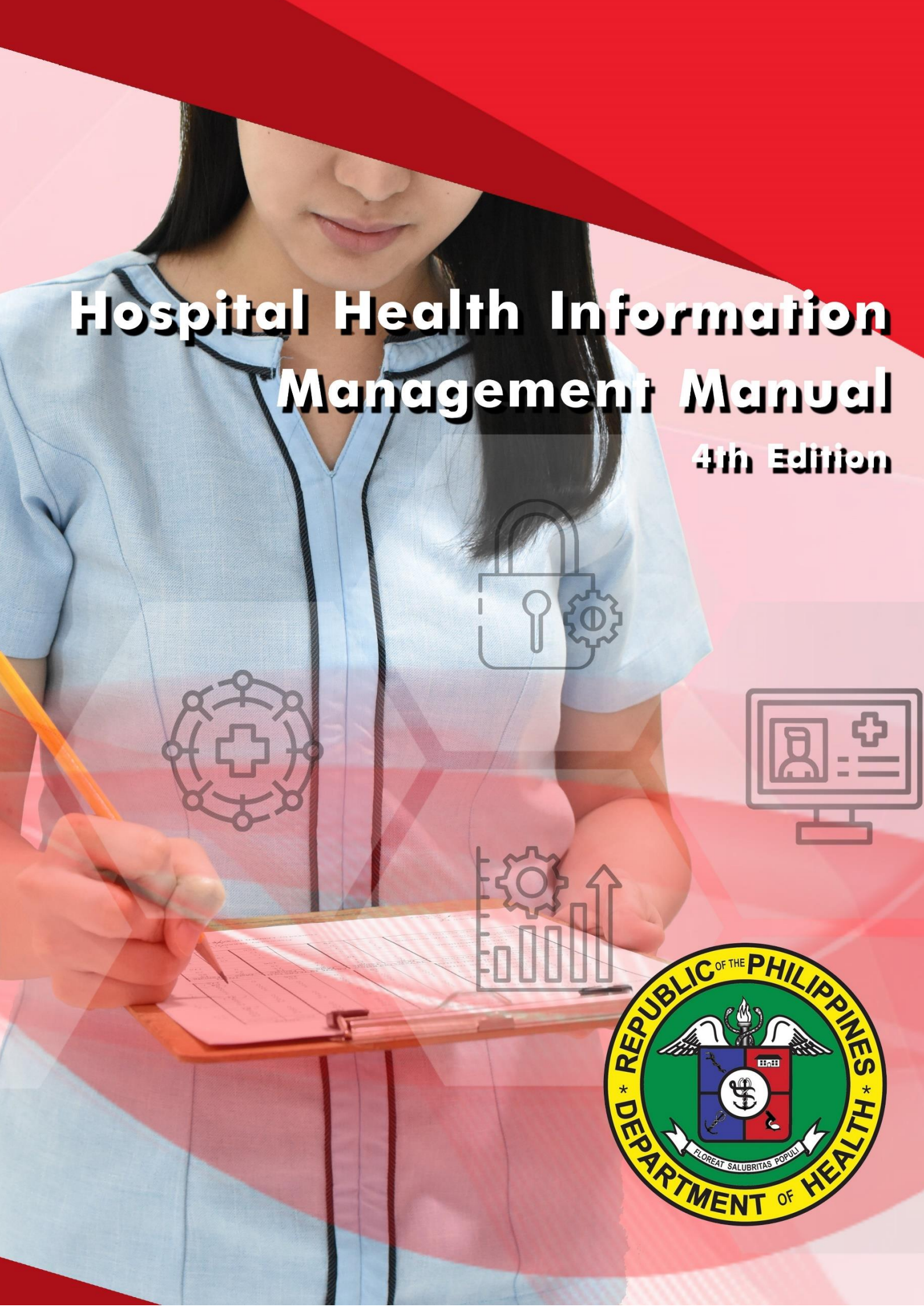
Hospital Health Information Management Manual

4th Edition



HOSPITAL HEALTH INFORMATION MANAGEMENT MANUAL

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Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

AUTHORIZATION

In accordance with the authority vested on the Secretary of Health, it is hereby declared that the standards and policies in this manual shall govern the organization, management, operations and activities of the Health Information Management Department in the Department of Health (DOH) Hospitals. The Manual can be used as reference of local government and other hospitals.

This shall take effect upon signing until revised and updated by the DOH.

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

MESSAGE

The Department of Health (DOH) steers the health sector towards developing a productive, resilient, equitable, and people-centered health sector to realize its vision of making Filipinos among Southeast Asia's healthiest people in 2022. This is outlined in the strategy map of the DOH's FOURmula One Plus for Health (F1 Plus).

The Universal Health Care (UHC) Act aims for better health outcomes, more responsive health systems, and more equitable health care financing. Hence, the DOH is working to ensure high-quality and affordable health services for every Filipino, including the effective and efficient information management of the health facilities. Thus, this manual endeavors to provide an organized system of documenting quality health services provided and to ensure that sufficient patient care data has been collected, maintained, and secured to warrant continuous quality improvement across all levels of care. Through these upgraded standards, the DOH calls for everyone to cooperate towards an interdisciplinary and coordinated delivery of high-quality and standardized management of health information.

I commend the Health Facility Development Bureau (HFDB) for its initiative and commitment in harmonizing and streamlining the standards and processes in health facility operations through the updating of the *Manual of Standards for Hospital Health Information Management*. The Health Information Management Department (HIMD) is a fundamental facet of hospital operations, with its role in the processing, maintaining, and safekeeping of all health records created in the health facility in the course of care.

We are confident that this manual shall be instrumental in fulfilling the Department of Health's aspiration of genuine Universal Health Care that is focused on people's needs and well-being while recognizing Filipinos diverse cultures, beliefs, and values.

Mabuhay!

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MESSAGE

The Universal Health Care (UHC) Act, also known as Republic Act (RA) No. 11223, mandates that the country's entire health sector shall ensure that all Filipinos have better access to appropriate health care services without experiencing financial hardship. This aspiration shall be achieved through a more responsive health system that makes them feel respected, valued, and empowered. This entails improving the quality of health care services in health facilities, where patients experience them first hand. Health facilities must then be venues of clinical quality, operational efficiency and people-centeredness.

This fourth edition of the *Manual of Standards for Hospital Health Information Management* aims to ensure that the collection and management of health information provided by patients in our health facilities adheres to current ethical and professional practice. The manual defines the Philippine Health Record Standards by combining the updated regulatory/mandatory policies such as RA 10173, the Data Privacy Act of 2012; RA 11223, the UHC Act; and RA 9470, the National Archives Act of the Philippines Act. The set standards also abide to the International Organization for Standardization (ISO 9001:2015), the PhilHealth Benchbook, the Licensing Standards as defined in Administrative Order No. 2012-0012 and the International Health Record Standard, as defined by the Joint Commission International Accreditation Standards.

The Manual emphasizes the important role of the Health Information Management Department in providing quality health care to patients in facilities. The latest edition has eight chapters divided into 3 main parts: the first addresses the administration of the Health Information Management Department; the second details the Philippine Health Record standards, the specific policies as well as the health record systems and procedures; and the third discusses the continuous quality improvement program in strengthening the implementation of the existing Standard Operating Procedures (SOPs). These shall serve as reference of standards, policies and guidelines to achieve a uniform practice for efficient and effective health information management.

Also, the manual determines the responsibilities of the HIMD personnel and provides guidance in their performance of duties in support to each unit or service in the hospital. The manual shall serve as DOH hospitals' reference in the standard operating procedures of the HIMD, of which the DOH encourages other public and private health facilities to adopt in their practice. Thus, we enjoin our stakeholders in promoting continuous learning, peer support and mentorship alongside the implementation of this Manual of Standards so we could boost Universal Health Care for all.

LILIBETH C. DAVID, MD, MPH, MPM, CESO I
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FOREWORD

The Health Facility Development Bureau (HFDB) of the Department of Health (DOH) is at the forefront in leading the continuous development of quality health facilities that are efficient and responsive to the needs of Filipinos. Towards this end, the Bureau has been tasked to develop policies, programs and standards, as well as provide technical assistance and advisory in the development, planning, operations and maintenance of health facilities.

Following the recognition for a distinct Health Information Management Department (HIMD) in the hospital organization, the *Manual of Standards for Hospital Health Information Management* is the Bureau's response to standardize policies and procedures vital to the quality of health record management. The standards developed and prescribed in this manual shall serve as reference for HIMD Officers and staff to effectively and efficiently perform their respective duties and responsibilities; as well as consideration in meeting the rising expectations of their facility's clientele and the public. Finally, the manual dutifully integrates the DOH policy framework and objectives in the implementation of Republic Act No. 11223, the Universal Health Care Act.

The HFDB is extremely grateful for the generosity of the Technical Working Group members and experts, invited resource persons, and other stakeholders, who dedicated their time, expertise and effort. This latest edition of the manual shall address the hospitals' needs for continuous quality improvement, especially among the Hospital's HIM Officials and staff.

The health facility is the people's primary interface with the health system. It is where the actualization of the Universal Health Care becomes tangible for the Filipinos. The HFDB's initiatives coupled with stakeholders cooperation shall guarantee the achievement of the DOH's goals of financial risk protection, a more responsive health service delivery, and better health outcomes for all.

MA. THERESA G. VERA, MD, MSc, MHA, CESO III
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PREFACE

The 4th Edition of the Hospital Health Information Management Manual addresses the changes brought about by new mandates and issuances related to the practice of and updates on the Health Information Management in the Philippines. At the forefront of these policies are the licensing standards as defined in Administrative Order No. 2012-0012 or the Rules and Regulations Governing the New Classification of Hospitals and Other Health Facilities in the Philippines, the Republic Act (RA) 10173, also known as the Data Privacy Act of 2012 and its Implementing Rules and Regulation (IRR), and the International Organization for Standardization (ISO 9001:2015), and the RA 11223, also known as the Universal Health Care Act.

In line with the Department of Health's (DOH) goal on access to quality health care services, the HFDB has created a Technical Working Group (TWG) through Department Personnel Order No. 2019-5098. The said TWG is composed of the Supervising Administrative Officers and technical experts from mostly DOH, and select local government and private hospitals. The TWG reviewed existing mandates and issuances to align the standards and policies and come up with a uniform procedure for efficient and effective health information management. New standards and guidelines were developed relative to the current practice and statistical needs. In addition, coordination with stakeholders for their suggestions and inputs in the new edition of the manual was prompted.

Published in 2010, the nine (9) Chapters of the 3rd Edition of the Hospital Health Information Management Manual, has been streamlined into eight (8) Chapters in this latest edition. Several Chapters from the previous edition were merged as needed and a new Chapter was added which is the Introduction to Electronic Health Record. The new chapter introduces the electronic health record as an obligation of every health facility to address the rapid changes in the delivery of healthcare and the public demand for more extended and improved health services. Uniformity of terms related to issuances were also reflected in the manual, such as the Medical Records Committee now termed as Patient Health Records Committee following the established name of the Department. Furthermore, this edition included Medical Research Standards and Procedures to address the gaps and define the role of the Health Information Management Department in Medical Research.

The standards, policies and guidelines in this manual are envisioned to serve as reference for the effective implementation of HIMD services and reinforce patient safety in the government and private hospitals in the Philippines.

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ACKNOWLEDGEMENT

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We extend our sincere appreciation to the chiefs of the health care facilities for providing inputs during the consensus building of the Manual, and who generously allowed their HIMD Officers, Statisticians and Administrative Officers to join the Technical Working Group (TWG).

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Definition of Terms

Autopsy Rate
The proportion of deaths that are followed by the performance of an autopsy.

Bed Occupancy Rate
The ratio of actual Inpatient Service Days to the maximum inpatient days determined by bed capacity during any given period of time.

Bed Turnover Interval
The average period in days that an available bed remains empty between the discharge of one inpatient and the admission of the next.

Bed Turnover Rate
The number of times a bed, on average, changes occupants during a given period of time.

Caesarean Section Rate
The ratio of the number of Caesarian sections performed to the total number of deliveries including Caesarian sections for a certain period.

Census
The number of patients present in the hospital at any given period with a standard cut-off time at 12:00 midnight

Clinical coding
The translation of diseases, health related problems and procedural concepts from text to alphabetic/numeric codes for storage, retrieval and analysis.

Complication
Any disease or disorder that occurs during the course of (or because of) another disease.

Confidentiality
A legal and ethical concept that establishes the healthcare provider's responsibility for protecting health records and other personal and private information from unauthorized use or disclosure.

Consent
The process by which patients are made to participate in the decisions involved in their health care. It includes a patient-doctor discussion on the nature of the decision for procedure, reasonable alternatives to proposed intervention, the relevant risks, benefits and uncertainties.

Consent Forms
Copies of consents for admission, treatment, surgery, and release of information.

Consultation Rate
The ratio of consultation following an attending physician's request to a consultant to examine a patient and give a second opinion.

Culling
The identification and removal of inactive records or those which have already reached their mandated and/or prescribed retention period from the filing/storage area for disposal.

Death Rate
The proportion of inpatient hospitalizations which ends in death; also serves as a basis in evaluating the quality of medical care.

Diagnosis
A word or phrase used by a physician to identify a disease from which an individual patient suffers or a condition for which the patient needs, seeks, or receives medical care.

Diagnostic Procedure
Any procedure employing analysis and examination to identify a disease or condition.

Discharge Summary
A concise summary of a hospital stay, including the reason for admission, significant findings from tests, procedures performed, therapies provided, response to treatment, condition at discharge, and instructions for medications, activity, diet, and follow-up care.

ED Death
Refers to deaths of patients occurring in the ER, including patients who were revived by initial resuscitative measures at the ER but eventually died there, regardless of the time of stay in ER

Clinical Cover Sheet
Also known as "Admission and Discharge Record" or "Face Sheet"; contains personal data like name, address and other social data.

Fetal Death Rate
The ratio of intermediate and late fetal deaths to total number of births including intermediate and late fetal deaths.

Health Facility
Refers to an institution that has health care as its core service, function or business. Health care pertains to the maintenance or improvement of the health of individuals or populations through the prevention, diagnosis, treatment, rehabilitation and chronic management of disease, illness, injury and other physical and mental ailments or impairments of human beings.

Health Information Management (HIM)
The study of the principles and practices of acquiring, analyzing, and protecting digital and traditional medical information vital to providing quality patient care. HIM is the link to clinicians, technology designers, and information technology; and is the value-adding bridge between patients' health information and government and regulating agencies.

Health Record
Formerly known as Medical Record, is a chronological written account of a patient's examination and treatment that includes the patient's medical history and complaints, the physician's physical findings, the results of diagnostic tests and procedures, and medications and therapeutic procedures.

Health Record Number
A permanent identification number assigned in straight numerical sequence by the admission staff and is recorded on all health record forms relating to that particular patient.

History and Physical Examination
A document that describes any major illnesses and surgeries you have had, any significant family history of disease, your health habits, and current medications.

Hospital
An institution, building or place, government or private, duly licensed by the Department of Health and accredited by PhilHealth, where there are installed beds, cribs or bassinets for 24-hour use or longer by patients in the treatment of diseases, injuries, deformities, abnormal physical and mental states, and/or maternity cases.

Imaging Reports
Describes the findings of x-rays, mammograms, ultrasounds, and scans. The actual films are maintained in the radiology or imaging departments or on a computer.

Immunization Record
A form documenting immunization given for diseases such as polio, measles, mumps, rubella, hepatitis, and the flu. Parents should maintain a copy of their children's immunization records with other important papers.

Indicator
A measurable variable or characteristic that can be used to determine the degree of adherence to a standard or achievement of quality goals.

Infant Death Rate
The ratio of the total number of infant deaths including neonatal and post neonatal deaths rate of a live born infant at any time from the moment of birth to the end of the first year of life (364 days, 23 hours, 59 minutes from the moment of birth)

Information
Meaningful, interpreted and processed data used to make judgment on a hypothesis or answer a research question.

Informed Consent
Generally understood as the implied or explicit (read: written permission) given by the patient prior to initiation of care following provision of sufficient information to make an informed judgment on medical treatment choices. It, however, refers more to the process by which patients are made to participate in the decisions involved in their health care. Informed consent is founded on patients' legal and ethical right to direct what happens to their bodies and from the doctor's ethical duty to involve patients in the treatment process. It includes a patient-doctor discussion of the following issues: the nature of the decision or procedure; reasonable alternatives to the proposed intervention; the relevant risks, benefits, and uncertainties serv

Inpatient
A patient admitted in the hospital receiving healthcare services and who is provided with room, board and continuous nursing services in a unit or area of the health facility.

Inpatient Service Days
A unit of measure denoting the services received by an inpatient in a 24-hour period or any fraction of the day thereof.

Laboratory Results
Describe the results of tests conducted on body fluids. Common examples include a throat culture, urinalysis, cholesterol level, and complete blood count (CBC). The health record does not usually include your blood type. Blood typing is not part of routine lab work.

Legitimate Purposes
Valid reasons for the request such as for management Decision, Statistical Purposes and reporting to DOH, Mortality/Morbidity Conferences of Clinical Departments, Submission to Regulatory bodies as per Republic Act, Administrative Orders and Memorandum Circulars, for submission to Adjudicatory bodies (PNP, NBI and other law enforcement agencies) provided a written request from the Chief/Director of their respective agency is presented etc.

Length of Stay
The number of days a patient remains in the hospital.

Loose Sheets
Vast quantities of unattached laboratory, ECG, and other tests results

Maternal Death Rate
The ratio of deaths resulting from obstetric complications of the pregnancy state (pregnancy, labor, and puerperium) from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

Medication Record
A list of medicines prescribed or given to a patient.

Morbidity
Refers to the state of having a disease (including illness, injury or deviations from normal health), the number of sick persons or cases of disease in relation to a specific population.

Mortality
Refers to the death rate in relation to a specific population; or a fatal outcome or in one word, death. The word ***"mortality"*** is derived from the word *"mortal"* which came from the Latin *"mors"* meaning death.

Nurses' Notes
Contains observations of the patient, the treatment given, the response to treatment, and any unusual occurrences, medication, instructions and the advice for follow-up consultations.

Operative Report
A document that describes surgery performed and gives the names of surgeons and assistants.

Outcome
The effect of care on the health status of patients and populations seen in less impairment of functions, less pain and suffering,

Out-patient
A patient who consults and receives health care services in the health facility without being admitted and does not occupy a bed for any length of time

Pareto Chart
Data analysis tool which combines analysis of the frequency of a problem and analysis of its causes by identifying the most influential cause or causes, also called the "vital few," thereby separating them from the "trivial many."

Pathology Report
Describes tissue removed during an operation and the diagnosis based on examination of that tissue.

Patient Rights
The moral and legal entitlement of a patient to care.

Perinatal Death
Refers to fetal deaths and live births with only brief survival, usually days or weeks, or the death of an infant between birth and at the end of the neonatal period.

Physician's Orders
Physician's directions to other members of the healthcare team regarding medications, tests, diets, and treatments.

Plan-Do-Study-Act Cycle
A structured, cyclical process for developing and implementing change and improvement.

Power of Attorney
A legal document giving a person (called an "agent" or "attorney-in-fact") the power to act for another person (the principal).

When incapacity is anticipated, a person may grant power of attorney to another person. Power of attorney is the legally recognized authority to act and make decisions on behalf of another party. This authorizes the designee to act on behalf of the person who is now incapacitated. The person with power of attorney is often responsible for making decisions regarding the disclosure of health information to others.

Problem List
List of illnesses, injuries, and other factors that affect the health of an individual patient, usually identifying the time of occurrence or identification and resolution.

Progress Notes
Notes made by the doctors, nurses, therapists, and social workers caring for you that reflect a patient's response to treatment, their observations and plans for continued treatment.

Quality Improvement
Upgrading from previously accepted minimal performance standards.

Quality Management
The organization-wide pursuit of quality.

Registers
An official list of all patients treated and/or admitted in a particular health facility

Risk management
An organized effort to identify, assess, and reduce, where appropriate, risks to patients, visitors, staff and organizational assets.

SOAP
Sequence of evaluating the care needed for any particular patient.

Standards
Statements of expectations for the inputs, processes, behaviors and outcomes of health systems.

Stillbirth rate
See *fetal death rate*.

Tracers
Also known as “outguides”, used to ensure proper record control whenever the health record is removed from file for any purpose.

Telemedicine
Refers to the practice of medicine by means of electronic and telecommunications technologies such as phone call, chat or short messaging service (SMS), audio- and video-conferencing, among others, to deliver healthcare at a distance between a patient at an originating site, and a physician at a distant site.

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CHAPTER 1
Health Information Management Department in Hospitals

The **Health Information Management Department (HIMD)** is responsible for enhancing patient care through the use of data contained in the health record (digital or manual medical information), either individually or collectively. The general function of the HIMD is to provide an organized system of measuring quality patient care and to ensure that sufficient data is written in a sequence of events to justify the diagnosis, warrant the treatment and end results. The department is tasked to process, analyze, maintain, and safekeep all health records created/maintained in the health facility in the course of the care. The department plays a key role in the generation of health statistics to evidence-based medical care and management practices. Quality of records and documentation are also one of the emerging roles of the HIMD in the Hospital. The revenues generated through reimbursements from third party payers are dependent on the quality of records and documentation.

1.1 Objectives

The HIMD shall provide effective and efficient service to clients of the health facility and shall meet the following objectives and standards:

1. Improve the accessibility of the health records.
2. Ensure the creation and maintenance of quality and standardized health records for every patient treated.
3. Ensure that data are electronically recorded using a health record system validated by the DOH in compliance with the EMR implementation.
4. Ensure greater utilization of health facility statistical reports.
5. Assist in strengthening quality programmes e.g., Patient Safety, Continuous Quality Improvement (CQI), Infection Prevention and Control, Risk Management, etc., in the

health facility.

6. Participate in research and studies which the facility, the members of the medical and allied staff, and other authorized researchers are engaged in.
7. Implement staff development.

1.2 Functions

1. Maintain all health records in accordance with the principles and practices of efficient and effective health record management.
2. Maintain comprehensive indexes (e.g. Master Patient Index, Disease Index) and registers (e.g. Admission, Discharge, Operation/Procedure, Delivery Room (DR), Out-Patient Department (OPD), Emergency Department (ED), Birth and Death Registers). These are official records for patient identification and important retrieval tools for needed data and information when health records are already disposed-of.
3. Review records for completeness and accuracy, coding of diseases, operations, and special therapies according to approved nomenclature and classification.
4. Maintain a comprehensive and up-to-date unit health record for each patient ensuring that all relevant information is collected and written in the record and filed correctly.
5. Respond to all subpoena *duces tecum* addressed to the HIMD.
6. Maintain and safeguard the confidentiality of the health record.
7. Provide health records, upon request for patients' visit to the OPD and Emergency Department (ED), and admission to the inpatient's ward for benefit claims, insurances and litigation/legal purpose/s.
8. Ensure that all diagnostic reports/results are promptly and accurately filed in their respective patient's record.
9. Collate and compile data and generate statistical reports required by respective health facility management, the DOH, as the health regulatory body, and Philippine Health Insurance Corporation (PHIC), as the country's health accreditation agency.
10. Prepare periodic statistical reports on morbidity and mortality, birth, utilization of hospital services, OPD/ED services, as well as surgery performed, and cases receiving special form of therapy and other related data.
11. Participate in approved research activities and study programs conducted by doctors and authorized researchers by providing data/information from patient's health records.

1.2.1 Other Functions

Patient Health Records Committee (PHRC)

The Head of the HIMD in Level 1, Level 2 and Level 3 hospitals, shall participate as a member of the Patient Health Records Committee (PHRC), formerly known as the Medical Records Committee. The PHRC may act as the Forms Committee and/or a liaison between the Chief of the Medical Service and other departments. The members

of PHRC shall consist of representatives from the various clinical services of the hospital. The committee shall provide efficient support to the Head of the HIMD in the formulation of effective institutional standards, policies, systems and procedures most especially in the timely documentation and the completion of health records.

The membership of the PHRC includes, but not limited to the:

- Chairperson – representative from the medical service.
- Members – representative from the hospital administration; nursing service; allied health services and the Head of the HIMD.

PHRC shall have the following functions:

1. Conduct regular meetings (once every three months or more frequently, if required) for performance evaluation of planned activities of the committee including monitoring of all health records not completed within the specified time.
2. Recommend standards, policies, systems and procedures in health record documentation and in the implementation of Clinical Documentation Improvement (CDI) in the hospital.
3. Monitor the quality of documentation of the health records.
4. Review all health record forms to determine its effectiveness in the collection of the needed data/information and revise if there is a need for it.
5. Validate health record analysis in relation to hospital's performance.
6. Lead in the implementation of accurate and complete Medical Certification of Cause of Death (MCCOD) for quality mortality data in the hospital.

1.3 HIMD Linkages

The HIMD must at all times maintain harmonious working relations with other service components of the health facility to efficiently and effectively perform its functions particularly in the creation and maintenance of quality health records for the benefit of the patient and facility in general. The Head of HIMD is mandated to implement facility-wide coordination and linkages to other departments.

A. Office of the Medical Center Chief of Hospital/Chief of Hospital

1. **Professional Education, Training and Research Office/Unit (PETRO/PETRU)**

   - Coordinates needed data/information on available technical Learning Development Intervention (LDI) and corresponding budget for the HIMD staff.
   - Provides lists of participants to undergo LDIs

2. **Integrated Hospital Operations and Management Service (IHOMS)**

   - Coordinates the maintenance of the Health Information System (HIS) of the hospital and other systems used by the HIMD, including the provision, repair & maintenance of IT equipment.

- Provides assistance in the enhancement of electronic health/medical records.

B. Medical Service

- Coordinates in the creation of accurate and complete medical information/ diagnostic results for patient care management for proper and timely documentation.
- Provides assistance in the completion of health records (digital/manual) and research studies.

C. Allied Health Professional Service

1. **Pharmacy**
    - Provides data/information on the drugs, medicines, intravenous fluid (IVF) and other dispensed for the treatment and care of the clients during the period of confinement and pharmacy interventions provided to patients.
2. **Medical Social Work**
    - Provides data/information on the classification of patient, social services extended or assistance provided to the patient for his treatment and care
    - Coordinates needed data/information for preparation of case study for service patients and others seeking assistance from concerned financial institutions.
    - Request for clinical abstract/discharge summary for absconded patients seeking financial assistance and insurance reimbursement with prior approval of the Medical Center Chief.
    - Assists in the identification of John Doe/Jane Doe, abandoned clients and unclaimed cadavers.
    - Assists in the completion of birth certificates for abandoned newborn babies and death certificates for unclaimed cadavers.
3. **Nutrition and Dietetics**
    - Provides data/information on the nutrition-related services given to the client such as diet during confinement, and diet counselling.
    - Coordinates with the nutrition and dietetics service in the implementation of Nutrition Care Process.
    - Provides technical assistance to the Registered Nutritionist Dietitian in the preparation of bi-annual hospital Nutrition Care Process reporting form.

D. Nursing Service

- Submits 24-hour daily floor census together with the health records of discharged patients.
- Coordinates prompt submission of completed and accurately accomplished pre-form/ worksheet of Birth and Death Certificates.
- Provides standards in health record documentation for the creation of quality health records.

- Provides assistance in the completion of health records (digital/manual), case presentation and research studies.

E. Hospital Operations and Patient Support Services (HOPSS)

1. **Human Resource Management Office (HRMO)**

   - Coordinates with PETRO for the conduct of needed HIMD technical LDI.
   - Coordinates for technical assistance in recruitment, selection and promotion of HIMD staff.
   - Recommends adequate human resource and appropriate qualification standards for the various HIMD staff.
   - Submits regular reports on hospital human resource complement to HIMD.
   - Complies with the prescribed HRMO requirements relative to HIMD personnel.

2. **Procurement Section and Materials Management**

   - Coordinates in the selection and purchase of needed HIMD office supplies and equipment.

3. **Engineering and Facilities Management**

   - Provides assistance and maintenance related to infrastructure of the HIMD working area

F. Finance Service

1. **Billing and Claims**

   - Coordinates with HIMD for the health records and documents needed for insurance purposes, e.g., insurance reimbursements for PhilHealth, HMO and other insurance companies.
   - Provides needed data for monthly mandatory hospital statistical reports.

2. **Budget**

   - Coordinates with the HIMD's needed operational budget.
   - Provides needed data and hospital statistics.

3. **Accounting**

   - Coordinates with HIMD's in the release of operational budget based on approved work and financial plan and Project Procurement Management Plan (PPMP).
   - Provides needed data and hospital statistics.

4. **Cash Section**

   - Provides order of payment for medical certificate and other requested health record documents/issuances.

CHAPTER 2

Administration and Management of HIMD

2.1 Organizational Structure of HIMD

Fundamental to effective management is the development of an organizational chart which shows the line of authority and responsibility. Likewise, it indicates the channels of communication and protocol. The institutional objectives, as well as the principles of effective organization are considered foremost in the formulation of the organizational chart.

To cope with the current trends in the Hospital HIMD, a new functional and organizational structure is proposed and is still subject for the approval of DBM as of this writing (See Figure 1). There is an existing Organizational Structure and Staffing Standards for Government Hospitals approved last 2013.

Figure 1. Organogram for HIMD.

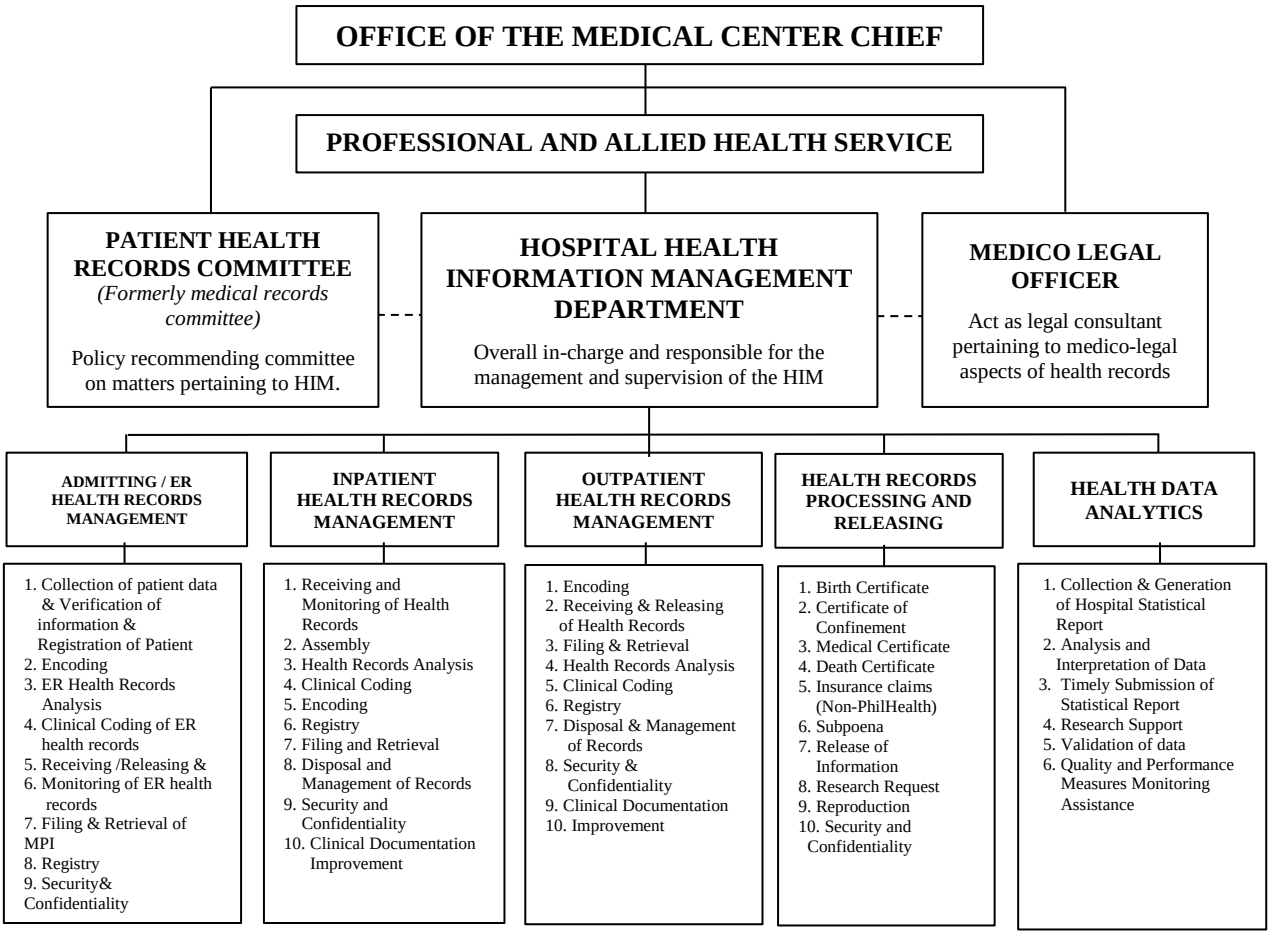


Figure 2. Organogram for Professional and Allied Health Services.

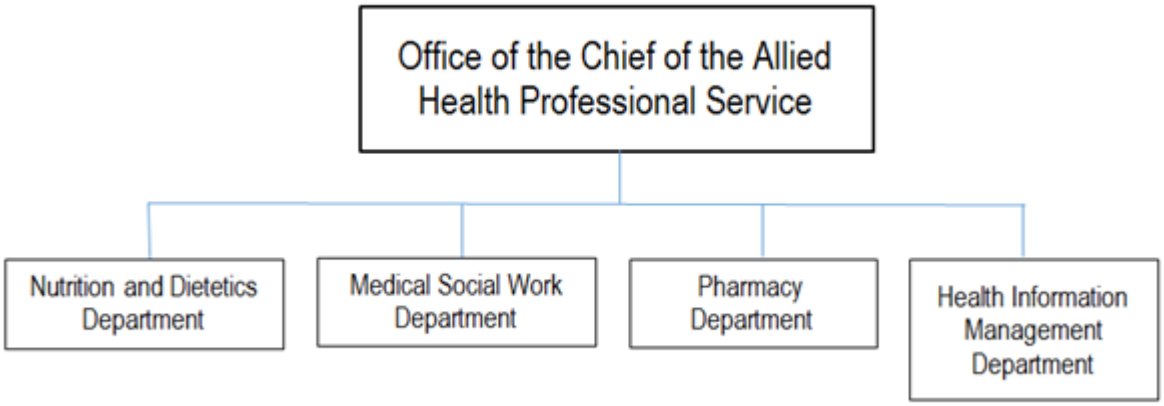
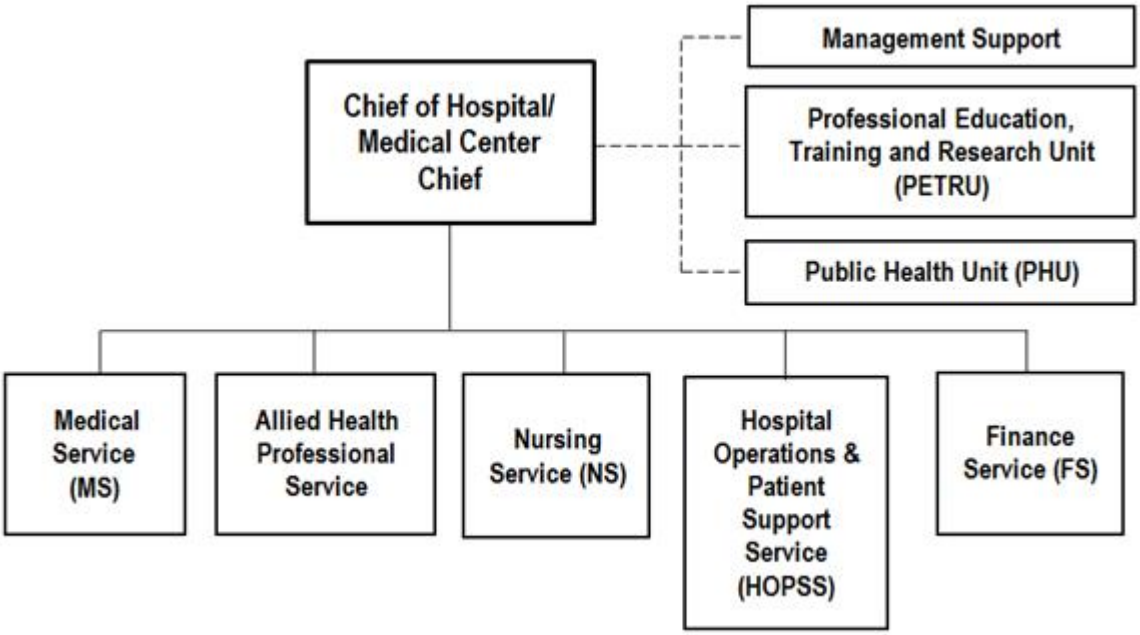


Figure 3. Organogram for Government Hospital Level 3 with 200 to 1500 Beds.



2.2 Management Process

Management is defined as the process of getting things done through and with people. It is the effective utilization of resources towards the accomplishment of the specified objectives. Four basic components emerge from any definition of management: objectives, staffing, processes/procedure, and resources.

Five Functions of the Management Process

1. ***Planning*** involves the identification and implementation of activities and programs to meet its objectives. Planning is the crucial step in the management process, but is often the most neglected. It includes the review and evaluation of the outcome in order to determine the planned objectives were achieved. The planning process for health information management involves:

    - Setting the objectives;

- Developing policies and procedures, rules and regulations; Setting standards and goals; Determining the projects and programs; Implementing and monitoring the plan; and Evaluating the plan in relation to the effectiveness, efficiency and impact on the goals/objectives of the HIMD.

Purposes of Planning

- Enables the HIMD to attain its goals and objectives;
- Facilitates the allocation of resources (e.g. time, people, supplies);
- Serves as a basis for measuring the performance and determining and addressing deviations or variances (actual vs. planned); and
- Serves as a useful reference in the preparation of the budget.

Table 1 below gives an example of practical HIMD planning that affects its performance.

Table 1. Example of Practical HIMD Planning.

Issues	Impact	Action Plan	Timeline
1. Incomplete health record	Delay in processing of health records, statistical reports and issuances	Strengthen hospital policies and procedures	End of first quarter
2. Unauthorized access of health record	Noncompliance to Data Privacy Act of 2012	• Review of existing policy • Reorientation of the HIMD personnel on Data Privacy Act	Immediately
3. Inadequate storage	Occupational risk	Observe regular disposal of valueless records	Annual
	Inaccessibility of health records	Request of additional storage space/filing shelves	Immediately

2. ***Organizing*** involves the identification, distribution, and scheduling of resources toward the accomplishment of the objectives. Organizing requires an understanding of the principle of staffing and work distribution. It also includes the allocation of materials, equipment and space. This is the process by which employees in the HIMD must have coordination, either within the department or with other departments.

Formalizing the organizational structure of the HIMD

a. Organizational chart is a graphic representation of all positions in the department.

b. Organizational manual. The HIMD shall have a set of written policies and procedures which shall be properly disseminated.

c. Organizational Development – this involves the following:

- continued in-service training and development for the staff
- regular meeting and communication between the staff and officers
- dissemination of results of the Patient Health Records Committee meetings

- feedback mechanism on the performance of the staff.

3. ***Directing*** is the act of leading and motivating individuals to work harmoniously, effectively and efficiently to attain the objective. It involves leadership, supervision, delegation, communication, coordination, motivation etc.

4. ***Controlling*** involves comparing against set standards, identifying unit of work and index of performance.

5. ***Evaluating*** involves determining results against plans, using effectiveness and objectives using effectiveness and efficiency of indicators.

2.3 Physical Facilities and Equipment

The Health Information Management Department (HIMD) shall be big enough to accommodate active, inactive and incoming health records. Ideally, it shall have a separate working area which shall be adequate for the HIMD staff and sufficient filing/storage area for confidentiality, security and health reasons. However, such requirements may vary depending on the category of the health facility.

HIMD shall be properly ventilated to protect the integrity and quality of written and electronically produced documents.

Volatile and flammable liquids shall not be placed inside the records room, and *"NO SMOKING"* and *"AUTHORIZED PERSONNEL ONLY " signages* shall be strategically posted inside the HIMD.

It is important to consider the accessibility of the location i.e., possibly near ER and OPD, the number of personnel, records generated and its prescribed retention period, the designated area for the activities involved such as the completion area for doctors, health record imaging/scanning, and sorting of health records for filing and safekeeping. It is a must that the working area and storage area should be separated to ensure the confidentiality and security of health records.

In the event the space allocated for the HIMD is not enough to accommodate all records, a plan to transfer inactive records to an inactive records storage area shall be considered. This shall decongest the filing area, give way to incoming records, and shall facilitate prompt retrieval of needed health records. A health record not activated within five (5) years or as may be determined by the health facility's management after the last date of treatment and/or admission of the patient shall be considered inactive.

2.3.1 Space Requirement

Space requirement for inpatient records shall be calculated using the following formula:

$$\textbf{Storage Space Required} = \frac{\text{(Annual Discharges including Newborn*) + (New Outpatient) x (Retention Period)}}{\text{(Records per meter)}}$$

** Newborn = Non-pathologic*

Example: ***Data Given***

Annual Discharges	=	23,000
New Admissions	=	6,720
Re-admissions	=	16,800

Annual New OPD Registration	=	3,000
Newborn	=	1,000
Retention period	=	15 years
No. of records/meter	=	200 records

$$\textit{Storage Space Required} = \frac{(23{,}000 + 3{,}000 + 1{,}000) \times 15}{200}$$

$$= \frac{405{,}000}{200}$$

$$= \textbf{202.5 meters of shelving}$$

Note: 10% of the computed required storage space should be added to the computed value to account for the projected increase in number of patients/year.

$$202.5 + 20.25 = \textbf{222.75 meters of shelving}$$

To calculate for the number of meters of shelving for each terminal the formula is:

$$\textbf{No. of meters required for each section} = \frac{\text{Meters of shelving required}}{\text{No. of sections in file}}$$

$$= \frac{8{,}910}{100}$$

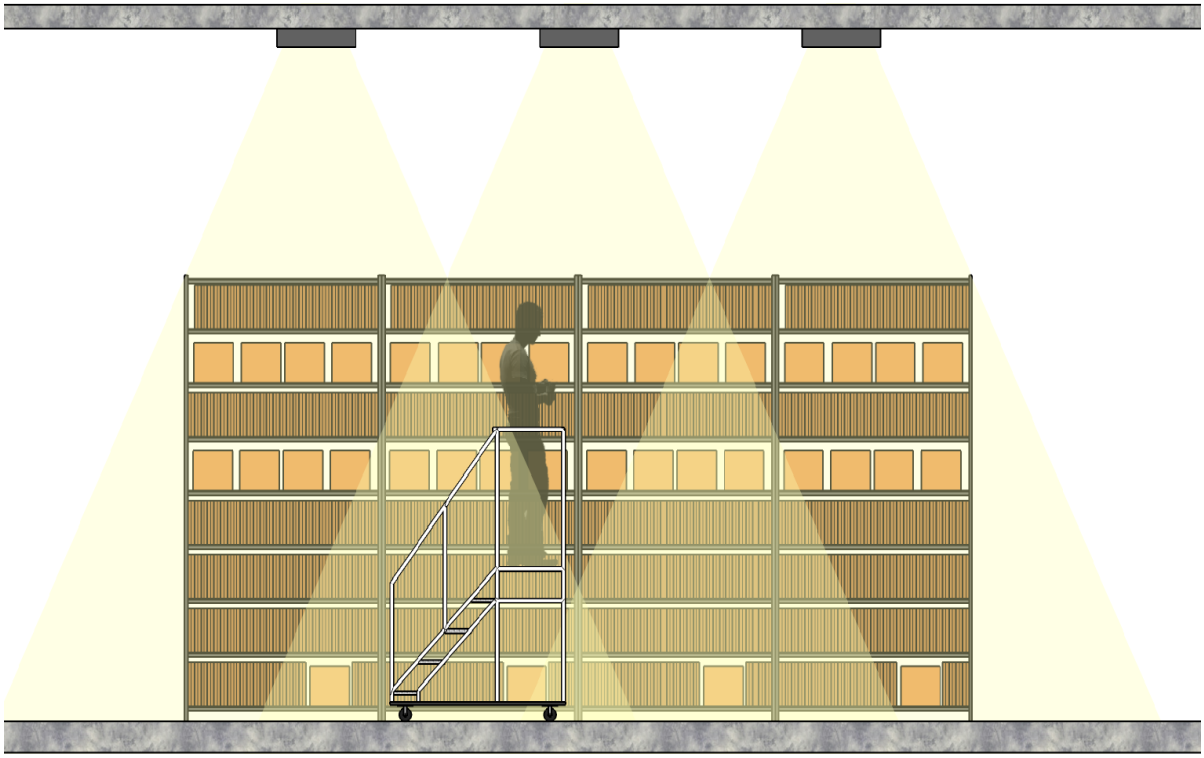
$$= \textbf{2.22 meters/primary section}$$

2.3.2 Filing Cabinets for Paper-based Health Records

The open shelf type shall be used for the following reasons: space saving, ease of filing, and easy retrieval. Although accumulation of dust and problems of security are some of its disadvantages, its advantages outweigh its disadvantages.

High stocking cabinets can be adopted to maximize the storage capacity of the filing area. However, provision for "kick stools" or "safety pulpit ladders" should be considered for the convenience and safety of the file and retrieval clerks.

Figure 4. Diagram Showing "Safety Pulpit Ladder" and "Kick Stool".



2.3.3 Cabinets for Indexes

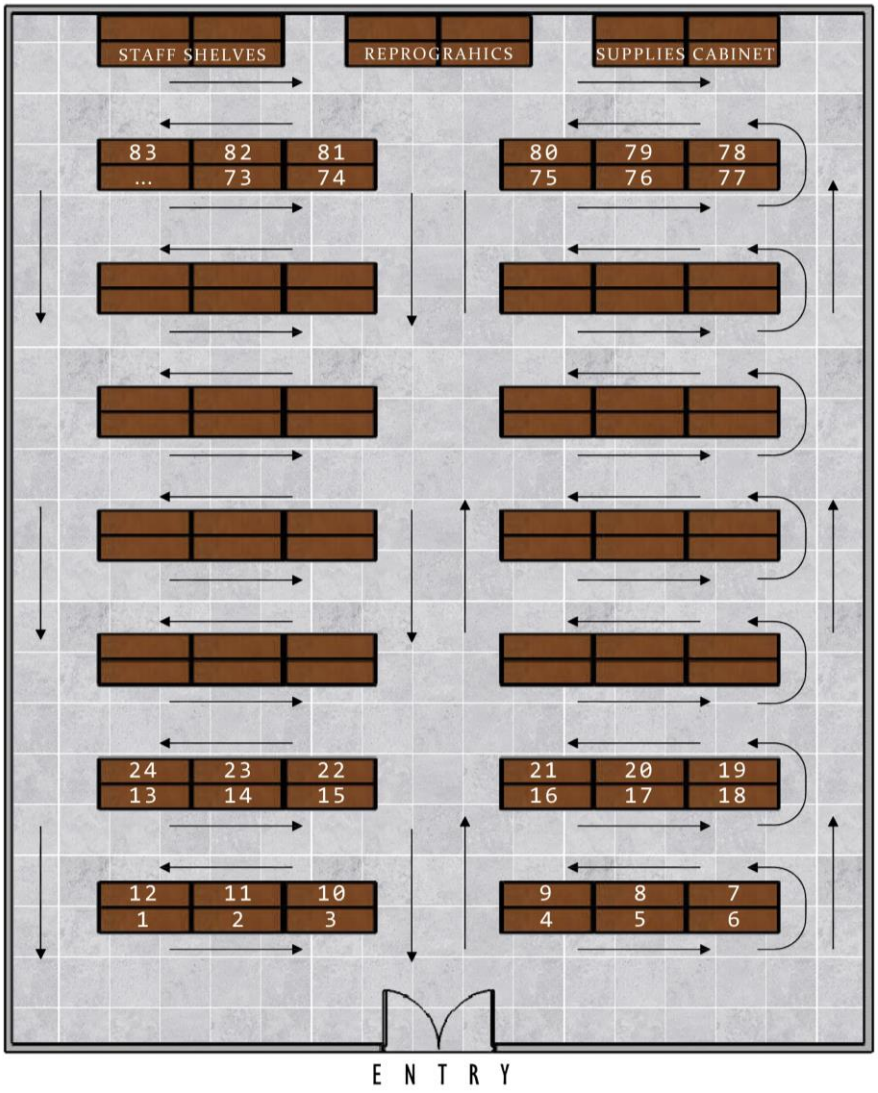
Cabinets for indexes come in standard sizes and these are oftentimes made of steel. For the master patient index, the cabinet must be able to accommodate 3" x 5" index cards, whereas, for the disease, operation, and physician indexes, a cabinet for 5" x 8" cards shall be used.

2.3.4 Arrangement and Distance of Filing Cabinets

The physical arrangement of the cabinets has a direct effect on the efficiency of the filing and retrieval processes. The cabinets shall be arranged for minimum walking. It is also important to remember that the direction of the expansion of the files shall always be from left to right.

A back-to-back arrangement of filing cabinets shall also be highly considered because this saves space and maximizes the storage capacity of the filing area.

Figure 5. Standard Arrangement of Filing Cabinets.

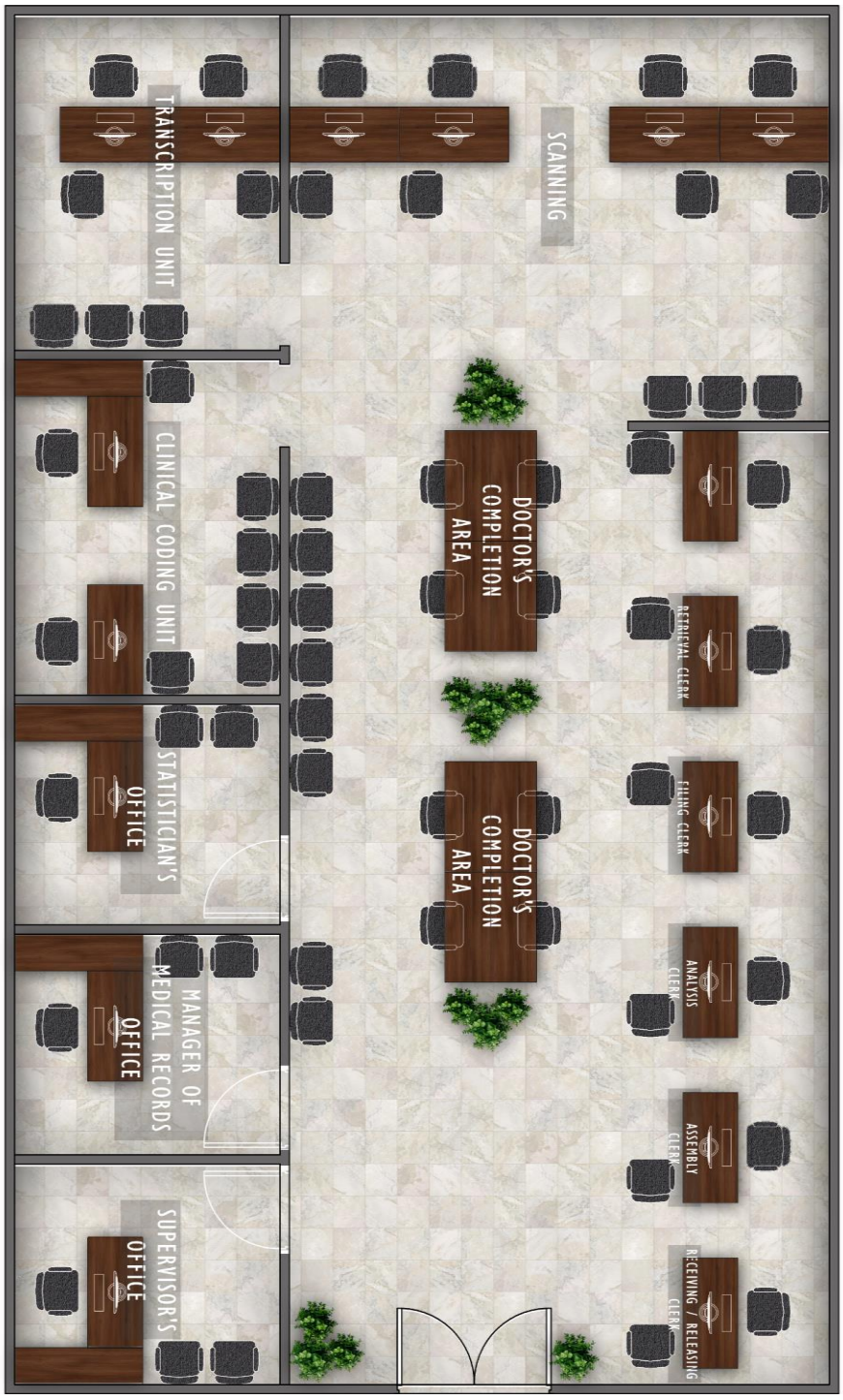


2.3.5 Working Tables

The physical arrangement of employees' tables shall be in accordance with their workflow. Efforts shall be made to lessen the travel time of paper within the department, to improve output and increase efficiency, by optimizing the workplace arrangement and the application of ergonomics.

Employees who are in constant contact with patients/clients shall be positioned near the main entrance. Employees performing technical jobs like coding and statisticians performing analytical work shall be positioned in an area free from distraction and noise, as much as possible near the Health Information Management Officer for better supervision and control.

Figure 6. Working/Completion Area.



Transcriptionists/typists shall be positioned farther from other employees. Their area shall be acoustically treated to lessen distraction.

The HIMD Head's room shall be positioned strategically to monitor subordinates for more effective supervision and control.

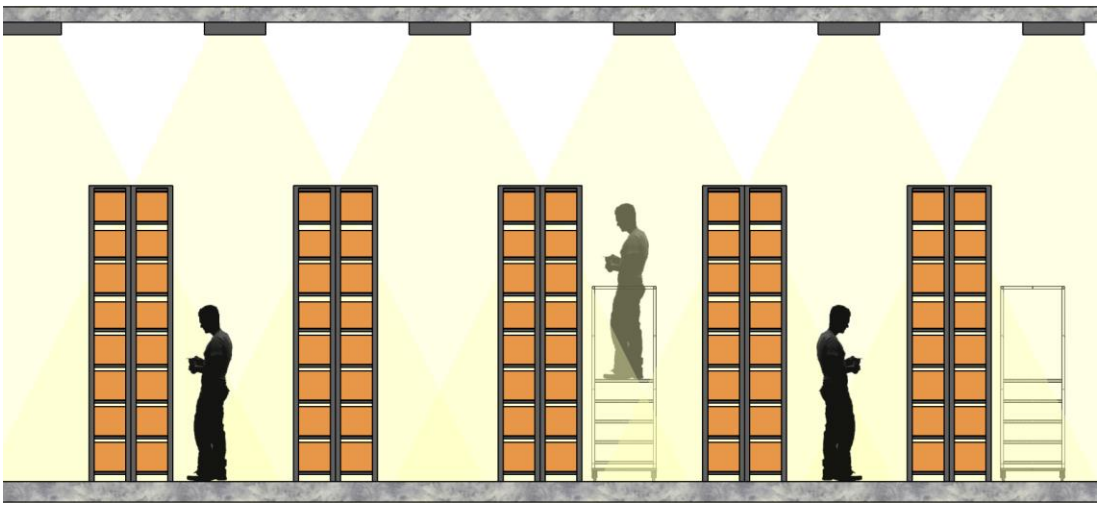
Distances between tables of employees shall be maintained at 1-1.5 meters to facilitate easy movement. A space of 5.57meters per employee shall be maintained, if possible.

2.3.6 Proper Lighting

Research shows that proper lighting directly affects employee performance. The level of lighting requirement (in foot candles) varies from activity to activity. A 100-foot candle light is required for the following activities: regular office work, reading or transcribing, handwriting, active filing, index referencing and mail sorting. Age level has also a direct influence on light requirement. Older people tend to work efficiently and effectively in well lighted working areas. Younger people, on the other hand, tend to prefer not too highly illuminated working areas.

The light in the storage and filing area shall be situated in between cabinets and should run parallel with the arrangement of the cabinets so that the illuminating capacity of the light is maximized.

Figure 7. Diagram Showing Proper Lighting.



2.3.7 Proper Ventilation

Planning a good HIMD layout also requires proper ventilation. It is not only considered for health reasons but also for the protection of health records. Filing and storage areas with very humid conditions have bad effects on the health records because papers absorb moisture to some extent and this could affect the quality of the health record.

2.3.8 Proper Room Temperature

It is a fact that room temperature affects the performance of a person. The temperature shall not be too warm nor too cold. Temperature which is just right and conducive for working shall be provided.

2.3.9 Aesthetic Consideration

Research shows that the color of the working area has a positive effect on employees' performance. So, the HIMD needs to consider light and color combinations, such as light yellow, to enhance performance and productivity.

The HIMD shall have a completion area, where doctors and researchers can do their work. This area shall be provided with the following: long table, chairs, pigeon hole for incomplete health records.

2.3.10 Equipment and materials

The HIMD shall also be provided with sufficient good quality office supplies. The basic equipment and supplies needed are the following:

A. <u>Mandatory</u>

1. Working tables and chairs
2. Computers with printers and Uninterrupted Power Supply (UPS)
3. Typewriters (electric or manual)
4. Photocopying machine
5. Air-conditioning-unit or electric fan
6. Exhaust fan
7. Sufficient filing cabinets for records, indexes and registers
8. Safety Pulpit Ladder/Kick Stool
9. Coding Tools (e.g., International Classification of Diseases (ICD), RVS International Classification of Diseases-9-CM, medical terminology, bookstand, bookmarker, electronic coding tools, etc.)
10. Medical Dictionary
11. Atlas Human Anatomy Book
12. Stamper and stamp pad/ Self-inking stamp
13. Dry Seal
14. Telephone Service/Mobile phone service
15. Paper Shredders
16. Numbering machine
17. Calculator
18. Heavy Duty Puncher/Puncher
19. Heavy Duty Stapler/Stapler
20. Heavy Duty Staple Wire Remover
21. Heavy Duty Puncher/Puncher
22. Pencil Sharpener

23. Fire Extinguisher
24. Emergency Light
25. Mini hammer

B. Optional

1. Mobile-compactor
2. Paper Scanner (heavy duty)/Document Management Imaging System (DMIS)
3. Facsimile (Fax machine)
4. Air purifier
5. Automatic Punching Machine
6. Paper Binder
7. Barcode scanner
8. Vacuum Cleaner
9. Automatic Punching Machine
10. Heavy Duty Paper Cutter
11. Index Card Sorter

2.4 Standard Staffing Pattern

For the HIMD to be efficient and more responsive to the needs and demands of its clientele, it shall have the required number of staff in relation to its bed capacity and the volume of work to be done.

The number of staff required by the HIMD is determined by the category of the health facility. A research health facility which needs a more comprehensive and sophisticated records-keeping system shall naturally require a greater number of staff compared to an institution which is not engaged in research and teaching.

Furthermore, the required HIM staff ratio shall be 1:20 of the Authorized Bed Capacity (ABC) for In-Patient and for Outpatients, the ratio shall be 1:35 visits per day.

The classification of personnel in the HIMD of a health facility shall depend on the following: (1) classification of the Director/Medical Center Chief and (2) category and bed capacity of the health facility.

(See Annex U for the qualification requirements and job descriptions for the different categories of the HIMD staff.)

2.4.1 Staff Development

A. Internal

1. Orientation of HIMD staff in relation to the existing policies and procedures;

2. Rotation of staff within the HIMD every two (2) years, or upon recommendation by HIMD Head
3. Conduct in service training and continued education of staff within HIMD;
4. Participation and involvement of staff in planned changes;
5. Evaluation of staff performance involving effective changes of work undertaken; and
6. Values Orientation Workshop

B. External

1. Basic/Advanced Health Information Management
2. Latest International Classification of Disease Coding of Diseases
3. Latest Advanced Mortality ICD Coding
4. Clinical Documentation Improvement
5. Problem Oriented Health Records Training
6. Risk Management in HIMD
7. Data Privacy Act
8. Medico Legal Aspects on HIM
9. Civil Registry Updates on Birth and Death
10. Records Administration and Disposition
11. Medical Certification on the Cause of Death
12. Health Facility Statistical Report Preparation

CHAPTER 3

Health Record Standards and Policies

Standards and policies are critical in the HIMD to achieve a uniform practice for efficient and effective health information management. Since patients' health records serve as a form of communication between health care professionals, it is important that the quality and form of these records adhere to certain standards.

Standards is a set of desired and achievable levels of performance against which actual performance is measured. Standards enable health organizations to imbed practice and effective quality improvement into their daily operations.

Policies, on the other hand, serve as a framework or general guide consistent with organizational objectives for decision making.

This particular chapter shall define the different standards and the corresponding policies needed to achieve uniform and consistent practices within and across health facilities. Observance and adherence to said standards and policies will help improve the quality of patient care management. In implementing these standards, it is likewise important for health facilities to assess and modify these according to the facility's context, however, modification should not deviate from the standard to the extent of adversely affecting the level of departmental performance and quality of patient care in general.

3.1 Overall Considerations in defining the Philippine Health Record Standards

The overall considerations in defining the Philippine Health Records Standards include:

1. Licensing Standards as defined in Administrative Order No. 2012-0012;
2. Other regulatory/ mandatory policies;
    a. RA 10173, also known as the Data Privacy Act of 2012 and its Implementing Rules and Regulation (IRR), an act protecting Individual Personal Information and Communications System in the Government and the Private Sector, creating for this purpose a National Data Protection Commission and other purposes,
    b. RA 11223, also known as the Universal Health Care Act, and its IRR
    c. AO 2013-0005, entitled National Policy on the Unified Disease Registry Systems of the Department of Health (Chronic Non-Communicable Diseases, Injury Related Cases, Persons with Disabilities and Violence Against Women and Children

Registry System), and its amendment.

d. RA 9470, also known as the National Archives Act of the Philippines 2007 which includes the DOH Circular No. 70, s. 1996, dated May 8, 1996, Revised Disposition of Medical Records Amending Ministry Circular 77, s. 1981, proposed by DOH and duly approved by the National Archives of the Philippines.

3. International Health Record Standard as defined by the Joint Commission International Accreditation Standards;

4. PhilHealth Benchbook; and

5. International Organization for Standardization (ISO 9001:2015).

3.2 Philippine Health Records Standards and Policies

3.2.1 Standard 1: Health Record Creation

3.2.1.1 Specific Standards

1. The health facility shall initiate and maintain a standardized health record for every patient assessed or treated and determine the record's content, format and location of entries.

2. Health records of patients should meet the education, research, and statutory requirements as provided by law.

3. Each patient confined and consulted in a health facility has a sufficiently detailed health record that correctly identifies the patient, supports the diagnosis, justify the treatment, and documents the course and results of treatment.

4. Collection of personal information is accompanied by a Data Privacy Consent form to be signed by the patient or his/her authorized representative.

5. Authorized personnel to make entries in the health record are clearly defined as per Hospital Policy.

6. The health facility uses standardized diagnosis and procedure codes and ensures the standardized use of approved symbols and abbreviations across the hospital.

7. The health records of patients receiving emergency care include the time of arrival and departure, the conclusions at termination of treatment, the patient's condition at discharge, and follow-up care instructions.

8. Relevant, accurate, quantitative and qualitative data are collected and used in a timely and efficient manner for delivery of patient care and management of services.

9. Data in the patient charts are coded and indexed to ensure timely production of quality patient care information and reports to PhilHealth.

10. The hospital has a process to address the proper use of the copy and paste function when electronic health records are used.

11. Standard Health Record Arrangement:

a. Clinical Cover Sheet
b. Admission slip
c. Triage slip
d. Data Privacy Consent Form
e. Informed Consent for Admission or Confinement
f. History and Physical Examination
g. Discharge Summary
h. Clinical Laboratory Test Result Forms
i. Doctor's Order and Progress Notes
j. Nurses Notes (FDAR)
k. Monitoring Sheet
l. Intravenous Fluid Sheet
m. Medication Sheet
n. Pharmacist's Notes/ Pharmacist's Intervention Form
o. Nutrition Care Plan
    - TPR
    - Pain Monitoring Sheet
    - Input and output
    - Vital Signs

3.2.1.2 Specific Policies

1. HIMD shall use standardized forms to ensure overall quality care, at the same time, serve as an effective cost control measure. WHO recommended in 1969 that ". . . *consideration should be given to standardizing the medical record at the national level, to include the size of the folder, the size of the record form, and the content of the case summary. This should be within an individual hospital or with all hospitals of a system."*

2. A Forms Committee should be established to help the Head of the Health Information Management Department in determining the forms needed by the hospital, as well as in the proper design of the forms. The Patient Health Records Committee (formerly known as Medical Records Committee) could also function as the Forms Committee if the former is already in existence, subject to approval by the Hospital Management.

3. All forms in the health record must be reviewed and approved by the Patient Health Records Committee and shall be registered with the Document

Controller before it is officially used.

4. Health record forms consist of standard/basic and supplemental/special forms. Standard or basic forms are those that are fundamental to or essential portions of all health records. Supplemental or special forms are forms added to certain patient health records as required by the case. These forms shall be added after the standard health record arrangement.

5. A consent form from the health facilities shall be incorporated in the admission/confinement form of hospitals, treatment/ health facilities which shall be accomplished prior to the patient's admission or management.

6. The health facility identifies members of the staff who are authorized to make entries in the patient health record. Thus, every patient health record entry identifies its author and shall indicate when the entry was made.

7. All health records shall contain all relevant and complete demographic data of the patient at least but not limited to the following:

    a. For OPD Records

    - Patient Hospital Number
    - Patient's full name
    - Address
    - Date of Birth
    - Place of Birth
    - Age
    - Gender
    - Civil Status
    - Religion
    - Nationality
    - Contact Number
    - E-mail Address
    - Name of Spouse
    - Father's name
    - Mother's name
    - Next of Kin to whom to notify
        - Address

- Relationship to patient
- Contact Number

b. For Inpatient Records (In addition to the OPD patient's demographic data, the following shall be included):

- File Number
- Room Number
- Admission date / time
- Discharge date / time
- Length of stay
- Social Service Classification
- Admitting Diagnosis
- Alert notation for Allergies and Adverse Drug Reaction

8. A health record with pending diagnostic results shall be completed in the HIMD within 15 days after the patient's discharge; otherwise, it shall be considered a delinquent health record.

9. The Attending Physician (AP)/nurse on duty and other authorized staff to document in the health record has the final responsibility for the completeness and accuracy of the data entry in the health record. The discharging nurse on duty shall be responsible in counter checking the completeness of the health record as to documentation and quantity before endorsing the same to the HIMD.

10. The accomplishment of History, Physical Examination, and Discharge Summary may be delegated to the interns. However, these records shall be reviewed, corrected and countersigned by the attending physician.

11. The HIMD staff shall assist the attending physician in reviewing records for completeness by checking for omissions and discrepancies to ensure that health records comply with set standards and policies.

12. The processing of health information for certificates adhere to the following policies:

    a. **Certificate of Live Birth**

    - Accomplishment of the Certificate of Live Birth shall be in accordance with the Civil Registry Administrative Book No. 1, series of 1993 (Implementing Rules and Regulations of the Republic Act no. 3753 and other laws on Civil Registration).
    - Preparation of the Certificate of Live Birth of all babies born inside the health facilities shall be done by the person who has witnessed the baby's (babies') delivery.

- Only the baby's parents shall be interviewed and shall sign the Certificate of Live Birth. If the mother died or is mentally incapacitated, the husband or any of the nearest kin shall act as the informant and shall sign the Certificate of Live Birth.

- For illegitimate births, the father may execute the Affidavit of Acknowledgment/Admission of Paternity as father and his surname to be reflected in the Certificate of Live Birth and further, the mother must sign the Affidavit to Use the Surname of the Father (AUSF), duly notarized.

b. **Certificate of Death**

- Preparation of the Death Certificate shall be done by the person who has witnessed the occurrence.

- All the data given by the informant are presumed correct and the health facility shall not be held liable for any erroneous data entered in the death certificate.

- No correction of data shall be done unless supported by a duly notarized affidavit of correction and other supporting documents. However, a death certificate that bears the LCR registration number will no longer be corrected.

c. **Certificate of Fetal Death**

- Registration shall be made in the office of the City Municipal Civil Registrar where the event occurred.

- Registration should be made within the 30-day reglementary period.

- The Certificate of Fetal Death is to be accomplished in 4 copies; assign a register number and enter it in the Registers Book of death.

- If death occurred in a health facility, the hospital (care) administrator, the parents, relatives or the attendant at death will register the Certificate of Fetal Death

3.2.2 Standard 2: Health Record Documentation

3.2.2.1 Specific Standards

a. The health record is a legal document. No form may be detached once it is filed at the HIMD.

b. The health record contains a complete and accurate set of information to facilitate effective and efficient patient care management.

c. All documentation must be legible and written in ink or typewritten.

d. Decision makers and other staff members are educated and trained in the principles of information use and management.

e. Written documents, including policies, procedures and programs, are managed in a consistent and uniform manner.

f. A health record number is assigned to the patient on his/her first encounter and will serve as his/her permanent unique identification number for future visits in the health facility.

g. Refer to Chapter 4 for Health Record Systems and Procedure

3.2.2.2 Specific Policies

a. The health record shall contain all original copies of examination results, operations and other required forms.

b. There shall be a standard format for health record documentation which must include demographic and assessment data.

c. Each form in the health record shall contain at least two (2) of the following unique identifiers: Health Record Number (HRN), Patients Name, Date of Birth, and Date of admission/consultation.

d. Collection of personal data shall include a Patient Information Sheet accompanied by a Data Privacy consent form to be signed by the patient/authorized representative, the latter to form part of the health record.

e. All required forms shall be properly filled out. If not applicable, NA or None shall be placed. For skipped and blank spaces, a single slanting line from bottom to top shall be drawn and the person responsible shall affix signature over printed name.

f. All consent forms shall be properly filled out and accomplished to be attached to the health record as needed.

g. All entries in the health record shall be made only by duly authorized staff of the health facility with the print name, signature and designation of the author, and date and time such entries were made.

h. The health record shall contain an Admitting Diagnosis by the medical practitioner who admitted the patient.

i. The health record shall contain the patient's history pertinent to the condition being treated, and relevant details of family history, present and past medical history and physical examination accomplished by the AP within 24 hours from date and time the patient was first seen.

j. The health record as a legal document must have no erasures of any sort. Entries made in error shall be immediately corrected in a legal way. *Refer to Chapter 4 under Analysis of the Health Record for the procedure in correcting an error.*

k. Correction and additional entries in the health record shall be made while the patient is still admitted and while the health record has not been processed.

l. If the patient requests for correction of personal data and demographic information, the patient shall accomplish an amendment form and attach a Valid Identification (ID) Card/ Identity document listed under PSA Memo Circular No.

2019-16 dated June 11, 2019, a birth certificate or a marriage contract.

m. If there is a need for additional entries and the space would not be enough, a separate blank sheet shall be properly labelled with patient's name, hospital number, birth date, date of consultation/admission. It will be called an addendum as part of the chart.

n. No abbreviations shall be used in writing the final diagnosis of the patient in the clinical cover sheet, discharge summary, clinical abstract, operative record and medical certificates. Only abbreviations and symbols approved by the World Health Organization (WHO) and the medical center chief upon the recommendation of the Patient Health Records Committee (PHRC) are allowed.

o. Documentation using forms specific/ unique to use for clinical departments, nursing service and other allied services shall follow the standards in completion as agreed upon by their specific departments/units/ special areas that utilize the forms. As such HIMD staff shall evaluate the form as to completeness and legibility and not to relevance of content.

p. Drug orders shall be clearly written in the health record by the attending physician.

q. Therapeutic and special diagnostic test orders shall be reflected in the health record.

r. Progress notes, observations, and consultation reports shall be written by the physician, as well as by the nursing and allied staff of the health facility.

s. When a patient is transferred to another facility, a certified copy of discharge summary and an accomplished original copy of referral notes shall be issued.

t. A discharge summary for each patient shall be completed upon patient discharge and shall include but not limited to discharge diagnosis, procedures performed, follow up arrangements, therapeutic orders (home medications), and patient home instruction/s.

u. In the processing of Certificate of Live Birth, the health facility shall be responsible for its transfer to the Local Civil Registrar within 30 days.

v. When an autopsy is performed, a provisional diagnosis is made. Final diagnosis shall be noted in the health record within 72 hours after the occurrence of death. A copy of the autopsy report shall be filed in the health record.

w. The health facility shall develop an ongoing review of health records to assure quality documentation. This shall be one of the major duties of the Patient Health Records Committee (formerly known as Medical Records Committee.)

3.2.3 Standard 3: Health Record Storage and Safekeeping

3.2.3.1 Specific Standards

a. The health facility safeguards the health records against loss/destruction or unauthorized use.

b. Inactive records are transferred to inactive filing storage to give way to the incoming records, decongest the area, and to facilitate retrieval.

c. The Integrated Hospital Operations Management Section (IHOMS) is responsible for the storage of health records on the server.

d. Inherent to health records is the ability to be retrieved for any authorized use. A good retrieval system reflects the efficiency of the HIMD.

e. An adequate filing area that ensures the speedy location and retrieval of health records must be maintained.

f. Refer to Chapter 2, Administration and Management of HIMD on the specifications on Physical Facilities and Equipment and Chapter 4, Health Records Systems and Procedures

3.2.3.2 Specific Policies

a. The health facility shall be responsible for providing the HIMD with appropriate office space and storage area with consideration for the health and safety requirements of staff, and (specifically for storage area) with proper environmental controls and adequate protection against fire, flood and theft.

b. Health records in whatever form or media, shall be kept by the health facility for the duration of time required by the Department of Health's records retention regulation mandated by Republic Act No. 4226 or the Hospital Licensure Act.

c. Health records shall not be taken out of the hospital premises except on court orders.

d. The health facility IHOMS shall be responsible for ensuring an efficient and effective program for HIMD, with provisions for back-up and records recovery and security measures.

e. All health records that are not in the processing stage and not in use shall be placed in the file/storage area.

f. Health facilities shall adhere to the provision of Department Order No. 13-A, Art. III, Rule 2.2, which states that, "*Agencies shall not dispose of their health records earlier than the period indicated for each record series. However, records may be retained for longer periods if there is a need to do so."*

g. Disposal of health records shall be guided by the latest Records Disposition Schedule as issued by the National Archives of the Philippines.

3.2.4 Standard 4: Health Record Accessibility

3.2.4.1 Specific Standards

a. Health records are readily accessible to facilitate patient care, are kept confidential and safe, and comply with all relevant statutory requirements and codes of practice.

b. Information privacy, confidentiality and security, including data integrity, shall be strictly observed.

c. Health information may be released by the health facility without the written

authorization of the patient in the following situations:

1. Court order
2. Administrative agency order
3. Subpoena duces tecum
4. Subpoena ad testificandum
5. Subpoena mandamus
6. Arbitration order
7. Search warrant

3.2.4.2 Specific Policies

1. **Access to Health Records**

   a. The health facility shall have a filing system maintained in a definite sequence at all times to facilitate accessibility and prompt retrieval of the health record.

   b. A patient's request to access his record may not be allowed to prevent misinterpretation of technical medical information which may lead to complaint/litigation. However, the patient's physical and mental condition shall be explained to him by his attending physician.

   c. Physicians access to health records:

      - Physicians and members of the allied health profession may review records of patients presently under their care.
      - Physicians who are members of the medical staff but are not members of the team assigned to the patient, shall require a written authorization signed by the patient/parent/guardian and the Attending Physician, before they are given access to the record.
      - The privilege against disclosure belongs to the patient and not to the Attending Physician (AP).
      - The health facility management may withhold access to the health record until a subpoena is issued.
      - Consent from the patient and Attending Physician shall be required of company physicians presently caring for the patient before giving access to health records.
      - Visiting consultants shall have access to records of patients referred to them.
      - It shall be the responsibility of the attending physician to inform his patient about the latter's health condition.

- Members of the Medical Staff may review charts of readmitted patients for continuity of care with verbal or written consent of the main Attending Physician from the last admission/consultation.

d. Nurses access to health records:

- Student nurses shall have access to health records of patients assigned to them while the patient is still in the ward.
- Private Nurses shall only be allowed to review the health records of those patients assigned to them.
- Ward nurses may review and complete all health records before forwarding them to the Health Information Management Department.
- Ward nurses must always see to it that health records are in a secure place away from the patients or the patients' relatives.
- Ward nurses shall be liable for the loss of a patient's health record while the patient is still admitted, and for the health records of discharged patients which have not yet been forwarded and endorsed to HIMD.

e. Other Interested Parties

- An authorized insurance verifier shall be required to submit an original copy of the patient waiver, duly notarized, before given access to the health record/information about a patient. The waiver shall also be countersigned and dated by the insurance verifier, and shall be filed in the health facility. Insurance verifiers representing the Philippine Health Insurance Corporation and other Health Maintenance Organizations shall be properly identified by the Head of the HIMD before being given access to review health records.
- Authorized researchers from other medical institutions could gain access to health records only after complying with the requirements set by the concerned institution.
- Patients' relatives making inquiries about the health status of their patients shall be referred to the attending physician.
- Adjudicatory agencies, i.e., Philippine National Police, National Bureau of Investigation and other law enforcement agencies shall need a written request duly signed by the Chief/Director of their respective agencies before being given access to the record.

2. **Exceptions to the Policy on Access to Health Record**

Instances where information contained in health records may be released without proper authorization from the patient shall be limited to the following cases:

a. **Court Order.** Hospitals and other health facilities shall release health information in response to court orders.

b. **Administrative Agency Order.** A health provider shall release health information when there is an adjudicative order from an administrative agency.

c. **Subpoena Duces Tecum** or **Order.** Subpoena Duces Tecum or order directs the head of the HIMD or his authorized representative to appear in court on a specified date and time to certify as to the authenticity of health records submitted as evidence.

d. **Subpoena Ad Testificandum**. Subpoena Ad Testificandum mandates physicians and other allied health professionals to deliver oral testimony in court. The document shall be served personally to the individual named therein, NOT to any member of the HIMD Staff.

e. **Subpoena Mandamus.** Subpoena Mandamus is a judicial order that mandates a health facility to present a health record in court.

f. **Arbitration Order.** An arbitration panel may issue an order authorizing a health facility to present specific portions of the health record before an arbitration proceeding.

g. **Search Warrant.** A government law enforcement agency which has issued a search warrant shall be entitled to receive any health information covered by the warrant.

h. **Medical Research.** Refer to standard 7 of this chapter.

i. Refer to Chapter 6 for Health Records in Medico-legal, Investigative and Court Procedures

3. **Review of Health Records**

a. A written letter of request or a data request form shall be accomplished by the reviewer before given access to the health records

- City Government
- RESU
- Provincial Government
- PHIC and DOH licensing inspection
- Medical Audit Committee Investigation
- Complaints from Clients

b. Insurance verifiers shall be required to submit a notarized original copy of the waiver signed by the patient/or his/her authorized representative before being given access to the health record of a patient.

c. DOH RESU staff are allowed to review charts of cases reported to them as per RA 11332; a data request form shall be accomplished before they are given access.

4. **Accession and Borrowing of Health Records**

    a. As a general rule, NO health records shall be brought out of HIMD except for legitimate purposes by legitimate requestors.

    b. Legitimate requestors shall include the Main Attending Physician, Chief Resident, Head Nurse as per old chart to floor, Researcher and/or Principal Investigator, Chairman Medical Audit/ Quality Assurance Committee, PhilHealth Section of the health Facility, Disease Surveillance Officers, Medical Center Chief, Assistant Hospital Director for Health operations and Chairmen of Investigation Committees.

    c. HIMO personnel shall seek permission from the last main attending physician based on records if a new physician would want to be given access to the said record.

    d. Physicians and allied health professionals may review records of patients presently under their care. If a patient is co-managed, the main attending physician shall be notified either by phone or in writing before permitting the borrower to access the health record.

5. **Release of Health Information**

    a. All information in the health record shall be treated as confidential and shall be safeguarded against loss, destruction and unauthorized use.

    b. Only authorized persons shall be given access to health records with personal and sensitive personal information.

    c. Patients may not be allowed to access their health records to prevent misinterpretation of medical information which may lead to complaint/ litigation.

    d. Patients' relatives making inquiries about the health status of the patient shall be referred to the attending physician.

    e. Release of information with clinical value shall be done with the consent of the physician in charge to prevent misinterpretation

    f. Verbal requests for clinical information shall be discouraged in favor of a written request.

    g. The health facility shall safeguard all information contained in the health record against loss, destruction, or unauthorized use.

    h. It shall be the policy of all health facilities not to use the health record in any way that will jeopardize the interest of the patient. Conversely, the health facility may use the record to defend itself against any complaint or legal controversy/case.

    i. The authority to release information is delegated to the Head of the Health Information Management Department. In instances where a problem arises beyond his/her control, the matter shall be referred to the Chief of Medical

Professional Staff/ Chief of the Health Facility, for decision/appropriate action.

j. Where the patient is a minor, parental consent or that of the legal guardian shall be secured before any information of clinical significance is released.

k. The health record is the physical property of the health facility. However, the patient has a right to the record since its content concerns his/her own clinical information. As such, release of information with clinical value shall be done only upon explicit, written consent/waiver from the patient.

l. In cases where litigation is likely to happen and is intended against the health facility or any of its staff, the Chief of the Health Facility may refuse or deny access to the record even with the patient's written authorization, except on court orders.

m. The issuance of Certificate of Confinement signed by the HIMD head for patients still admitted and Medical Certificate to patients who are still confined with a working diagnosis approved and signed by the Attending Physician for legitimate purposes.

n. Certified photocopies of portions of the health record may be released upon patient's request, but shall be limited to discharge summary, clinical abstract, laboratory and diagnostic results and report of operation.

o. No portion of the health record shall be reproduced, printed, photographed, photocopied or created in any manner without the explicit, written consent by the patient or parent/s or guardian of the patient if the latter is a minor, and/or approval by the HIMD Head.

p. In the event the patient is unable to sign the authorization by reason of physical or mental disability, the authorization should be signed by the next of kin or the legally appointed guardian. If possible, verification of such disability should be obtained from a physician.

q. If the patient has died, the consent must be signed by the identified next of kin, or by the administrator or executor of the decedent's estate.

r. Institutional policy referenced in the provisions of the Data Privacy Act of 2012 shall be considered before the release of non-clinical information, i.e., name of patient, address, Attending Physician, name of relative staying with patient during admission, admission and discharge dates.

s. The health record shall not be taken out of the health facility premises except on court orders. Those authorized to do research and studies shall use the records inside the HIMD Office.

t. Incomplete health records shall be referred to the Attending Physician before entertaining any authorized request to access and review the health record.

u. The staff of the Medical Social Service shall have access to the health records for purposes of establishing patient classification and referrals.

v. Death Certificates shall be released only to nearest kin. The person who claimed the death certificate shall be responsible for the LCR registration within 48 hours after death.

w. Information may be released to other health facilities where the patient is now under their care, upon the facility's written request.

6. **Health Information and Aggregate Data Requests**

a. The Data Privacy Officer shall verify the authenticity and purpose of the request for the health data and shall have the authority to approve and disapprove.

b. Legitimate requestors shall fill out the data request form stating the purpose and indicating the sole and exclusive use of the data.

c. Legitimate requestors shall not in any case reproduce, distribute and/or publish the data and shall properly and securely dispose of the same after use.

d. Disclosure of Health Information to legal authorities or any government agency may only be allowed pursuant to lawful order of a court or upon presentation of a written request duly approved by the head of the health facility or any authorized representative.

3.2.5 Standard 5: Health Record Report Generation

3.2.5.1 Specific Standards

1. The data and information needs of those in and outside the hospital are met on a timely basis in a format that meets user expectations and with the desired frequency.

2. The organization provides resources for data generation, collection and aggregation methods.

3. For Health Facilities using iHOMIS or other information systems, all data needed for statistical report preparation shall be electronically recorded and generated, hence manual collection of data is no longer necessary.

4. Refer to Chapter 5 on Hospital Statistics and Annex for the list of Standard formulas

3.2.5.2 Specific Policies

1. All diagnoses and surgical/medical procedures in the health record shall be properly and accurately following the International Classification Standards for generation of statistical reports using quality statistics data.

2. All hospitals shall adhere to RA 4226 otherwise known as the "Hospital Licensure Act" by ensuring that the Hospital Statistical report is prepared and submitted to

regulatory agencies in accordance with set standards.

3. Generation, preparation and submission of hospital statistical reports shall emanate from units concerned where data are captured and encoded. All units shall submit all needed reports to HIMD without delay.

4. Each department/unit shall have existing mechanism and work instructions in the collection of data for every service encounter for required reports

5. All hospitals shall abide with AO 2013-0005 or the National Policy on the Unified Disease Registry System of the DOH based on the final diagnosis for each health record received. HIMD is obliged to report online all reportable cases for UDRS and shall maintain a log of reported cases for legitimate purposes

6. Statistical data that can be generated collated by respective departments and units shall not be limited to required reports in the Annual Hospital Statistical Report required by the Department of Health

3.2.6 Standard 6: Continuous Quality Improvement

3.2.6.1 Specific Standards

1. Data from the patient charts are routinely collected, aggregated and reported for use in quality improvement activities and for administrative purposes enhancement and mandatory reporting to the DOH and PhilHealth.

2. As part of its monitoring and performance improvement activities, the hospital regularly assesses patient health record content and completeness.

3. Refer to Chapter 8 on the Continuous Quality Improvement for HIMD

3.2.6.2 Specific Policies

1. Quality improvement activities shall be evidence-based and shall utilize the risk-based approach.

2. HIMD shall pursue CQI to:

   - Strengthen the implementation of the existing SOPs of HIMD;
   - Provide quality health records for the continuity of care and for research purposes; and
   - Assess and determine the quality of service delivered and to identify the areas that need improvement to attain excellent service.

3. The results of the implementation of QI activities and continuous monitoring using relevant indicators by HIMD shall be integrated in iHOMIS or their existing hospital information system, and utilized in decision-making.

4. The health facility's Integrated Hospital Operations Management Program shall extend full assistance to HIMD to coordinate continuous improvement efforts.

5. HIMD shall undertake a continuous improvement of its processes to improve quality of service to patients.

3.2.7 Standard 7: Medical Research

3.2.7.1 Specific Standards

1. There should be a unified and clear guideline in the data gathering procedure for approved research and clinical trials in the health facility.

2. Principal investigators for institutional researchers and outside physicians intending to do research may be given access to review health records of patients enrolled in their study provided the research has been approved by the Research Ethics Committee (REC) of the health facility.

3. The health facility shall safeguard all information contained in the health record against loss, destruction or unauthorized use.

4. Hospital Management may, at its discretion, permit the use of health records for research, stressing that no information which will directly identify the patient shall be published.

5. Anonymity for respondents/participants is assumed to be an integral feature of Ethical Research.

3.2.7.2 Specific Policies

1. Health information shall be disclosed to public agencies, clinical investigators, Healthcare organizations or accredited education or health institutions for purposes of bona fide research.

    a. Regulatory body – They can access health records of research related information, sourced document data in relation to their role as regulatory body. Upon request of the monitor, auditor, IRB (Institutional Review Board)/REC or regulatory authorities, the Investigator/Institution should make available for direct access all requested trial-related records.

    They shall advise the HIM Department on any incoming activities for readiness of the health records to be accessed

    b. Clinical Research Monitors/Associates – May have access to personal health information which is acceptable based upon the inclusion of one or more of the following controls: The Institutional Review Board (IRB) or Ethics Committee approves informed consent signed by the patient or their legal representative, including the authorization for access to Protected Health Information (PHI).

    The Informed Consent Form should explicitly state the following:

    - The Confidentiality of information collected during the clinical trial
    - How records that identify the subject will be kept
    - The possibility that the FDA or other authority may inspect the records

The Informed consent form that is signed and dated by the subject is valid.

- Authorization signed by the patient or their legal representative grants access to their PHI.
- They are to ensure security of patient information by signing the Non-Disclosure Agreement prior to its access.

c. Internal researchers shall seek the approval of the hospital management prior to access to health records and shall follow the HIMD protocol on access.

- A Non-Disclosure Agreement (NDA) shall be executed by the staff who have access to health information and/or involved in the processing of personal data/health information.

d. External Researchers/Physicians from other medical Institutions intending to do research/studies in a particular health facility shall seek the written approval of the management before they are given access to the health record.

- All information in the health record shall be treated as confidential and shall be disclosed only to authorize individuals.

2. Consent from the data subject shall be required prior to the processing of health information in all health facilities.

3. An approved informed consent document signed by the patient or his/her legal representative includes the authorization for access to Protected Health Information (PHI); and must contain the following:

   a. The name and signature of the patient authorizing the release of medical information,

   b. The date of the written authorization,

   c. The name of the individual or organization that is authorized to release the medical information,

   d. The name of the designated representative (individual or organization) that is authorized to receive the released information,

   e. A general description of the medical information that is authorized to be released.

4. Confidentiality of patient's data shall be maintained at all times and shall be used only for the declared purpose stipulated in the patient authorization/consent.

5. Access of Information with clinical value shall be done only with the written consent/waiver from the patient.

6. Where the patient is a minor, a parent's consent or that of a legal guardian shall be secured before any information of clinical significance is accessed.

7. Health care providers directly attending to the patients and authorized entities shall have access to the patient's health information provided that there is an accomplished consent form from the patient.

8. Consenting patients or clients shall have the right to access information on how their personal data/health information is used. The health facility shall ensure that disclosures and any subsequent changes are in accordance with the law and are properly documented.

    a. The health facility/HIMD shall ensure that the research is legitimate and shall safeguard all information contained in the Health Record against loss, destruction or unauthorized use.

        - Hospital Management may, at its discretion, permit the use of health records for research, provided that no information which will directly identify the patient shall be published.

        - A copy of the approved protocol by the Institutional Review Board (IRB)/Research Ethics Committee that contains the patient authorization/consent shall be submitted to HIMD to ensure legitimacy of access to patient information.

        - Health records shall not be taken out of the health facility except on court orders. Those authorized to do research and studies shall use the records inside the HIMD only.

        - No cameras in any form shall be authorized inside the HIM Department while doing research.

    b. It shall be the policy of all health facilities not to use the health record in a way which will jeopardize the interest of the patient.

        - The rights of the data subject shall be respected and protected at all times in processing data.

        - For the processing of health information, the processor shall ensure utmost protection of the right to privacy of an individual.

        - Processing of personal information shall be held under strict confidentiality and shall be used only for the declared purpose.

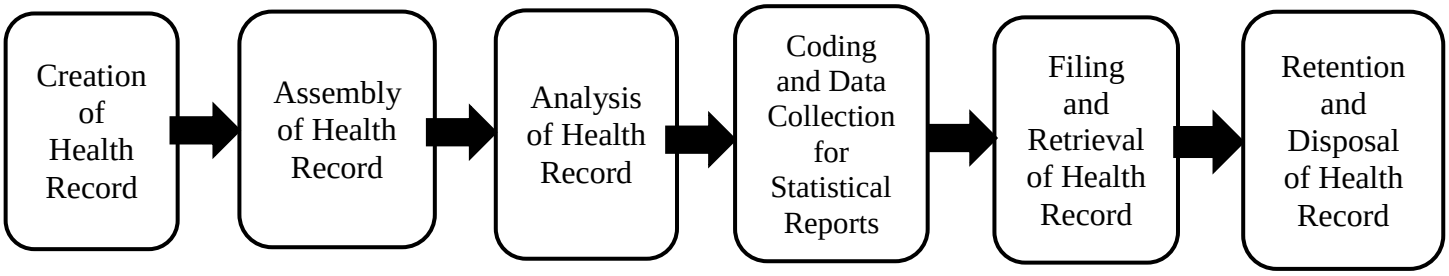
        - In processing health information for research, research institutions/individuals shall comply with the legal and ethical standards in accordance with the National Ethics Guidelines for health and health related research and other pertinent rules and regulations.

CHAPTER 4

Health Record Systems and Procedures

An effective and efficient health record system depends on the systems and procedures used for facilitating and handling of health records. In managing patient's health records in hospitals, the following procedures are done in sequence: creation, assembly, analysis, coding and data collection for statistical data, and filing.

Figure 8. Process Flow of Health Record.



4.1 Creation of Health Record

The creation of a health record through patient registration is the first step to establish patient identification for safe, accurate, effective and efficient patient care. All patient's personal information needed for patient care shall be obtained and reflected in the health record.

4.1.1 Health Record Identification System

Two things are highly considered in identifying health records. First is the correct and complete name of the patient and second is the assigned health record number (HRN).

The patient's name is recorded in the following manner: last name, first or given name (including extension names, e.g. Jr., III, etc.) and middle name as a way of alphabetically identifying a health record. While, the HRN is assigned to a patient upon admission or consultation which serves as a unique numerical identifier for a particular patient for effective management of health records.

The use of a unit number to uniquely identify a patient has a direct influence on the filing system for prompt and timely retrieval of health records. In order to avoid duplication and discrepancy, a unique record identification is needed whether in alphabetic or numeric.

4.1.1.1 Alphabetic System

Alphabetic System is the simplest form of record identification, using the patient's name to identify and file the patients' health record.

In filing patients' names, the arrangement is as follows: last name, first or given name and middle name. In cases where the last names are the same, consider the first name and if the last and given names are the same, the middle name is to be noted. If the aforementioned has already been applied, arrange the patients' records by birth date. (Refer to *4.6 Filing of Health Record* for further discussion.)

4.1.1.2 Numerical System

Numerical System has a direct influence on the filing system. Upon admission, the patient's unique Health Record Number shall be assigned. The use of a Master Patient Index (MPI) to cross-reference the patient's name with their HRN is required.

Two main systems of numbering the patient health record:

1. **Serial Numbering**

   Under this method, the patient receives a new number on every inpatient admission or out-patient visit to the health facility. That is, the patient is treated as a new patient each time with a new number, new index card and new record, filed totally independent from the previous health records.

   Serial numbering is only useful in a small health facility with a low daily census (rate of re-admission).

2. **Unit Numbering**

   The patient shall be assigned a unique identification number or HRN on his first contact with the health facility, whether it is for an admission, emergency room attendance or outpatient clinic visit, including the new-born babies delivered in the health facility. The use of unit-number leads to the implementation of a unit record. Irrespective of the number of records a patient has, his/her health records are filed in one folder only.

   The same number is maintained and used on all subsequent visits, whether as an inpatient, outpatient, or emergency patient. Having one number assigned per patient and only one Master Patient Index card results in easier access to the patient's health record.

   When using a unit record, it is essential for all HIMD staff to check the MPI before issuing a new health record folder.

   Advantages of Unit Numbering

   - Provides an integrated overall picture of a patient's medical history because all records of admissions, visits and encounters are maintained in one folder only, commonly known as a unit record.

- Eliminates the task of gathering separate parts of a patient's health record together, like in the serial system where a new number is given to a particular patient after every admission or visit.

- Eliminates the task of transferring the previous health record to the new location and assigning a new admission number.

The Unit Number. A patient who is admitted or attended as an outpatient, or on an emergency basis including a newborn baby is issued a six-digit identifying number. This is the patient's unit number also called the Health Record Number (HRN).

The HRN is grouped into three sets of two-digits. These are referred to as the primary, secondary and tertiary numbers.

Example of a unit number:

16	*55*	*82*
Tertiary	*Secondary*	*Primary*

Assignment of the Unit Number. The collection of patient data and the assignment of the HRN should be the first step in every admission or visit to a health facility and it is done at the Admitting Office/Outpatient Department (OPD). This facilitates the retrieval of properly identified documents.

Two ways by which numbers can be assigned:

a. ***Centralized Assignment of Numbers.*** The responsibility for number allocation is retained at the Admitting Unit in coordination with the HIMD.

b. ***Decentralized Assignment of Numbers.*** Predetermined blocks of numbers are issued to the Admitting Office/OPD. This is done by the hundreds, depending on the projected number of patients for the day. This process should be done with utmost care as chances of duplication are greater compared to when only one area is in charge of assigning patient numbers.

Six-digit numbers are used ranging from 00-00-00 to 99-99-99. The very first health record received by the HIMD shall be numbered 00-00-00, the second health record, 00-00-01, and so on, until the first hundredth record, which shall be numbered 00-00-99, is reached. The record after this shall be numbered 00-01-00, the next, 00-01-01, followed by 00-01-02, and so on until it reaches 00-01-99. Next shall be 00-02-00 to 00-09-99 then from 00-10-00 to 00-99-99, next 01-00-00 until 99-99-99. If the six-digit numbers are already used, the numbers will expand to 8 digits and so on (e.g., 01-00-00-00)

Numbering of the records shall be done serially and the necessary digits are added to complete the required six digits. An HIMD maintaining a centralized health records-keeping system must keep numbering patients regardless of whether the health record is for in-patient or for out-patient. The HIMD with a decentralized health records-keeping system shall maintain a separate number for an in-patient, out-patient record, and E.R. patient's records.

From the time the HIMD starts implementing the unit numbering system, the last health record that you receive on any given day plus one (1) shall represent the total number of patients that the health facility has served. Hence, if the last number assigned is 00-20-99, the health facility already has served a total of 2,100 patients.

4.2 Assembly of Health Record

4.2.1 Inpatient Health Record Assembly

The clinical departments may adopt arrangements based on their needs while the patient is still under their care/management. But upon the patient's discharge, the nurse on duty should arrange the chart according to the standard chart arrangement before forwarding it to the HIMD. The received health records should be recorded and indexed (MPI) prior to assembly.

In assembling the health record, the forms are arranged in the order upon admission of the patient to give the Attending Physician and other healthcare staff who shall handle the health record, a clear picture of the condition of the patient in its chronological order.

A. Source Oriented Health Record

This is the conventional form of arranging the health record. The patient's health record is organized in sections according to the patient care department which provides care and the corresponding diagnostic results as the case may be. The health record is arranged in reverse chronological order for the convenience of the doctors in the ward and those forms frequently used appear on top of the file of forms. Upon the patient's discharge, the HIMD re-arranges the health record based on the approved sequence or arrangement.

B. Problem Oriented Health Record

Problem oriented medical records or the "POMR" is another form of structured health record. First developed by Dr. Lawrence Weed in the USA in the late 1970s, and is structured as a total approach to patient care. It prompts the staff to take a comprehensive and structured look at a patient's problem and treatment. It requires health professionals to approach all problems of a patient, treat each problem individually in its proper context within the total number of problems, and the inter-relationship of the problems.

This is the most logical format of arranging the health record and it is computer-based and research-based as well. The four basic components of this format are as follows:

1. **Database - Collection of data**

   The database includes the following information:

   - Chief complaints
   - History of the Present Illness
   - Patient's profile
   - Past history and review of the system
   - Physical examination results
   - Base-line laboratory plan

2. **Problem List - Formulation of problems**

   A problem list is a mere listing of all the problems which need medical management. Problems are numbered and titled from the most to the least severe complaint of the patient. The list may include anything that requires management from the past to social, economic, and demographic problems. It may also contain a statement of a symptom, an abnormal finding, a physiological finding, or a specific diagnosis. Additions or changes are made in the list as new problems are identified and active problems resolved.

3. **Initial Plan - Development of a care plan**

   The initial plan describes the steps to be taken in order to learn more about the patient's condition, the treatment to be applied, and ways to educate the patient about his physical condition.

   Specific plans for each problem are delineated and fall under three categories:

   - Diagnostics – plans for collecting more information
   - Therapeutic – plans for treatment
   - Patient education – plans for informing the patient on what is to be done

   Problems are dated, numbered and titled with the problem status clearly defined as active, inactive or resolved.

4. **Progress Notes - Numbered and titled progress notes**

   The progress notes are follow-ups for each problem. Each note is preceded by the number and title of the appropriate problem and may include all of the following elements:

   - Subjective (symptomatic)– written in the patient's own words.
   - Objective (measurable, observable) – doctor's observation and test results.
   - Assessment (interpretation or impression of the current condition)
   - Plan statements for contained treatment.

   The acronym for this process is SOAP, and the writing of progress notes in the POMR format is often referred to as SOAPING.

   The emphasis is on unresolved problems. A slightly different way to describe the patient's progress, other than the narrative method mentioned, is through the use of flow sheets. Flow sheets are recommended in situations where several factors are being monitored or when the patient's condition is changing rapidly.

   The discharge summary and transfer note are also included in the progress note category. These should address all the numbered problems on the patient's list. It may be necessary for the physician to use an overall summary and use flow sheets to clarify the patient's progress. It is recommended that certain forms (e.g. physician's orders, consultant's reports, and nurse's notes) be done in the problem–oriented style with reference to titled and numbered problems. Other data in the record may be in the conventional format, such as laboratory and operative reports.

C. Integrated Health Record

In the integrated format, the information is organized in strict reverse chronological order, with the most current entries at the beginning of the health record. The forms from various sources are intermingled, thus, history and physical examination may be followed by a progress note, a nurse's note, an x-ray report, a consultation, and so on. The forms for each episode of care are organized in separate sections of the record.

Table 2. Advantages and disadvantages of the types of health record assembly.

SOURCE ORIENTED	
ADVANTAGES:	**DISADVANTAGES:**
● It is easy to determine the assessment, treatment and observations which a particular department has provided. ● Most health professionals are familiar with this conventional or traditional way of arranging the health record. ● This results in prompt and easy retrieval of needed data/information.	● Prompt determination of all the patients' problems is not facilitated promptly. ● All treatments provided to the patient cannot be determined easily.
PROBLEM ORIENTED MEDICAL RECORD	
● Physicians are required to consider the patient's problems in its total context. ● The record clearly indicates the goals and methods of the physician in treating the patient. ● Medical education is facilitated by the documentation of logical and thorough processes done by the attending physician. ● Quality assurance process is easier because the data is logically arranged.	● The format usually requires additional training for the medical and professional staff. ● To be effective in a facility, a significant number of physicians must be convinced of the system's worth or at least must be willing to try it.
INTEGRATED HEALTH RECORD	
● All information on a particular episode of care is in a single file, thus, providing a clear picture of the patient's illness and response to treatment. ● A patients' progress can be determined promptly because the current notes of all disciplines are incorporated in one file. ● The number of specialized forms is reduced. ● The team concept of health care is encouraged.	● It is difficult to compare similar information over a series of admissions because the reports are not in the same section as that of the record. ● Only one person can document at a time. ● It may be difficult to identify the professions/positions of the individuals making the entries unless notes are always followed by the title of the record.

Upon receipt of the health records from the different clinical wards, the HIMD staff should check and assemble the patient health records according to the approved sequence of arrangement by the Patient Health Records Committee. *Refer to Chapter 3 for the Standard health record arrangement*.

4.2.2 Outpatient Health Record Assembly

Outpatient visits are documented in an outpatient record/card with a health record number assigned. They should be arranged chronologically in ascending order. If there are diagnostic results, other procedures performed, and records from previous confinement should be based on the standard sequence. All diagnostic results may not be attached in the outpatient record, instead results should be recorded.

4.2.3 Emergency Health Record Assembly

Emergency patients are identified in the same manner as inpatients and outpatients with the same health record number (HRN). If the patient is admitted, the record should be attached to the inpatient record, if not, it should be forwarded to the HIMD Outpatient Record for filing. Those ER health records of medico-legal cases should be filed in a secured locked filing area.

4.3 Analysis of the Health Record

After recording and assembly, the health record undergoes the process of analysis. The health information analyst shall perform two kinds of analysis, quantitative and qualitative.

One of the most important functions of the HIMD is the health record analysis to ensure maintenance of quality documentation.

The health record reflects the quality of care rendered to patients. As such, at any point in time during admission and consultation, the record should accurately and clearly document the care provided.

The HIMD is responsible for assisting the members of the medical and allied medical staff in identifying deficiencies to correct errors and omissions. Analysis is the process of evaluating and/or checking health records to ensure completeness, accuracy and adequacy of documentation. Both quantitative and qualitative analysis should be performed on the health record.

In the analysis of health record, the general documentation guidelines used to ensure quality documentation are as follows:

1. There must be a health record for each patient confined/treated in the health facility.
2. Documentation in the health record must reflect the patients' physical condition, and the orders and care provided from admission to discharge.
3. Documentation must reflect observation and must be objective and non-judgmental.
4. A unit record must be maintained for each patient. This shall include all admissions and consultations to the health facility, discharge summaries and quality documentation by the physician and other inter–disciplinary team members who participated in the care of the patient.
5. Any person making an entry on the health record must affix signature and date to properly authenticate the entry made.

6. Documentation of the inpatient health record must be completed within 48 hours upon the patient's discharge. History and Physical Examination must be completed within 24 hours upon admission of the patient. However, outpatient health records must be endorsed to the HIMD daily.
7. Every health facility must develop an ongoing review of health records to assure quality documentation. This must be one of the major functions of the Patient Health Records Committee.
8. It must be the policy of every health facility not to allow the use of abbreviations in writing the diagnosis. But for symbols which might be written by the authorized person, an explanatory legend shall first be approved by the said health facility.
9. Short forms like laboratory and other results must be securely attached to the health record to prevent loss, and/or pasted on an official form for proper filing. May consider to paste on an official form for proper filing.
10. The health record is a legal document. No form maybe detached once it is filed. Furthermore, there must be no erasures of any sort. In order to correct an error or insert missing entry, the following shall be done:
    a. Draw a single line through the information to be corrected or changed.
    b. Write the correct entry near the information to be corrected.
    c. Affix the attending physician's/nurse's initial, date and time.
11. In cases where the patient wants some data corrected, especially on the demographic/ sociological data, the correction should not be done on the original entry, but shall appear as an amendment using official form. Corrections can only be done while the patient is still confined. It is important to require a Valid Identification (ID) Card/ Identity document listed under PSA Memo Circular No. 2019-16 dated June 11, 2019, a birth certificate or a marriage contract, as an attachment.
12. The health records must contain all original copies of examination results, operations, and other required forms.

The inpatient health record must be completed and it must include the following parts properly accomplished, signed, and dated:

1. ***Admission and Discharge Record/Clinical Cover Sheet/Face Sheet,*** which includes personal data like name, address and other social data;
2. ***Admitting and final diagnosis***, as well as a description of any operation and procedures performed and disposition and results upon discharge;
3. ***Medical /Clinical abstract*** which contains chief complaint, brief clinical history, pertinent diagnostic examinations and diagnosis;
4. ***History sheet*** which contains the chief complaint, personal and family history (past and present), including obstetrics history for women;
5. ***Physical examination sheet*** contains all pertinent (positive and negative) findings and impressions;
6. ***Physician's order*** contains all of the doctor's orders; (Note: This form may also contain progress notes that may be referred to as ***Physician's order and Progress Notes***)

7. ***Diagnostic and other report sheet*** contains the results of all laboratory, radiologic and other procedures;

8. ***Progress notes sheet*** includes the doctor's positive and negative observations and comments. It gives a chronological picture of the clinical condition of a patient;

9. ***Discharge summary*** summarizes the significant findings and events occurring during the patient's hospitalization, final diagnosis, operation (if performed), complications (if any), condition on discharge, recommendations and arrangements for future care (OPD, follow-up treatment), and classification of injury (if it is a medico-legal case);

10. ***Anesthesia record*** (if an operation was performed);

11. ***Report of operation records***, which authenticate a pre-operative diagnosis before surgery. The record shall then contain a report of all findings, a description of the surgical technique used, a description of any "tissue" removed, and a post-operative diagnosis;

12. ***Nurses' notes,*** which contains observations of the patient the treatment given, the response to treatment, and any unusual occurrences, medication and/or instructions and the advice for follow-up consultations;

13. ***Consent and waivers*** with signature over printed name/thumb mark of the person giving consent including witness;

14. ***Certificate of Live Birth, Fetal and Death Certificate***, if either of these events occurred; and

15. ***Other records*** that contain medication and treatment, monitoring sheets e.g., vital signs record, etc.

4.3.1 Quantitative Analysis of Health Record

After recording and assembly, the health record, whether inpatient, outpatient or ER patient, undergoes the process of analysis. The health information analyst shall perform the following:

1. Check basic forms required by the case.
2. Check all the forms which are explicitly ordered.
    - The analysis clerk shall read the physician's order and counter check it with the nurses' notes to confirm whether or not the order was carried out.
    - When the nurses' notes state so, the health information analyst shall see to it that the result of the order is attached.
    - The analysis clerk shall check on the explicitly ordered forms. (Forms included in a block)
3. The analysis clerk shall check all the required information.
    - Every page should contain the name, age, sex, room/ward number and HRN of the patient.
    - Every form shall be properly filled-up.
    - Accounts of all tests, treatments, and observations shall be reflected in the record.
4. The analysis clerk shall check all necessary authentications.

- Check whether all reports of treatment, medication, examination or evaluation of the patient were dated and signed by the person who made the report.
- Check if all orders were dated and signed.
- Verbal, telephone and Short Message Service (SMS) orders of the doctor received and written by a licensed nurse on the health record were signed and dated by the nurse and countersigned by the doctor as soon as possible.

5. Analysis clerk shall check if all necessary consents/waivers are attached to the health record.
    - Check if the consent/waiver was dated, signed by the patient, and signed by a witness
    - Check if special procedures performed had corresponding consent
    - If there was surgical intervention, check if there is surgical consent and completely fill-out corresponding OR Blocks.

4.3.2 Qualitative Analysis of Health Record

Analysis clerk shall check for errors or unexplained inconsistencies in health records of inpatient, outpatient and ER patient:

1. Check if every page contains the name, age, sex and Health Record Number of the patient.
2. Check spelling of names and correct Health Record Number.
3. Check if there are inconsistencies between one part of the record and another (e.g., if the pre-operative diagnosis differs from the post-operative diagnosis), the discrepancy shall be noted and/or referred to the attending physician.
4. Check if accounts of all tests, treatment and observations are reflected in the health record.
5. Check if all consultations are properly documented, signed and dated.
6. Check if the final diagnosis coincides with the diagnostic results attached in the health record.
7. When the analysis clerk finds an incomplete health record, a “Deficiency Slip” shall be attached and placed in a pigeon hole for completion.

4.4 Clinical Coding

Without complete and accurate documentation of health records, accurate coding cannot be achieved. Precise and meaningful health statistics are used by health implementers to plan and evaluate health programs. Likewise, these serve as an aid to assess the quality of care rendered and to make decisions about staff, facility and resource allocation.

Health records are coded to enable the retrieval of information in diseases and injury. This information is used:

- at a national level for planning a health facility

- in determining the number of healthcare staff required
- in educating the population and health risks within their country
- at the international level in comparing the health status of countries.

4.4.1 Steps in Coding

1. Locate the main term in the alphabetical index.
2. Refer to any notes under the main terms.
3. Refer to any sub-terms indented under the main term.
4. Follow cross-referencing instructions, if the needed code is not located.
5. Verify the code number in the tabular list.
6. Read and be guided by any instructional terms.

4.5 Collection for Statistical Data

4.5.1 From 24-hr Floor Census

Report of 24-hour Floor census is submitted to HIMD before 9:00 am by the nursing staff on duty together with the health record of discharged patients. Upon receipt, the HIMD should check the completeness and accuracy of the report. The number of admissions should tally with the census report submitted by the admitting section, and the number of discharges is the same with the number of health records attached to the report. *See Annex E for the Daily Floor Census Report.*

Collection of Statistical Data from 24-hr Floor Census Report

1. Check completeness of the 24-hr Floor Census Report.
2. Check the number of admissions from the report of the Admitting Section.
3. Check the number of discharges from the actual number of discharged patients including deaths.
4. Check for double recording of admissions, discharges, including transfer in and transfer out.
5. Count the number of patients admitted and discharged/ died on the same day.
6. Check and validate the computation on the summary of the census report.
7. Add the number of admitted and discharged patients on the same day to get the in-patient service day of care.
8. Consolidate the 24-hour floor census report in the Summary of 24- Hour Floor Census Report Per Ward. See Table 3 for the sample table.

9. All data generated from the Summary of 24- Hour Floor Census Report Per Ward should be indicated on the Summary of the Daily Floor Census Report for The Month**.** See Table 4 for the sample table.

10. Collect the needed data for the preparation of monthly/annual Statistical report e.g., Total No. of Census, Total No. of Admissions, Total No. of Discharges, Total No. of Discharges Alive, Total No. of Deaths, No. of patients admitted and discharged on the same day, and Total No. of in-patient service days of care.

11. Compute the average daily census, bed occupancy rate, bed turnover interval, and bed turnover rate for the month/annual, refer to *Chapter 5 Hospital Statistics for the Formula*.

Table 3 Sample

SUMMARY OF 24- HOUR FLOOR CENSUS REPORT PER WARD **DATE: _____**							
Line no.	PARTICULARS	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	TOTAL
1	Remaining last report						
2	Admitted						
3	Transferred-in from other Census Unit						
4	Total of Lines 1, 2 and 3						
5	Discharged						
6	Transferred-out to other Census Unit						
7	Absconded						
8	Expired						
9	Total of Lines 5, 6, 7 and 8						
10	Remaining at 12:00 midnight (L4-L9)						
11	Admitted and Discharged the same day						
12	Actual Inpatient Service Days (L10+L11)						

Table 4 Sample

SUMMARY OF DAILY FLOOR CENSUS REPORT FOR THE MONTH OF _____							
Line no.	PARTICULARS	1	2	→	31	TOTAL	Cumulative
1	Remaining last report						
2	Admitted						
3	Total of Lines 1 and 2						
4	Discharged						
5	Died						
6	Total of Lines 4, 5, and 6						
7	Remaining at 12:00 midnight (L3-L6)						

8	Admitted and Discharged the same day						
9	Actual Inpatient Service Days (L7+L8)						

Table 5. Processing of 24-hour Floor Census

Description	Person/Department Responsible	Interface/Form/ Document
1. Prepares and submit 24-hour Floor Census from each ward	Head Nurse	Daily Floor Census
2. Acknowledges receipts of the duplicate copy of the floor census	HIMD Staff	Daily Floor Census
3. Validates all floor census report into hospital daily census	HIMD Staff	Hospital Daily Census
4. Consolidates, collects and records data from the hospital daily census for statistical purposes	Statistician	Hospital Daily Census
5. Furnishes copy to the COH/MCC, CMPS, and Chief Nurse.	HIMD Staff	Hospital Daily Census
6. Files one copy of the hospital daily census	HIMD Staff	Hospital Daily Census

4.5.2 From Patient Health Record

It is important that prior to collection of data, the health record should be processed completely and should have ICD10 code/s. To facilitate an efficient and effective data collection, HIMD must have a sheet template or any similar form to use.

Collection of Statistical Data from Patient Health Record

1. Count the number of discharges per day, per service. Refer to floor census report.
2. Compute for the length of stay, exclude the date of admission. Example, if the admission date is Jan 1 and the patient was discharged on Jan 10, the length of stay is 9 days.
3. Consolidate all the length of stay of the discharged patients.
4. Count the total number of conditions on discharge as improved/recovered, transferred, HAMA, absconded, unimproved, and died of all discharged patients. (May include census on No. of consultation, No. of patients who died 10 days post-op, etc.)
5. Identify and count all deaths under and over 48 hours of all discharged patients.
6. All data collected on a daily basis should be summed up to come up with a monthly report.
7. All monthly reports should be summarized to get the annual report.

Note: The template below is just a sample format, this can be modified and improved depending on the need of the end user/statistician.

SERVICE: _____ MONTH: _____

DATE	No. of Patients	LOS	Condition on Discharge						
			R / I	**T**	**H**	**A**	**U**	DIED	
								<48 HRS	>48 HRS
1									
2									
3									
4									
5									
6									
31									
TOTAL									

4.5.3 Reports from other Services

1. Receives monthly reports from dietary, pharmacy, laboratory, radiology and other concerned offices.
2. Checks and validates the accuracy of the submitted report.
3. Consolidate data for the preparation of annual report.

Table 6. Preparation of Statistical Report

Description	Person/Department Responsible	Interface/Form/ Document
1. Collects and consolidates data from the different units/sections (pharmacy, laboratory, radiology, dietary, and other concerned offices) at the end of each month.	Statistician	Statistical report; reports of operating units
2. Computes for the required hospital indicators (e.g. bed occupancy rate, average length of stay, etc.) based on the collected data from the 24-hour hospital census report and health records.	Statistician	Statistical report; Reports of operating units
3. Determines the ten leading causes of morbidity and underlying causes of mortality.	Statistician	Statistical report
4. Validates hospital statistical report through coordination with the concerned units/departments and the Patient Health Records Committee.	Statistician/HIMD Head	Statistical report

5. Reviews and affixes initials on the hospital statistical report.	HIMD Head	Statistical report
6. Reviews and approves the statistical report and forwards with the transmittal letter to the COH for review and signature.	Chief Medical Professional Staff/Head of the Allied Health Professional Service	Statistical report and transmittal letter
7. Approves and signs statistical reports.	COH/Medical Center Chief	Statistical report and transmittal letter
8. Submits statistical report to DOH and through the Online Hospital Statistical Reporting System (OHSRS)	Statistician	Statistical report and transmittal letter
9. Retains a file copy of the report and transmittal letter.	Statistician/HIMD staff	Statistical report and transmittal letter

4.6 Filing of Health Record

4.6.1 Indexing

Indexing is essential for the protection of files and documents of large size. There are several indices used such as Master Patient Index (MPI), Disease Index, Operation Index and Physicians Index. The use of cards is the standard method for indexing, 3''x 5'' size of index card is used for MPI while 5''x 8'' is for Disease and Operation Index.
Records indexing is generated and maintained manually in the HIMD which may require additional cost for the health facility, therefore those with existing IHOMIS or other health information systems, these indices can be automatically generated and maintained or dispensed to save space.

4.6.1.1 Steps in Indexing

1. Provide an index card for every coded disease.
2. Record the ICD-10 code, disease and year for every Disease Index Card.
3. List down the following based on the patient's health record:
    a. Health Record Number
    b. Patient's Name
    c. Age
    d. Sex
    e. Other Disease
    f. Result
    g. Operation (if any)
    h. Date of Admission
    i. Date of Discharge
    j. Disposition/Result
    k. Attending Physician

4. When a particular card is filled-up, a new one should be added for filing in front of the old one.

5. When the year ends while a card is still unfilled, a line should be drawn under the last entry to show the cut-off date.

6. Index cards should be kept in file drawers.

4.6.1.2 Types of Indexes

1. **Master Patient Index (MPI)** is one of the most important tools in the Health Information Department.
   - It is the key in locating health records maintained in the file.
   - It serves to identify the patient and helps in the retrieval process of health.
   - The patient index is maintained as a permanent file.
   - MPI is maintained manually in a 12cm x 7cm or 3”x5” card.
   - It is filed in strict alphabetical order by the patient’s name.

   The minimum data requirements for the patient index card are as follows: the patient’s name, HRN, age, date of birth, sex, civil status, date of admission and discharge and the name of the physician.

_____
NAME OF HEALTH FACILITY

MASTER PATIENT INDEX

_____ _____
NAME: FAMILY FIRST MIDDLE Health Record Number

_____ _____ _____ _____
AGE DATE OF BIRTH SEX STATUS

ADDRESS: _____

ADMISSION	DISCHARGE	ATTENDING PHYSICIAN

2. **Disease Index** is a listing on a card for specific disease based on standard classification/nomenclature, arranged according to code number.

_____
NAME OF HEALTH FACILITY

CODE NO. DISEASE: YEAR

Health Record No.	Patient Name	Age		Civil Status	Address	Other Diseases	Result	Operation/ Procedure	Date/ Time Adm.	Date/ Time Disch.	Attending Physician
		M	F								

3. **Operation Index** is a listing on a card for a specific operation according to standard classification/nomenclature, arranged according to code numbers.

_____
NAME OF HEALTH FACILITY

OPERATION INDEX

CODE NO. OPERATION: YEAR

Health Record No.	Patient Name	Age		Civil Status	Address	Other Operating Procedures	Result	Diagnosis	Date/ Time Adm.	Date/ Time Disch.	Attending Physician
		M	F								

4. **Physician's Index** is a record of the work done and the results of treatment rendered by the physician practicing in the hospital or an index containing a list of all the patients a doctor has. These cards are filed alphabetically according to the doctor's name.

_____
NAME OF HEALTH FACILITY

PHYSICIAN'S INDEX

CODE NO. PHYSICIAN'S NAME: YEAR

Date	Health Record No.	Patient Name	Age		Civil Status	Address	Date/ Time Disch.	Days	Type of Service	Cons.	Result
			M	F							

4.6.2 Filing Systems

An effective and efficient filing system is a vital requirement in the HIMD. All health records shall be filed in one established sequence. An adequate filing area that will ensure the rapid location and retrieval of health records must be maintained. The following are the systems of filing health records:

4.6.2.1 Alphabetical filing system

When no health record number is assigned, and the patient's name is the only identifier, then the alphabetical filing is the only possible method to use. All records of discharged patients are filed in strict alphabetical order from A to Z. Filing is by patient surname first, then given name and last the middle name.

This method of filing system is only useful for health facilities with limited patients and a small filing area.

Rules on Alphabetical Filing

1. Place the surname first, then the given name, followed by the middle name and file in strict alphabetical sequence.

2. Arrange index cards in alphabetical order.

3. When a patient requires more than one card to accommodate all of his admissions, the cards shall be arranged in chronological order, with earliest first, working from front to back in the drawer.

4. If there is more than one person with the same surname and given name, the cards shall be arranged alphabetically by middle initial. If no middle initial is given, the cards shall be arranged according to birth date, filing the oldest card first.

5. Names with prefixes of D, dela, De, Des, Di, Du La, Mc, Mac, Ma, Van, Von, etc. shall be filled alphabetically as D-e-l-a-C-r-u-z; D-e-l-a-F-u-e-n-t-e.

6. Names beginning with Sta. and St.shall be filed as S-a-n-t-a and S-a-I-n-t, as in S-a-n-t-a-M-a-r-i-a and S-a-i-n-t.

7. Compound or hyphenated names shall be filed as one word; thus, Navarette-Clemente shall be filed under N-a-v-a-r-e-t-t-e- C-l-e-m-e-n-t-e.

8. Names with religious titles such as Reverend, Mother, Father, Brother, and Sister shall be filed under the surname, the titles disregarded followed by the given name. Father Jose Romero is filed as Romero, Jose or Romero, Jose (Father).

9. If an initial is given instead of a person's first name or middle name, the rule is "file nothing before something" Thus, J. Romero shall precede M. Jose Romero and Miguel Jose Romero.

10. It is customary for people of Spanish descent to combine the name of the mother with the name of the father. For instance, with the name Soto Ramirez, Soto is the surname of the father and Ramirez is the surname of the mother. These are filed in alphabetical sequence, the father's name first, followed by the mother's name. Thus, the name Maria Dolores Soto Ramirez shall be filed in the section of the file in the following order; S-o-t-o-R-a-m-i-r-e-z, Maria Dolores.

11. If the patient's name has changed since a previous admission, a cross-reference shall be made to the former name. For instance: If Dayrit, Josefina is admitted, a cross-reference should be made to her previous admission as Manalastas, Josefina.

12. When looking for a given person's name card, one must keep in mind that there may be many spellings of the same name. A thorough search must be made under every possible spelling of the name before stating that there is no card for that name.

13. The Master Patient Index shall contain ***sufficient alphabetical guides for speedy reference.*** As a rule, no more than 20 cards shall be filed behind a guide.

14. To maintain uniformity in the patient index when a personnel change is made, filing directions shall be explicit. Whenever possible, only one person shall be responsible for filing the index cards.

15. Card files should be audited regularly for misfiled records.

16. Additional training of Master Patient Index clerks shall be provided as necessary.

4.6.2.2 Numerical filing system

When a numerical record identification system is adopted, then a numerical filing system is used**.** There are two systems of filing records numerically: straight numeric and terminal digit.

4.6.2.3 Terminal Digit Filing System

For terminal digit, a six-digit number shall be used and divided into three (3) parts:

Part 1 – The **PRIMARY** digits which are the last two (2) digits on the right-hand side of the assigned number.

Part 2 – The **SECONDARY** digits which are the two (2) middle numbers.

Part 3 – The **TERTIARY** digits which are the first two (2) digits on the left of the assigned number.

For example, the unit number 19-30-90 is divided as follows:

19	*30*	*90*
Tertiary	*Secondary*	*Primary*

The inpatient's health records of a health facility shall be filed and stored in terminal digit-filing system. This means that they shall be filed in the order of primary digits (that is, last two digits of the HRN and then the secondary digits and finally the tertiary digits).

When filing health records under the terminal digit system, the unit number shall be first considered. This shall be divided into three parts- in pairs of digits. Taking health record 509326, this divides as follows- 50-93-26 and the process of filing commences by considering the part of the number on right hand or "terminal" digit. The filing area shall have 100 terminals (primary sections) starting from 00,01,02,03,04,05,..99.

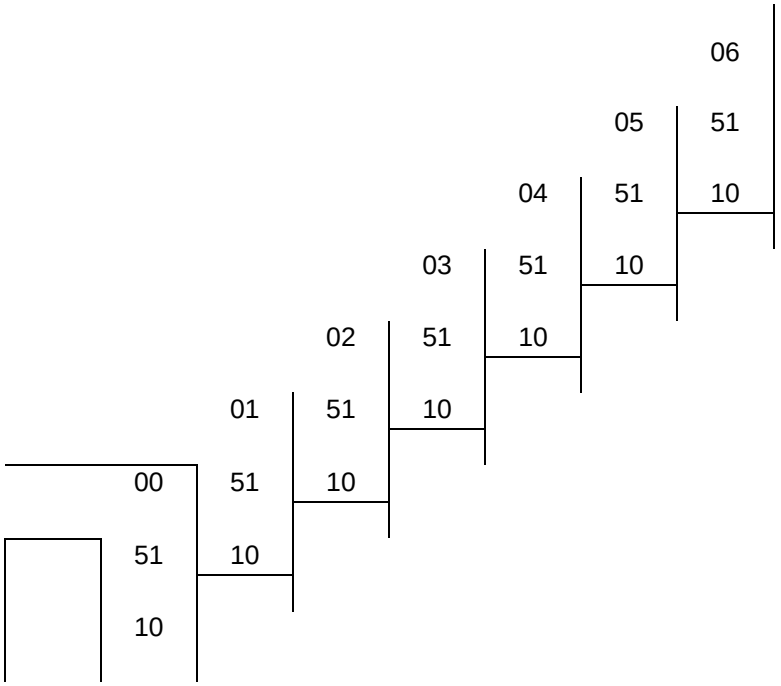
When filing, the clerk shall take the health record to the primary section corresponding to the terminal pair of digits. Once in the right terminal, the row of records shall be located by considering the secondary or the middle number which, in the above example, "93". Within each secondary section, health records shall be filed in order of their tertiary (left hand) pair of digits. Every 100 processed records shall be equally distributed throughout the 100 terminals.

If someone is looking for a record, it shall be in the order shown below (or a tracer shall be in its place).

An example of sequence is:

46-52-02	98-05-26	98-99-30
47-52-02	99-05-26	99-99-30
48-52-02	00-05-26	00-99-31
49-52-02	01-06-26	01-00-31

Note: A misfiled record may take hours to locate or could be lost forever. File all records correctly.



In PH hospitals, the common practice adopted is a modified Terminal Digit Filing system wherein the First Two is the secondary, the Middle Two is the Tertiary and the Last Two will still act as the terminal digit. It is a practical method that's easy for filing and retrieval since it enables quick inspection because numerals placed at both ends are easier to spot than those placed in the middle. For example, 50-97-26, 26 is the terminal digit; 97 is the tertiary or the middle two digit and 50 is the secondary or the first two digits. Considering 50-97-26 as the first health record in a series, the sequence is shown below:

50-97-26
50-98-26
50-99-26
51-00-26
51-01-26

The advantage of a modified terminal digit filing system is eliminating the process of culling which requires additional manpower.

4.6.2.4 Ways of Filing

1. **Centralized Filing System**

    a. The records of the patient shall be filed in one location, usually the Health Information Management Department.

b. The patient may have different health records (in-patient records, emergency room record, outpatient record) but they shall be brought together in one unit record, or at least filed under the same number in the same place.

c. The main objective of the Health Information Management Department is to maintain a continuous health record of a patient, which shall be available at all times. The implementation of a unit number and a centralized record filing system is the best way to achieve this objective.

2. **Decentralized Filing System**

a. The health records of the patient shall be filed in multiple patient care areas.

b. This may be under the same unit number if the HIMD is maintaining a unit record or with totally unrelated numbers if serial numbering is employed.

c. Under strict supervision by the Health Information Management Head, the HIMD staff shall maintain centralized records keeping because it is cost effective in terms of resource utilization and effective supervision can be attained if only one system is employed

Table 7. Advantages and disadvantages of filing systems

ALPHABETIC SYSTEM	
ADVANTAGES:	**DISADVANTAGES:**
1. The easiest method of record retrieval is the master patient index as there is no need to cross reference the patient name to the health record number. It is necessary to train staff to verify patient's names and spellings. 2. An accurate and consistent health record filing. 3. Most practical in small health facilities without a computerized system.	● In this type of record identification, a patient's confidentiality is not safeguarded.
NUMERICAL SYSTEM	
1. Confidentiality is ensured 2. The expansion of files is easy 3. Reveals certain information like total number of patients and the like	● Not applicable for small health facility
TERMINAL DIGIT SYSTEM	
1. Records are easily distributed throughout the 100 primary sections. 2. Only every 100th new health record shall be filed in the same primary section of the file. 3. Elimination of personnel congestion in the filing area. 4. Staff shall be assigned responsibility for certain sections of the filing area. 5. Work can be evenly distributed among the HIMD staff. 6. Inactive health records may be pulled out from each terminal digit section as	● It requires an adequate storage area for the implementation of one hundred (100) primary sections.

new ones are added, thus eliminating the need to backshift records. 7. Misfiled records are reduced.	

4.6.5 Other Considerations in Filing Systems

Management of Misfiled Health Records

1. A system of ensuring that no file is missing or misfiled shall be in place.

2. In locating misfiled records, the following shall be applied:
   a. Check for the transposition of digits in a number. For example, 963615 may be filed as 963651 or 693615.
   b. Check for missing files under similar looking numbers such as "3" under "5" or "8" or vice versa. Or "7" or "8" under "9".
   c. Check for a certain number such as 714 under 713 or 715 or under a similar combination.
   d. Check for the transposition of the first and last numbers.
   e. Check the health record immediately before and after the particular missing record.
   f. Check the shelf immediately above and below where the record should be filed.

3. The file room shall be checked once a month to ensure that:
   a. All records are standing straight on the shelves.
   b. There is no dust on the shelves (including the very top shelves).
   c. The floor should be clean.

Management of Loose Sheets

Vast quantities of unattached laboratory, ECG, and other test results (loose sheets) are produced daily and make their way to the Health Information Department. These reports contain vital patient information and it is essential that they are filed promptly and accurately to maintain complete, comprehensive and effective health records.

1. **Sorting**

   Loose sheets are delivered to the HIMD from the different services or clinics of the health facility. The in-patient sheets should be separated from the out-patient loose sheets in a decentralized health record keeping system. Then they shall be pre-sorted terminally, in preparation for the actual filing process. The procedure shall be as follows:

   a. Separate loose sheets which have been stapled together
   b. Date stamp all loose sheets received
   c. Check names and numbers on the loose sheets

   Note: For loose sheets forwarded to the HIMD without corresponding numbers, the Master Patient Index shall be consulted.

2. **Locating the record**

   When using the manual system, an in-house box shall be maintained to determine whether or not the patient has already been discharged.

   For patients whose names are not in the in-house box, the MPI shall be consulted for the HRN, then the health record shall be retrieved from the permanent file area.

   Health Records which are not in the permanent filing area shall be recalled from the respective borrower in order to incorporate loose sheets.

   Any loose sheets that were not filed the first time shall be retained for a future attempt.

3. **Filing Loose Sheets**

   The patient's HRN and date on the report shall be checked and re-checked if they correspond to the number and date indicated on the health record.

   1. The loose sheets shall be refilled using the "Assembly of Health Records" list as a guide to correct filing order.
   2. Reports from each department shall be filed chronologically within each admission.
   3. Statistics on loose sheets received by the HIMD shall be maintained for any administrative use.

4.7 Retrieval of Health Records

All health records not in the processing stage and not in use shall be placed in the file/storage room. Inherent to documents and records is the ability to be retrieved from the permanent file for further use.

A good retrieval system directly affects the total efficiency of the HIMD.

It is a good practice for small health facilities with a small filing/storage area to transfer inactive records to the inactive file to give way to the incoming records, in order to decongest the area, and to make retrieval easy.

A retrieval process will not be efficient and effective if there is no provision for adequate finding aids, captions, locator aids and retrieval tools.

Retrieval tools in the health record are classified into three, namely: (1) indexes, (2) registers, and (3) tracer**s.**

4.7.1 Retrieval Tools

4.7.1.1 Indexes

An index serves to guide, point out, or facilitate reference to comprehensively organize patients' health records through demographic data, disease-related/treatment-related information and clinical history.

The following are the types of indexes (refer to indexing part of this chapter for discussions):

a. Master Patient Index (MPI)
b. Disease Index
c. Operation Index
d. Physician's Index

4.7.1.2 Registers

A register is an official list of all patients treated and/or admitted in a particular health facility. It is considered a permanent document to be maintained by the health facility as mandated by the Health Facilities and Services Regulatory Bureau of the Department of Health. Also, it is a source of data/information when the original copy of the health records is already disposed of after the prescribed retention period.

a. ***Admission Register.*** This is a list of all patients admitted in a particular health facility. This register shall be done daily as patients are admitted. Each section of this register shall be maintained in chronological order. This register is a permanent record, and as such, all entries shall be made in ink. It shall be maintained manually or computerized as mandated by the Philippine Health Insurance Corporation effective January 2006. The minimum data requirement for an admission register are as follows: Health record number (HRN), date and time of admission, name of patient, date of birth, sex, address, membership, admitting diagnosis and admitting physician.

_____
NAME OF HEALTH FACILITY
(Address)

ADMISSION REGISTER

HRN	Date/Time of Admission	Name of Patient	Age	Date of Birth	Sex	Address	Membership	Admitting Diagnosis	Admitting Physician

b. ***Discharge Register.*** This is a list of all patients discharged from a particular health facility. This register shall be done daily as patients are discharged. Each section of this register shall be maintained in chronological order. This register is a permanent record, and as such, all entries shall be made in ink. It could be maintained manually or computerized as mandated by the Philippine Health Insurance Corporation effective January 2006. The minimum data requirements fora Discharge Register are as follows: Date & Time of the Discharged, Health Record Number (HRN), Name of Patient, Age, Sex, Address, Membership,

Discharge Diagnosis, Operation/Procedure, Attending Physician, Service, Disposition and Result.

_____
NAME OF HEALTH FACILITY
(Address)

DISCHARGE REGISTER

Date & Time	HRN	Name of Patient	Age	Sex	Address	Discharge Diagnosis	Operation/ Procedure	Attending Physician	Service	Disposition	Result

Note: In the absence of a computerized system, Admission and Discharge Register can be combined in one Register Logbook provided that the Admitting Section is adjacent to HIMD.

c. ***Birth Register.*** This is a chronological listing of all the names of the children delivered in a particular health facility.

_____
NAME OF HEALTH FACILITY
(Address)

BIRTH REGISTER

Date & Time	HRN	Name	Sex	Birth Weight	Name of Mother	Attendant at Birth

d. ***Death Register.*** This is a record of all deaths occurring within the health facility. This is a listing of all the names of the patients who died in a particular health facility and arranged according to the date of death.

_____
NAME OF HEALTH FACILITY
(Address)

DEATH REGISTER

Date & Time	HRN	Name of Patient	Age	Sex	Address	Cause of Death *(Underlying & other diseases)*	Physician

e. ***Out-Patient Register.*** Every out-patient who comes in for consultation must be listed in the Out-Patient Register. If a logbook is utilized for this purpose, at the end of the year, it should be forwarded to the Health Information Service for safekeeping. This register is classified as a permanent file/record.

If, however, this register is maintained on a loose sheet or loose leaf, at the end of every month it must be forwarded to the Health Information Management Department for the preparation of Notifiable or Reported Diseases which is prepared monthly. This is also necessary for the compilation and collation process.

_____
NAME OF HEALTH FACILITY
(Address)

OPD REGISTER

HRN	Date &Time	Name of Patient	Age	Sex	Address	Diagnosis	Operation/ Procedure Done	Attending Physician

f. ***Other Registers.*** Other required registers that government health facilities need to maintain are as follows: Emergency Room Register, Delivery Room Register, Operating Room Register, Laboratory Register, Radiologic Register, Tumor Register and Injury Register.

4.7.1.3 Tracers

A ***tracer*** is used to ensure proper record control, whenever the health record is removed from file for any purpose. Tracers or "outguides" enable health records to be traced when not on file.

4.7.2 Essential Requisites for Easy Retrieval

Efficient and effective filing system. This is an important factor that makes retrieval easy because it is adaptable to the type of records maintained. Proven to be very effective in managing voluminous health records is the full knowledge of the movement of the records such as the terminal digit filing. However, to be truly effective, it needs to adopt the corresponding unit numbering system.

1. ***Time element*** is very crucial in health record management. Retrieval time of health records shall be as short as possible because the information that may be retrieved from the health record might be the deciding factor between the patient's life or death.

2. ***Monitoring of chart movement.*** Another important factor to consider in the efficient and effective management of health records is the full knowledge of the movement of the records. This is the reason why the Health Information Management Department shall maintain an effective tracking or follow-up system. The use of such a system coupled with the full knowledge of the workflow shall help the health record staff control the records more effectively.

3. ***Good Physical Layout.*** In order to attain a good physical layout, the Health Record Service shall consider flexibility and functionality. The arrangement of the employees should (1) follow the workflow, (2) facilitate smooth flow of paperwork, and (3) improve coordination between / among employees.

   The physical location of the Health Information Management Department shall be near the Out-patient Department and Emergency Room as the activity rate of health records is considered high in these services.

4.7.3 Retrieval Procedure

The authorized requesting party shall completely fill out borrower's slip form and duly signed by concerned signatories (Refer to Annex O on Request to Access to Health Records).

1. The requesting party/authorized representative shall bring the request to the HIMD and shall give it to the HIMD Staff.

2. The HIMD Staff receives and verifies whether the borrower is authorized to borrow and also checks the completeness of the request.

3. The HIMD staff assigned shall retrieve the requested health records.

4. After the retrieval, the HIMD Staff shall record the borrowed health record in the tracking system and place the tracer card where the record was retrieved.

5. The HIMD Staff assigned in the retrieval shall charge out the borrowed health record to the authorized borrower.

6. The borrower/authorized representative shall acknowledge the receipt of the record and shall review/access within HIMD.

4.8 Retention and Disposal of Health Records

Retention period is the period of time established and approved by proper authority after which records shall be deemed ready for disposal. It is recommended however, that those institutions where active health records cannot be maintained for five years in the active file may transfer their health records to another designated storage area because of limited space.

Aside from this legislation, the Department of Health issued Ministry Circular 77, series of 1981 which further qualifies the 25-year retention period for all hospitals under the Department of Health regardless of its category/classification. The period of health records' retention is amended by Department Circular No. 70 s. 1996. The National Archives of the Philippines (NAP) also issued a general circular on guidelines on the establishment and use of general records disposition schedule (GRDS) that can be used as a guide in the disposal of other records maintained by the HIMD.

4.8.1 Transfer of Inactive Records

Transfer of inactive records shall follow the retention disposition schedule. All active records that reached its retention period shall be transferred to inactive file area while waiting for the prescribed retention period for disposal. If there is no available space to accommodate active records, a decision must be made to determine the length of time and/or appropriate storage where inactive records shall be kept.

4.8.2 Culling

Culling is the identification and removal of inactive records or those which have already reached their mandated and/or prescribed retention period from the filing/storage area for disposal. The process shall decongest the file area, provide more room for the filing of in-coming health records and facilitate prompt retrieval of needed health records.

4.8.3 Disposal

Disposal of health records in government health facilities/institutions is governed by Department Circular No. 70 series of 1996: The Revised Disposition Schedule of Medical Record amending Ministry Circular 77 series of 1981, Department Circular 2021-0226 and NAP General Circular 3, GRDS.

Department Order 13-A, Article III, Rule 2.2, specifically states that: "Agencies shall not dispose of their health records earlier than the period indicated for each record series. However, records may be retained for longer periods if there is a need to do so."

The disposal of health records must be done in close coordination with the National Archives of the Philippines (NAP), the government agency in charge of health record disposal.

Table 8. Procedure in the Disposal of Health Records

Description	Person/Department Responsible	Interface/Form/ Document
1. Initiates the disposal of valueless health records based on the records disposition schedule.	HIMD staff	Records Inventory and Appraisal (Form 1) Records Disposition Schedule (Form 2)
2. Culls out valueless records	HIMD staff	
3. Prepares request to dispose of records and forwards to the Chief of Medical Professional Service (CMPS)	HIMD staff	Request letter
4. Endorses request to dispose of records to RMIC	CMPS	Request letter
5. Recommends request to dispose of records and submits to COH for approval	Records Management and Improvement Committee (RMIC)	Request for Authority to Dispose of Records (Form 3)
6. Approves request for authority to dispose	COH	
7. Submits request to NAP	RMIC	
8. Receives, evaluates and assigns a representative to evaluate & examine records for disposal.	NAP	
9. Approves the submitted request for authority to dispose with analysis report and recommended manner for disposal	NAP Director	Authority to dispose
10. Coordinates with concerned offices/agencies (concerned departments/unit, COA, NAP, official buyer) for witnessing and disposal of valueless health records	RMIC/Administrative Service	Letter of availment for NAP official buyer
11. Disposes valueless health records through sale (public bidding or official buyer of NAP as per recommendation of NAP)	RMIC/ NAP/COA/ NAP Official buyer	
12. Issues OR to official buyer	Cashier	
13. Signs Certificate of Disposal and provides copy to concerned offices	NAP, COA, RMIC, official buyer	NAP Form No. 6 Certificate of Disposal of Records
14. Files copy of the Certificate of Disposal from NAP.	RMIC	Certificate of Disposal

4.9 Processing of Health Information/ Issuance of Certificates

4.9.1 Certificate of Live Birth

Live birth is the complete expulsion or extraction of a product of conception from its mother, irrespective of the duration of pregnancy, which after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut off or the placenta is still attached; each product of such birth is considered alive.

A fetus with an intrauterine life of seven (7) months or more and born alive at the time it was completely delivered from the maternal womb but died later shall be considered as live birth and shall be registered in the registry of births.

However, if the fetus has an intrauterine life of less than seven (7) months, it is not deemed born if it dies within 24 hours after its complete delivery from the maternal womb *(Article 41 R.A 386).* For statistical purposes, a certificate of Live Birth shall be prepared in duplicate copy, a copy which shall be forwarded to the office of the Civil Registrar-General and the other copy for the Civil Registrar's file.

Table 9. Procedure in the Preparation of Birth Certificate

Person Responsible	Action
Informant (Parent)	1. Fills up the Birth Certificate (BC) preform/worksheet given by the nurse 2. Submits accomplished BC preform to the nurse.
Nurse/Midwife	1. Receives accomplished BC preform/worksheet from the parent/informant. 2. Checks completeness and accuracy by interviewing the patient 3. Forwards the accomplished preform worksheet with four (4) copies of the COLB to the HIMD
Medical Transcriptionist of HIMD	1. Acknowledges receipt of accomplished COLB with preform from Nursing Staff 2. Rechecks the preform for accuracy and completeness of data entry 3. Counter checks all COLB from the census/delivery registry for validation 4. Transcribes data from BC preform to the COLB 5. Checks COLB for completeness, correct spelling of names, dates and other details 6. Forwards the COLB to the nurse/midwife
Nurse/Midwife	1. Acknowledges receipt of accomplished COLB 2. Secures the signature of informant 3. Seeks signature of the attending physician on the COLB
Attending Physician	1. Checks and affixes signature on appropriate space(s) on the COLB
Nurse/Midwife	1. Forwards signed COLB to the HIMD
Medical Transcriptionist of HIMD	1. Prepares transmittal letter to the Local Civil Registrar's Office (LCRO) 2. Forwards transmittal letter with the attached COLB to HIMD Head/Officer-in-Charge for signature

HIMD Head/Officer-In-Charge	1. Checks all the attached COLB against the list of names on the transmittal letter 2. Affixes signature on the transmittal letter 3. Sends back the transmittal letter with all the attached COLB to the HIMD staff.
HIMD staff	1. Transmits the prepared COLB to LCRO 2. Monitors and safe keeps a duplicate copy of the transmittal letter and hospital copy of COLB for future reference.

4.9.2 Certificate of Death

Certificate of Death provides information on the cause of death of the deceased determined by the last attending physician. It also informs the family of the deceased on conditions, diseases and circumstances that might occur or could be prevented. Also, it is used to process funeral arrangements and other legal purposes including wills and testaments.

Note: To Submit Within 24 Hours

Table 10. Procedure in the Preparation of Death Certificate / Fetal Death

Person Responsible	Action
Nurse-on-Duty	1. Facilitates preparation of the draft copy of the COD 2. Forwards the prepared draft COD to the attending physician
Attending physician	1. Accomplishes the medical certificate portion of COD and other required details 2. Affixes signature on the draft COD 3. Return the accomplished draft COD to the nurse-on-duty
Nurse-on-Duty	1. Receives the accomplished draft COD from the attending physician 2. Checks draft COD for completeness of data entry 3. Secures signature of the informant
Informant/ Relative	1. Confirms accuracy and completeness of information 2. Signs draft copy of COD
Nurse-on-Duty	1. Forwards the draft COD to the medical transcriptionist of the HIMD
Medical Transcriptionist of HIMD	1. Acknowledges receipt of the draft COD 2. Rechecks accuracy and completeness of the COD 3. Transcribes the data from the draft COD into four copies of official COD 4. Returns the transcribed copies of official COD to the nurse-on-duty
Nurse-on-Duty	1. Acknowledges receipt of the official COD 2. Signs and secures signature of the informant and attending physician 3. Incorporate one (1) copy of the COD to patient's health record 4. Issues three copies of official COD to the nearest kin and advices to register it within 48 hours upon receipt to the Local Health Office (LHO)
Next-of-Kin	1. Acknowledges receipt of the three (3) copies of COD in the Logbook for registration to the Local Civil Registrar Office (LCRO).

4.9.3 Certificate of Fetal Death

Fetal Death is the death prior to the complete expulsion of a product of conception, irrespective of the period of pregnancy. The death is indicated by the fact that after such separation, the fetus does not breathe nor show any other evidence of life, such as the beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, as defined in the *2nd Edition Medical Certification of Death Handbook for Filipino Physicians, Guidelines and Procedures.*

Procedure

The preparation of Certificate of Fetal Death shall follow the procedure in preparing Certificate of Death.

4.9.4 Certificate of Confinement

Certificate of Confinement, signed by the head of the Health Information Management Department, shall be issued while the patient is still confined in the health facility. This certificate should be a controlled document. The health facility should pre- number them and their issuance should be recorded by the HIMD. This should be released with a dry seal.

4.9.5 Medical Certificate

Medical Certificate shall be issued when the patient is already discharged. This certificate should be a controlled document. The HIMD should pre-number and record the issuance. It is the attending physician who shall certify the medical certificate. This should be released with dry seal.

4.9.6 Medico-Legal Certificate

Medico-legal Certificates shall be certified by the Attending Physician/Chief of the Health Facility/Medico-legal Officer and released with dry seal.

4.9.7 Certifying of Health Records

Certified copies of the following health records may be requested:

1. Discharge Summary/Clinical Abstract
2. Laboratory and diagnostic results
3. Report of Operation

4.10 Telemedicine

As defined in the Joint Memorandum Circular No. 2020-0001 issued by the DOH and the National Privacy Commission dated March 28, 2020, telemedicine refers to the practice of medicine by means of electronic and telecommunications technologies such as phone call, chat or short messaging service (SMS), audio- and video-conferencing, among others, to deliver healthcare at a distance between a patient at an originating site, and a physician at a distant site.

With this, the DOH and the University of the Philippines Manila, through the National Telehealth Center, has issued the Joint Memorandum Circular (JMC) No. 2020-0001 entitled *"Telemedicine Practice Guidelines,"* which reiterates the implementation of telemedicine practice among health

care providers. All telemedicine consultations should have proper documentation, which includes, but not limited to, the following:

a. Patient and provide location;
b. Family members or other companions present during the telemedicine consultation;
c. Patient consent;
d. Referring physician, if applicable;
e. Telemedicine platform or videoconference or communication software used; and
f. Patient's feedback about the telemedicine consultation

All health care providers whose services are sought through telemedicine shall keep records of all electronic clinical abstracts/consultation summaries, prescriptions and/or referral forms issued.

CHAPTER 5
Hospital Statistics

Statistics is the process of collection, analysis, interpretation and presentation of facts as numbers or numerical facts, which break down data into concise, useful form.

Accurate and comprehensive data collection is vital in statistical preparation and the effectiveness of statistical reports depending upon the terminology used. There must be a mutual/ common understanding of its meaning between the person who prepares the statistical report and its users. It would also be essential to know what data to collect and how to collect them.

Hospital Statistics serves as a tool in planning, monitoring, and evaluation of the effectiveness of hospital operations and management. Effective and efficient health indicators are considered an integral part of the decision support system that managers use in any major decision-making.

5.1 The Need for Hospital Statistics

1. Provide data for management activities:
    a. Administrative Level
        - Budgeting and resource allocation
        - Capacity Utilization
        - Cost Accounting
        - Disbursement of funds
        - Decision-making and evaluation
        - Organizing staffing levels
        - Data for accreditation purposes
        - Licensure approved hospital and their services
    b. Clinical Level
        - Assessment of the quality of care
        - Appraisal of medical, nursing and allied health professionals' performance
        - Teaching purposes
2. Present a comparison of the past and present performance of health facility
3. Provide information for both internal and external agencies
4. Meet legal requirements
5. Serve as reference for education, research and service development

5.2 Characteristics of Quality Hospital Statistics Data

1. Accuracy and validity of the original source data;
2. Reliability – Data is consistent and information generated is understandable;
3. Completeness – All required data are present;
4. Legibility – Data are readable;
5. Current and timely – Data are recorded at the point of care; and
6. Accessibility – Data is available to authorized persons when and where needed.

5.3 Collection of Healthcare Statistics

Healthcare statistics are collected and generated from multiple sources using different data collection methods. Collection of data is done daily through the use of 24-hour floor census, patient health record and routine reporting of various concerned sections. The Health Information Management Department (HIMD) coordinates with different departments/units/sections to improve the quality of health information. The accuracy of data collected relies heavily on the manner of collection by the concerned unit and clear understanding of the definitions of reports needed and its purpose.

The following services are some of the data sources for statistical reports:

- Medical Service
- Allied Health Professional Service
- Nursing Service
- Hospital Operations and Patient Support Services
- Finance Service
- Professional Education, Training and Research Office

5.4 Measures of Hospital Utilization

5.4.1 Inpatient

Inpatient is a patient admitted to the hospital receiving health care services and is provided with room, board and continuous nursing services in a unit or area of the health facility.

1. ***Census*** indicates the number of patients present in the hospital at any given period with a standard cut-off time at 12:00 midnight e.g. the Daily Floor Census Report for May 3 will include patients' admitted, discharged, death, transfer-in and transfer-out from 12:01 to 12:00.

   Census = Inpatients remaining at midnight + Admissions - Discharges & Deaths

   - ***Average Daily Census*** is the average number of inpatients per day. The factors that influence this indicator are the inpatient service days and the number of days in the same period.

$$\textbf{Average Daily Census} = \frac{\text{Total Inpatient Service Days for a period}}{\text{Total days in the same period}}$$

Newborn census records must be reported separately. Average Daily Census can also be computed by the wards or specialty departments, using the same formula.

Sample Computation:

To compute the average daily census of a 100 authorized bed capacity health facility with an accumulated 2,750 inpatient service days for the month of January is to divide 2,750 (total inpatient service days) by 31 (number of days in the month).

$$\textbf{Average Daily Census} = \frac{2750}{31} = \underline{\textbf{88.7 ~ 89}}$$

The average daily census for the month is 89.

2. ***Inpatient Service Days*** is a unit of measure denoting the services received by an inpatient in a 24-hour period or any fraction of the day thereof.

$$\textbf{Inpatient Service Days} = (\text{Inpatients remaining at midnight} + \text{Admissions}) - \text{Discharges \& Deaths} + \text{Admitted \& discharged on the same day}$$

Sample Computation:

To compute for the inpatient service days of a 500 bed capacity with 597 remaining inpatients at midnight, admission of 116, discharges of 112 and admitted and discharged the same day of 22.

Inpatient Service Days = 597 + (116 – 112) + 22 = **623**

Total Inpatient Service Days of care is compiled on the 24-Hour Daily Census Report and the grand total for the month is listed on the last day of the month.

3. ***Bed Occupancy Rate (BOR)*** is the ratio of actual Inpatient Service Days to the maximum inpatient days determined by bed capacity during any given period of time. Health experts suggest that bed occupancy rate should not exceed 85% so as not to compromise the quality of care of the health facility (Bontile, 2013).

- **Bed Day** – The World Health Organization defines Bed Day as a unit of measure denoting the presence of an inpatient bed (occupied or unoccupied) set-up and staffed for use in one 24-hour period.
- **Bed Count** – It is referred to as the number of beds, whether occupied or unoccupied, that has been set-up and staffed for use in a designated inpatient area of a hospital or institution. Beds from special areas are not to be counted, such as Operating Room (OR), Labor Room (LR), Recovery Room (RR) or temporary set-ups for temporary overflow beds in hall, etc., beds in the ward setup but with no staff or patients using them (vacant or closed off area or wards, stored beds). The patients in special areas are only occupying them for a short period of time and are assigned to another bed in the hospital. Bassinets used by newborns are to be counted and reported separately.
- **Authorized Bed** – Approved number of beds issued by the Health Facilities and

Services Regulatory Bureau, the licensing offices of DOH.

- **Implementing Bed** – Actual beds used based on hospital management decisions. (This is not the basis for computing Bed Occupancy Rate).
- **Actual Bed** – Actual number of beds utilized by the patients within the period.

Additional Bed Used – Actual number of beds minus the number of implementing beds for the period.

$$\textbf{Bed Occupancy Rate} = \frac{\text{Total Inpatient Service Days for a period}}{\text{Total no. of authorized beds x Total days in the same period}} \times 100$$

Sample Computation:

An example of bed occupancy rate for the month of June, 1,380 inpatient service days were provided at a health facility that has an authorized bed capacity of 50.

$$\textbf{Bed Occupancy} = \frac{1380}{50 \times 30} \times 100 = \underline{\textbf{92}}$$

Taking into account that June has 30 days, the bed occupancy for that period is 92.00%.

4. ***Bed Turnover Interval (BTI)*** is the average period in days that an available bed remains empty between the discharge of one inpatient and the admission of the next.

$$\textbf{Bed Turnover Interval} = \frac{\text{(Implementing beds x days in the period)} - \text{Inpatient Service Days for a period}}{\text{Total discharges \& deaths in the same period}}$$

Sample Computation:

An example of bed turnover interval for the month of October 2008, a total of 12,420 inpatient service days were provided at a tertiary health facility with implementing beds of 462.

$$\textbf{Bed Turnover Interval} = \frac{(462 \times 31) - 12,420}{1,400} = \underline{\textbf{1.36 ~ 1}}$$

During the period a total of 1,400 patients were discharged and died. The bed turnover interval is 1 day.

At a given BOR, the BTI indicates how efficient a hospital's system is in readying the bed for the next patient. A short BTI indicates better efficiency. However, very short BTI should be looked at cautiously as studies have shown that a short BTI is linked to an increase in hospital acquired infections such as MRSA (Methicillin-resistant *Staphylococcus aureus*).

5. ***Bed Turnover Rate (BTR)*** is the number of times a bed, on average, changes occupants during a given period of time.

$$\textbf{Bed Turnover Rate} = \frac{\text{No. of discharges (including deaths) for a period}}{\text{Average bed count during the period}}$$

Sample Computation:

A good example of bed turnover rate is a 200-bed health facility that supplied the following information for the year 2008: patients discharged including deaths are 6,500.

$$\textbf{Bed Turnover Rate} = \frac{6500}{200} = \underline{\textbf{32.5}}$$

This example shows that during the year, the health facility's 200 beds have changed occupants about 32 times. This is helpful in measuring the level of efficiency and productivity of the health facility in terms of vacant bed availability.

High BTR generally indicates better utilization. It means patient turnover is high and the hospital is treating more patients in a given period of time. BTR, along with BOR, gives a very good understanding of how well the hospital's beds are being utilized.

6. ***Length of Stay*** is the number of days of care rendered to an inpatient from admission to discharge. The duration of an inpatient's hospitalization is considered as one (1) day if he has been admitted and discharged on the same day and also if he has been admitted on one day and discharged the next day.

   It is used in utilization management that evaluates the hospital's efficiency in providing necessary services in the most cost-effective manner, while also evaluating the level of care required.

7. ***Average Length of Stay (ALOS)*** is the average number of days each inpatient stays in the hospital for each episode of care. It is calculated by dividing the total number of occupied bed days for a period by the number of separation in the same period and expressing the result as an average for all inpatient discharges, or the average number of days of service rendered to each inpatient discharged during a given period.

$$\textbf{Average Length of Stay} = \frac{\text{Total Length of Stay of discharged patients for a period}}{\text{Total discharges and deaths in the same period}}$$

Sample Computation:

In June 2010, a health facility discharged a total of 2,086 patients (including deaths). Their combined length of stay was 13,654 days. Using the above formula, the average length of stay of discharged patients is 7.

13, 654

$$\textbf{Average Length of Stay} = \frac{\text{---------}}{2,\ 086} = \underline{\textbf{6.54 ~ 7 days}}$$

It should be noted that the total length of stay of patients discharged during the month (regardless of date of admission) is taken from the actual days of confinement from each patient's chart for the period. The figure derived at is used as the numerator in computing for the ALOS. A patient admitted and discharged on the same day is considered as having stayed one day.

Note:

- In computing for the length of stay, the date of admission is counted but not the day of discharge.
- Newborn (born alive and well) must not be included in computing for this indicator.

5.4.2 Outpatient

Outpatient is a patient who receives health care services without being admitted for inpatient medical care or health care services and does not occupy a bed for any length of time; or a patient who consults and receives health care services in the health facility without being admitted.

1. ***Total Number of Outpatient Visits*** refers to the total number of outpatients attended and who received healthcare services in the health facility for a given period of time.

   - ***New visits*** refer to the total number of outpatient first visits, and grouped by age and sex.
   - ***Revisits or Follow-up visits*** refer to the total number of outpatient second and subsequent visits, and grouped by age and sex.

2. ***Total Number of Encounters*** refers to the number of health care services given to outpatients during the visit.

3. ***Average Number of Outpatient Visits per OPD day*** refers to the average number of out-patients who were attended for a given period.

$$\textbf{Average no. of Outpatient visits per OPD Day} = \frac{\text{Total no. of Outpatient visits/attended (both new and revisits) during a period}}{\text{Total no. of days for the same period}}$$

* where total no. of days refers to OPD days.

Sample Computation:

A health facility with an outpatient service operating 6 days per week has a total number of new outpatient visits of 38,949 and a total number of revisits of 254,911.

$$\textbf{Average no. of Outpatient visits per OPD day} = \frac{38,949 + 254,911}{288} = \underline{\textbf{1020}}$$

5.4.3 Emergency Department

Emergency Department is a health facility or primary care department that provides initial treatment to patients with a broad spectrum of illness and injuries, some of which may be life-threatening and requiring immediate action; or a health facility or primary care department that provides initial treatment to patients in response to an increased need for rapid assessment and management of critical illnesses.

1. ***Total Number of ED Consults*** refers to the total number of emergency patients attended and who received health care services in the health facility for a given period.

    - ***Emergency patients*** refers to a patient with a condition or state wherein based on the objective findings of a prudent medical officer on duty for the day there is immediate danger and where delay in initial support and treatment may cause loss of life or cause permanent disability to the patient, or in the case of a pregnant woman, permanent injury or loss of her unborn child, or would result in a noninstitutional delivery.
    - ***Non-Emergency patients*** refer to patients afflicted with minor injuries or illnesses who arrive late at night or at times when the regular clinics of the health facility are closed.

2. ***Average Number of ED Patients per day*** refers to the average number of both ED consult and non-emergency patients who were attended to in the Emergency Room for a given period.

$$\textbf{Average number of ED patients per day} = \frac{\text{Total no. of ED Consults}}{\text{Total no. of days for the same period}}$$

Sample Computation:

A health facility has a total number of 55,010 emergency patients attended in the ER.

$$\textbf{Average number of ED patients per day} = \frac{55{,}010}{365} = \underline{\textbf{151}}$$

5.5 Measures of Health Facility Performance

5.5.1 Morbidity

Morbidity refers to the state of having a disease (including illness, injury or deviations from normal health), or the number of sick persons or cases of disease in relation to a specific population.

Morbidity usually relates to a single episode of health care. An episode of health care may be defined as:

- A period of inpatient care; or
- A contact (or series of contacts in a specific time period) with a health care practitioner in relation to the same condition or its immediate consequences.

Source of Morbidity Data

Sources of data for morbidity coding include:

1. Hospital records
2. School health records
3. Death certificates
4. Armed services records
5. Occupational health records
6. Health surveys
7. Outpatient records (ambulatory care)
8. Maternal and child health services records
9. Recording of occurrence of 'sentinel' conditions or conditions such as congenital anomalies, communicable diseases etc.
10. Cancer and chronic disease registry records
11. Follow-up of people born at a specific time, those who have suffered from a specific 'index' disease or injury
12. Others

Uses of Morbidity Data

Morbidity data may be used, among other things, to provide clues to causes of disease, and it may form the basis on which decisions are made about previous measures or the allocation of resources or priorities for disease prevention programs.

Coding and selection rules for morbidity

At the end of an episode of care, the clinician should record all conditions that affected the patient in the period. The latest revision of the ICD provides guidance for morbidity coding for the selection and coding of the "main condition" to be considered for morbidity tabulation.

The country adopts a multiple coding policy, wherein all conditions are coded, but for statistical purposes only the main condition is tabulated. Applicable morbidity coding rules shall be used to select the correct main condition for morbidity tabulation.

A. Infection Rate

May be calculated separately for a specific infection, such as surgical wound, puerperal and respiratory, urinary tract, and blood infections and so on.

1. ***Gross Infection Rate*** is the rate of those infections that have occurred following clean wound operations or births, or have developed into medical cases after admission in the health facility.

$$\textbf{Gross Infection Rate} = \frac{\text{Total no. of infections in the health facility (or ward) for a period}}{\text{Total discharges and deaths on the health facility (or ward) for the same period}} \times 100$$

Sample Computation:

The Infection Control Committee of a health facility reported a total of 45 infections for the year 2010. Total discharges including deaths for the same period were 2,000. Using the above formula, the gross infection rate is calculated as follows:

$$\textbf{Gross Infection Rate} = \frac{\text{45 (Total No. of infections)}}{\text{2,000 (Total discharges including deaths)}} \times 100 = \underline{\textbf{2.25\%}}$$

Note:

- The infection to be included shall be a health facility acquired and shall be so determined by a committee or a physician.
- Up to two percent (2%) is considered normal by Western standards.

2. ***Net Infection Rate*** is the rate of Health-Associated Infections (HAI) that can be spread in many ways. Some transmission can occur through touch and some through the air (via sneezing or coughing). The most prevalent infections acquired during health facility stays are pneumonia and bloodstream, surgical site and urinary tract infections.

$$\textbf{Net Infection Rate} = \frac{\text{Total no. of infections debited against health facility (or ward) for a period}}{\text{Total discharges and deaths from health facility (or ward) for a period}} \times 100$$

Sample Computation:

For the month of August 2020, the infection control committee reported a total of 9 infections in the hospital ward. The total discharges and deaths in that period were 555 and 91, respectively.

$$\textbf{Net Infection Rate} = \frac{9}{555 + 91} \times 100 = \underline{\textbf{1.39\%}}$$

3. ***Postoperative Infection Rate*** is the rate these infections are occurring after a clean surgical operation (OP) or procedure.

$$\textbf{Postoperative Infection Rate} = \frac{\text{Total no. of infections occurring after a clean surgical operation}}{\text{Total number of clean surgical operations/ procedures for the same period}} \times 100$$

Sample Computation:

In the month of December 2009, a health facility performed and reported 658 cases of surgical operations. The ICC reported 2 cases of post-operative infections in a clean surgical case. Based on the formula, the Post OP infection rate for the month is computed as follows:

$$\textbf{Postoperative Infection Rate} = \frac{2}{658} \times 100 = \underline{\textbf{0.30\%}}$$

4. ***Consultation Rate*** is the ratio of consultation following an attending physician's request to a consultant to examine a patient and give a second opinion.

$$\textbf{Consultation Rate} = \frac{\text{Total consultations (all departments) for a period}}{\text{Total discharges and deaths}} \times 100$$

Sample Computation:

A health facility reported a total of 9,528 consultations for the year 2010. Total discharges and deaths for the same period were 8,098.

$$\textbf{Consultation Rate} = \frac{9{,}528 \times 100}{8{,}098} = \underline{\textbf{1.18\%}}$$

Note:

- Include newborns in computing for this indicator.
- Twenty percent (20%) is considered normal for teaching hospitals and which is acceptable by Western standards.
- A ten to fifteen (10-15%) is acceptable by Western standards.

5. ***Caesarean Section Rate*** is the ratio of the number of Caesarean sections performed to the total number of deliveries including Caesarean sections for a certain period.

$$\textbf{Caesarean Section Rate} = \frac{\text{Total no. of Caesarean sections in a region in a given period}}{\text{Total no. of deliveries for the same period}} \times 100$$

Sample Computation:

Four (4) caesareans were performed for the month of August 2011, during which there were 350 deliveries. Following the formula, the caesarean section rate is 1.14%.

$$\textbf{Caesarean Section Rate} = \frac{4}{350} \times 100 = \underline{\textbf{1.14\%}}$$

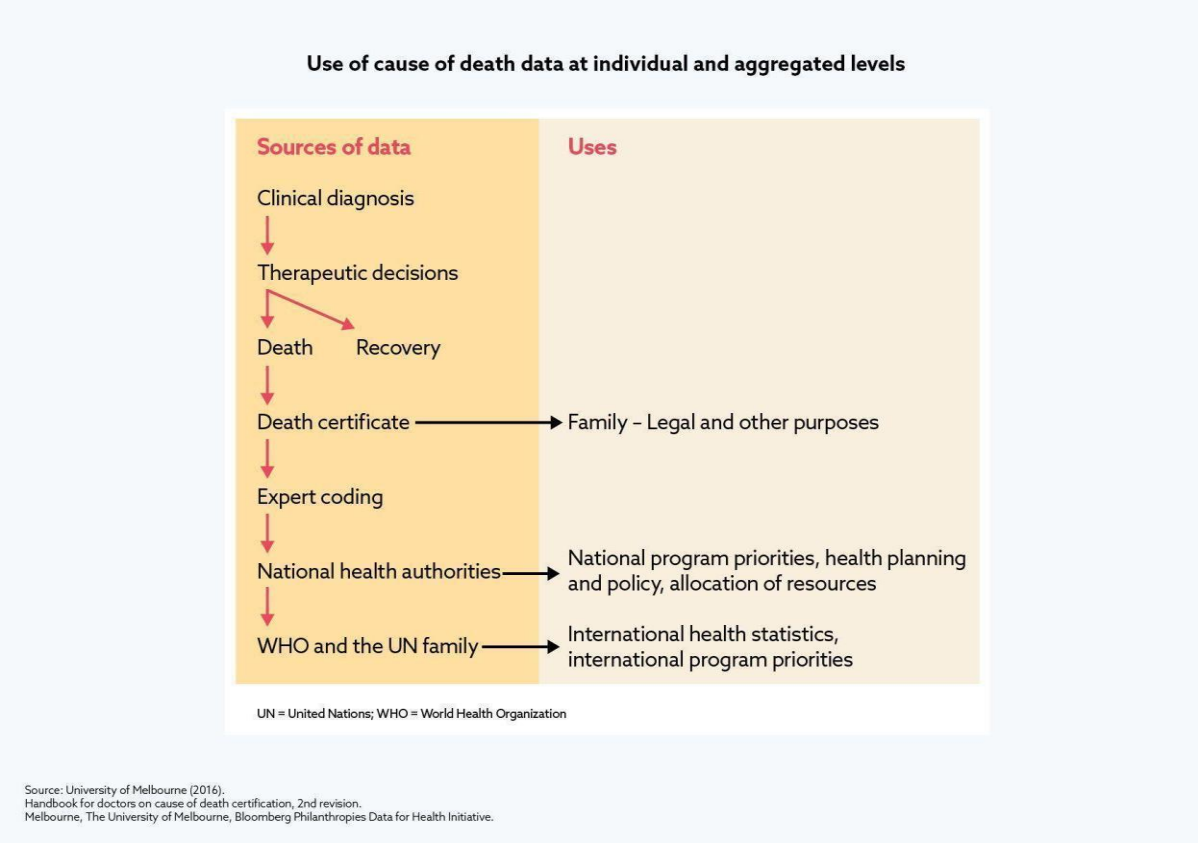
Note:

- A three to four percent (3-4%) rate or lower is acceptable by Western standards.
- Regardless of whatever the outcome of delivery i.e. one child, twins, etc. and whatever a dead or live newborn is delivered, the mother is considered to have only once.

5.5.2 Mortality

Death certificates are the main source of mortality statistics. The information recorded in death certificates helps decision-makers determine health priorities for prevention of deaths

due to similar causes in the future. Health decision-makers and planners all around the world make extensive use of mortality statistics.



Source: University of Melbourne. (2016). Handbook for doctors on cause of death certification. CRVS technical guides. (2nd Edition). University of Melbourne, Civil Registration and Vital Statistics Improvement, Bloomberg Philanthropies Data for Health Initiative. https://crvsgateway.info/file/9582/57

The person certifying the cause of death should enter the sequence of events leading to the death (morbid conditions that led directly to death and any antecedent conditions giving rise to this cause) on the death certificate which conforms to the international format.

From the standpoint of prevention of death, it is necessary to break the chain of events or to effect a cure at some point. The most effective public health objective is to prevent the precipitating cause from operating.

The underlying cause of death is used for mortality statistics tabulation and reporting purposes.

The underlying cause of death is defined as:

- the disease/injury, which initiated the train of morbid events leading directly to death; or
- the circumstances of the accident or violence which produced the fatal injury.

The ICD-10 or the latest revision of the ICD provides guidance for mortality coding for the selection and coding of the "underlying cause of deaths" to be considered for Mortality tabulation.

Applicable Mortality coding rules shall be used to select the correct underlying cause of death for Mortality tabulation.

- **Dead on Arrival (DOA)** refers to patients brought to a health facility without cardio-pulmonary and brain functions, including patients who did not respond to initial resuscitation and patients with signs of Rigor Mortis, Livor Mortis, Algor Mortis but excluding cases of decapitation not susceptible for resuscitation and patients brought in an advanced state of decomposition (as per Administrative Order No. 2020-0008).
- **ED Deaths/**ER Death refer to deaths of patients occurring in the ER, including patients who were revived by initial resuscitative measures at the ER but eventually died there, regardless of the time of stay in ER (as per Administrative Order No. 2020-0008).

Death Rate

The proportion of inpatient hospitalizations that ends in death. It has always been an important information for health facilities in evaluating the quality of medical care.

1. ***Gross Death Rate*** is the ratio of all inpatient deaths, including newborns, for a given period to the total number of discharges, including deaths, for a given period. This is also known as the **Mortality Rate.**

$$\textbf{Gross death rate} = \frac{\text{Total deaths including newborn for a given period}}{\text{Total discharge and deaths for the same period}} \times 100$$

Sample Computation:

If the health facility had 4 deaths and 385 discharges for the month, the gross death rate is:

$$\textbf{Gross death rate} = \frac{4}{385} \times 100 = \underline{\textbf{1.04\%}}$$

Note:

- Do not include Dead on Arrival (DOA), stillbirth, and ED deaths.
- Include newborn death in computing for this indicator. Below three percent (3%) is acceptable by Western standards.

2. ***Net Death Rate*** is the ratio of deaths excluding under 48 hours of admission. It produces a lower figure than the gross death rate. This is also known as **Institutional Death Rate.**

$$\textbf{Net death rate (Institutional death rate)} = \frac{\text{(Deaths, including newborn) – (Deaths under 48 hours for the period)}}{\text{(Total no. of discharges, including deaths and newborn) – (deaths under 48 hours for the same period)}} \times 100$$

Sample Computation:

A health facility had a total of 424 deaths for the year 2008, 183 of which died less than 48 hours after confinement. The total number of discharges for the same period is 16,500. Net death rate is 1.47%.

$$\textbf{Net death rate} = \frac{(424) - (183)}{(16{,}500) - (183)} \times 100 = \underline{\textbf{1.47\%}}$$

Note:

Death occurring at the ER is not counted if the patient is not yet considered admitted. The 0.5-2.5% rate is acceptable by Western standards.

3. ***Maternal Death Rate*** is the ratio of deaths resulting from obstetric complications of the pregnancy state (pregnancy, labor, and puerperium) from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

Types of Maternal Deaths

a. **Direct Cause** are deaths resulting from obstetric complications of the pregnancy state (pregnancy, labor, and puerperium) from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

b. **Indirect Cause** is the death of a woman resulting from a previously existing disease or a disease that developed during pregnancy, labor, or the puerperium that was not due to obstetric causes, although the physiologic effects of pregnancy were partially responsible for the death, also known as Indirect Obstetric Death.

$$\textbf{Maternal death rate} = \frac{\text{Total no. of direct maternal deaths in a given period}}{\text{Total no. of maternal (obstetrical) discharges including deaths for the same period}} \times 100$$

Sample Computation:

For example, two (2) mothers died after delivery at a health facility having annual OB discharges of 7,000. The maternal death rate derived from the formula is 1.14%.

$$\textbf{Maternal death rate} = \frac{2}{7{,}000} \times 100 = \underline{\textbf{0.31\%}}$$

Note:

- To be counted, death must occur between conception and puerperium.
- Up to two and a half percent (2.5%) is considered normal by Western standards.
- Count only those patients whose death was a direct result of an obstetric complication of pregnancy, labor or puerperium from interventions, omissions of treatment or chain of events resulting from any of these.
- A woman who dies following an abortion is a maternal death, as in an obstetrical patient who dies before the delivery of a cause due to pregnancy.

4. ***Postoperative Death Rate*** is the ratio of total number of post-operative deaths (deaths within 10 days after surgery) to the total number of patients operated on during that period.

$$\textbf{Postoperative death rate} = \frac{\text{Total postoperative deaths for the period}}{\text{Total patients operated for the same period}} \times 100$$

Sample Computation:

For example, a health facility had a total of 72 surgical operations performed for the month of February, one (1) of which died due to coronary artery bypass after ten (10) days of surgical operation, computation is as follows:

$$\textbf{Post-operative death rate} = \frac{1}{72} \times 100 = \underline{\textbf{1.39\%}}$$

5. ***Perinatal Death*** refers to the number of stillbirths and deaths in the first week of life (early neonatal mortality). (WHO definition)

$$\textbf{Perinatal mortality rate} = \frac{\text{(Early neonatal deaths + stillbirths)}}{\text{Total births}} \times 100$$

where total births = live births + stillbirths.

$$\textbf{Perinatal mortality rate} = \frac{48 + 12}{5877} \times 100 = 1.02\%$$

6. ***Fetal Death Rate (Stillbirth Rate)*** is the ratio of intermediate and late fetal deaths to the total number of births including intermediate and late fetal deaths. Fetal deaths are classified as:

   a. Early Fetal Death – less than 20 weeks of gestation (500 grams or less)
   b. Intermediate Fetal Death – 20 weeks of gestation but less than 28 weeks (501 to 1000 grams)
   c. Late Fetal Death – 20 or more weeks of gestation (1001 grams – stillbirth)

$$\textbf{Fetal death rate} = \frac{\text{Total no. of intermediate and late fetal deaths for the period}}{\text{Total no. of birth (including intermediate and late fetal deaths) for the same period}} \times 100$$

Sample Computation:

For example, in January, a health facility had a total of 98 live births, one (1) intermediate and 4 late fetal deaths. To determine the fetal death rate, the total number of intermediate (1) and late fetal deaths (5) is divided by the total number of live births and the intermediate and late fetal deaths (98+5). The computation is as follows:

$$\textbf{Fetal death rate} = \frac{1 + 4}{98 \quad 5 \quad 103} \times 100 = \frac{5}{} \times 100 = 4.85$$

Note:

Below two percent (2%) is considered normal by Western standards.

7. ***Neonatal Death Rate (infant Newborn Mortality Rate)*** is the ratio of newborn deaths to the total number of newborn discharges including deaths.

$$\textbf{Neonatal death rate (Infant newborn mortality rate)} = \frac{\text{Total no. of newborn deaths for the period}}{\text{Total no. of newborn infant discharges (including deaths) for the same period}} \times 100$$

Sample Computation:

For example, a health facility reported the following statistics for the year 2010: newborn deaths 3, newborn discharges 3,850. Infant newborn mortality rate is 0.08%.

$$\textbf{Neonatal death rate} = \frac{3}{3{,}850} \times 100 = 0.08\%$$

Note:

- Final deaths of less than 20 weeks shall not be included as well as those who were admitted after their deliveries/births outside the health facilities.
- For infant death rate, below 2% is acceptable by Western standards.

Neonatal Death could be divided into:

1. Neonatal Period I – from the hour of birth through 23 hours and 59 minutes.
2. Neonatal Period II – from the beginning of the 24th hour of life through 6 days, 23 hours, and 59 minutes.
3. Neonatal Period III – from the beginning of the 7th day of life through 27 days, 23 hours, and 59 minutes.

8. ***Infant Death Rate*** is the ratio of the total number of infant deaths including neonatal and post neonatal deaths rate of a live born infant at any time from the moment of birth to the end of the first year of life (364 days, 23 hours, 59 minutes from the moment of birth)

$$\textbf{Infant Death Rate} = \frac{\text{Total no. of Infant deaths (neonatal and post neonatal during a period}}{\text{Number of live births during the period}} \times 100$$

Sample Computation:

Using the same data on the above example on the computation of Infant Newborn Mortality rate with total live births of 3,856, the infant death rate is calculated as follows:

$$\textbf{Infant death rate} = \frac{3}{} \times 100 = 0.08\%$$

3,856

9. ***Autopsy Rate*** is the proportion of deaths that are followed by the performance of an autopsy.

    a. **Gross Autopsy Rate** is the ratio of all autopsies performed in the health facility to all in-patient deaths in the health facility.

$$\textbf{Gross autopsy rate} = \frac{\text{Total no. of autopsies performed for a period}}{\text{Total no. of inpatient deaths for the same period}} \times 100$$

    Sample Computation:

    For example, in September 2010, a health facility discharged 942 patients with 36 deaths (including newborn) and performed 11 autopsies. Using the formula given above, the gross autopsy rate is:

$$\textbf{Gross autopsy rate} = \frac{11}{36} \times 100 = 30.56\%$$

    b. **Net Autopsy Rate** is the ratio of all autopsies to all inpatient deaths minus the un-autopsied cases during the period.

$$\textbf{Net autopsy rate} = \frac{\text{Total no. of autopsies performed for a period}}{\text{Total deaths – un-autopsied cases for the same period}} \times 100$$

Sample Computation:

In July 2011, a health facility had a total of 32 deaths and performed 12 autopsies. Three (3) bodies were released to the forensic examiner for autopsy. Therefore, 3 cases are subtracted from the denominator because they were not autopsied by the health facility. Dividing the number of inpatient autopsies performed (12) by autopsy rate of 41.38%

$$\textbf{Net autopsy rate} = \frac{12}{(32\text{-}3)} \times 100 = \frac{12}{29} \times 100 = 41.38\%$$

Note: Exclusions:

- Stillbirth, dead on arrival (DOA)
- Death in the Emergency Department when a patient is not admitted. (ED Death)
- Medico-Legal cases are referred to the proper authority.

CHAPTER 6
Health Records in Medico-legal, Investigative and Court Procedures

6.1 Ownership of the Health Record

Health facilities own the physical aspect of the health record, but legally, the privilege against disclosure belongs to the patient and the attending physician. In a health facility setting, proper notification of the Attending Physician prior to the release of clinical information is ideal in order to protect the legal interest of the doctor and other healthcare providers as well as the health facility, hence verbal requests for clinical information shall be discouraged in favor of written requests.

6.2 Accessibility

As a general rule, all members of the health professionals who are directly involved in the treatment of a patient shall have access to the patients' health record. In cases where the patient is discharged and the health records are turned over to the HIMD, all requests for access must be put in writing, which will require the approval of the HIM Head or the Chief of Hospital/Medical Center Chief or his duly authorized representative.

The health record is a legal document, as such, all records shall be stored in areas where only authorized staff are allowed access and appropriate security measures are instituted. No clinical information concerning a patient or client shall be released to another person without the consent of the patient or authorized representative.

6.3 Confidentiality

A health record is confidential and the patients' right to privacy must be the primary concern in the release of information. It serves as a privileged communication between the physician or other health professional and the patient.

6.3.1 Rules on Confidentiality pertaining to Specific Health Records

The following are the rules pertaining to the confidentiality of specific health records according to law:

6.3.1.1 Records of Drug Dependents

a. Records under the Voluntary Submission Program

In accordance with Section 60 of Republic Act 9165, "Judicial and medical records of drug dependents under the voluntary submission program shall be confidential and shall not be used against him for any purpose, except to determine how many times, by himself/herself or through his/her parent, spouse, guardian or relative within the fourth degree of consanguinity or affinity, he/she voluntarily submitted himself/herself for confinement, treatment and rehabilitation or has been committed to a Center under this program."

b. Records under the Compulsory Submission Program

In accordance with Section 64 of Republic Act 9165, "The records of a drug dependent who was rehabilitated and discharged from the Centre under the compulsory submission program, or who was charged for violation of Section 15 of the Comprehensive Dangerous Drug Act of 2002, shall be covered by Section 60 of this act. However, the record of a drug dependent who was not rehabilitated, or who escaped but did not surrender himself/herself within the prescribed period, shall be forwarded to the court and their use shall be determined by the court, taking into consideration public interest and the welfare of the drug dependent."

6.3.2 Health Information on Violence against Women and their Children

In accordance with Section 44 of Republic Act 9262, "All records pertaining to cases of violence against women and their children including those in the barangay shall be confidential and all public officers and employees and public or private clinics to hospitals shall respect the right to privacy of the victim. Whoever publishes or causes to be published, in any format, the name, address, telephone number, school, business address, employer, or other identifying information of a victim or an immediate family member, without the latter's consent, shall be liable to the contempt power of the court."

6.3.3 Health Information of Human Immunodeficiency Virus (HIV) Patient

Medical confidentiality shall protect and uphold the right to privacy of an individual who undergoes HIV testing or is diagnosed to have HIV. It includes the safeguarding of all health records obtained by health professionals, health instructors, co-workers, employers, recruitment agencies, insurance companies, data encoders, and other custodians of said records, file or data.

Confidentiality shall encompass all forms of communication that directly or indirectly lead to the disclosure of information on the identity or health status of any person who undergoes HIV testing or is diagnosed to have HIV.

This information may include but is not limited to the name, address, picture, physical description or any other characteristics of a person, which may lead to his/her identification.

To safeguard the confidentiality of a person's HIV/AIDS record, protocols and policies shall be adopted by concerned officials, agencies and institutions.

6.3.3.1 Exceptions to the mandate of confidentiality

The requirement for medical confidentiality shall be waived in the following instances, as stated in Sec. 45 of Article VI Confidentiality of the Philippine HIV and AIDS Policy Act (RA 11166):

- When complying with reportorial requirements of the national active passive surveillance system of the DOH: Provided, That the information related to a person's identify shall remain confidential;
- When informing other health workers directly involved in the treatment or care of a PLHIV: Provided, that such worker shall be required to perform the duty of shared medical confidentiality; and
- When responding to a subpoena duces tecum and subpoena ad testificandum issued by a court with jurisdiction over a legal proceeding where the main issue is the HIV status of an individual: Provided, That the confidential medical record, after having been verified for accuracy by the head of the office or department, shall remain anonymous and unlinked and shall be properly sealed by its lawful custodian, hand delivered to the court, and personally opened by the judge: Provided, further, That the judicial proceedings be held in executive session.

6.3.3.2 Release of HIV/AIDS Test Results

Likewise, the IRR of RA 11166 states that, the result of HIV/AIDS testing shall be confidential and shall be released on to the following:

- Person who was tested;
- Parent of a minor who was tested;
- Legal Guardian or a duly assigned licensed social worker or health worker, whichever is applicable, for a minor, mentally incapacitated person or orphan who was tested;
- Person authorized to receive such results in conjunction with the DOH Monitoring Body
- A judge of the Lower Court, Justice of the Court of Appeals or Supreme Court Justice who has jurisdiction over the case.

6.3.4 Health Information of Psychiatric Patient

Health information of psychiatric patients shall be released only upon presentation of a written authorization from the patient's nearest kin or by a person appointed by the court as the legal guardian. If the request is from a psychiatric facility where the patient is presently confined, the information shall be released as soon as an approval from the Head of Health facility is obtained.

The Mental Health Act or Republic Act 11036 states that "Confidentiality of all information, communications, and records, in whatever form or medium stored regarding the service user, any aspect of the service user's mental health, or any treatment or care received by the service user, which information, communications, and records shall not be disclosed to third parties without any written consent of the service user concerned or the service user's legal representative except in the following circumstances;

- Disclosure is required by law or pursuant to an order issued by a court of competent jurisdiction;
- The service user has expressed consent to the disclosure;
- A life-threatening emergency exists and such disclosure is necessary to prevent harm or injury to the service user or to other persons;

- The service user is a minor and the attending mental health professional reasonably believes that the service user is a victim of child abuse; or
- Disclosure is required in connection with an administrative, civil or criminal case against a mental health professional or worker for negligence or a breach of professional ethics, to the extent necessary to completely adjudicate, settle, or resolve any issue or controversy involved therein.

6.4 Health Record with Investigative Concerns

Prior to the release of health records for any investigative concerns, it shall undergo a thorough quantitative and qualitative analysis to ensure accuracy and completeness of all information that the case requires.

During and after the conduct of the investigation, the Head of HIMD or an authorized representative shall ensure that there are no alterations of the information and no pages detached or missing.

6.4.1 Insurance (PHIC, SSS, GSIS, Private Insurance Companies)

An insurance verifier shall be required an original copy of the waiver from the patient, or patient's next of kin in case of death or physical/mental disability, duly notarized before being given access to the health record/information about the patient. The copy of the waiver shall also be countersigned and dated by the insurance verifier and shall be filed with the record. Insurance verifiers representing PHIC and other Health Maintenance Organization shall be properly identified by the head of the HIMD before given access to review health records for reimbursement purposes.

6.4.2 Adjudicatory Agencies (PNP, NBI, CIDG, BJMP, PDEA and other Law Enforcement Agencies)

In the event that there is a need for a review of the health record concerning investigation of a certain case, a representative shall be allowed to have access provided that a written request duly signed by the Chief /Director of their respective agency is approved by the Head of the health facility.

6.4.3 Clinical Research/Studies

Researchers may be given access to health records only after complying with the requirements set by the Research Ethics Committee or the Standing Policy of the Health facility.

6.4.4 Patients Complaints (CHR, PRC, CSC, Presidential Hotline)

Any complaint pertaining to a patient has to be validated. It is the role of the Head of HIMD to review the health record following standards on the release of clinical information.

6.5 Records Subpoenaed by the Court

Subpoena testificandum is a process directed to a person to attend and to testify in any investigation being conducted under Philippine law. He may also be required to bring books, documents, or other materials that may be required by the Court, in which case, it is called a ***subpoena duces tecum***.

Subpoena duces tecum ad testificandum is issued when a person is mandated to testify and to bring the documents to court.

Oftentimes, the HIMD receives a ***subpoena duces tecum***, which only requires the HIMD head to bring a particular record(s) to court.

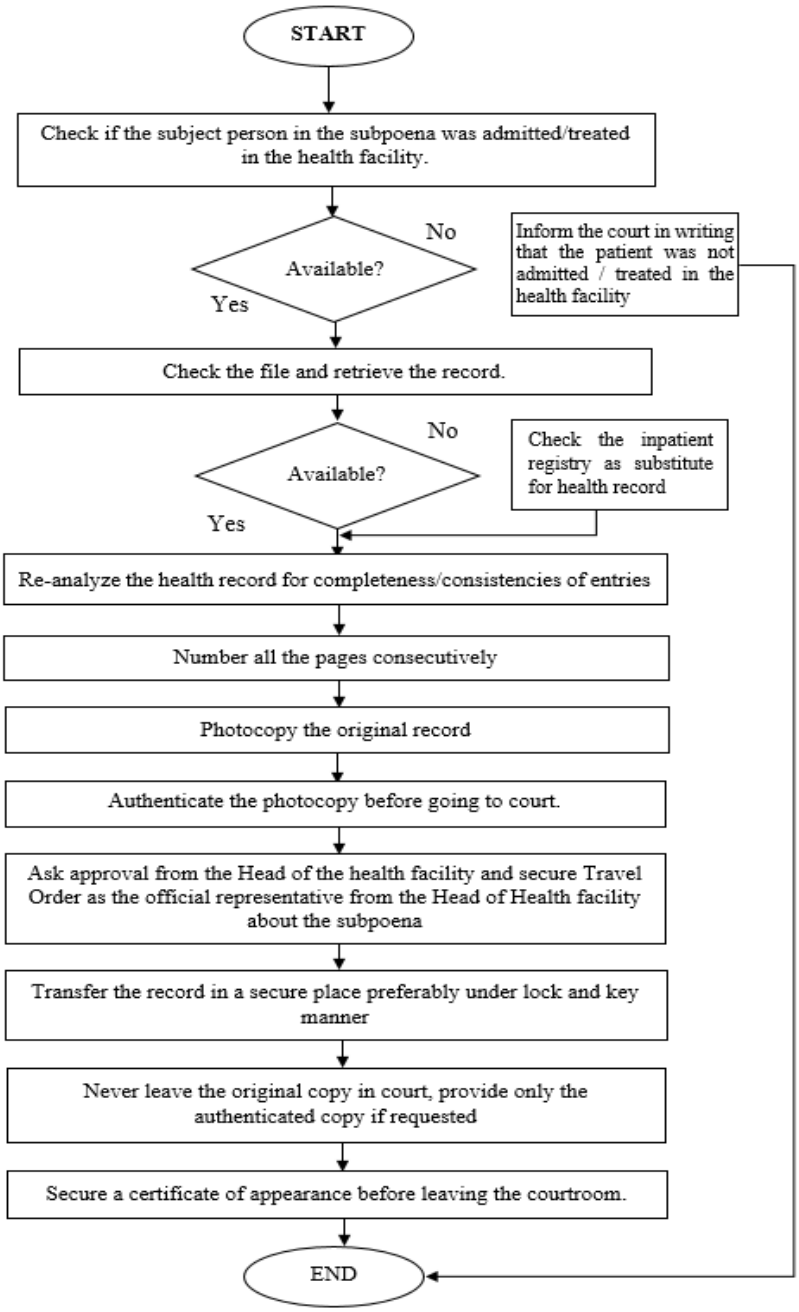
A legally served subpoena is binding on the person to whom it is addressed. The HIMD staff should not accept any subpoena not directly addressed to HIMD. If a subpoena is addressed to a particular doctor, it must be served to the doctor or his representative.

In situations where a subpoena is served to a doctor who is no longer connected with the institution, a letter of notification signed by the MCC, addressed to the presiding Judge shall be accomplished and submitted to the court.

Upon receipt of the subpoena, the recipient must always indicate the time and date of receipt.

Exceptions – The provisions of Sections 8 (Compelling Attendance) and 9 (Contempt) of rule 21 of the 1997 Rules of Civil Procedure shall not apply to a witness who resides more than 100 kilometers from his/her residence to the place where he is to testify by the ordinary course of travel, or to a detention prisoner if no permission of the court.

Process Flow in Response to Subpoena duces tecum



In the event that the health record can no longer be provided in court, the following shall apply:

REASON	ACTION
1. Misfiled/ Lost Health Record	Bring In-patient / Operating Room / Delivery Room / Birth and Death Registry to court
2. Disposed in accordance with the Law on Records Disposition	Certificate of Disposal from National Archives of the Philippines (NAP)
3. Destroyed by Calamities	In-Patient Registry, if available or Certification from concerned agencies of the damaged records due to calamities.

6.6. Informed Consent for Medical and Surgical Procedure

As a general rule, no treatment or procedure may be performed without the patient's/relative's consent. There are instances where consent could not be obtained from an incapacitated person (for example when a patient is comatose or a minor) therefore surrogate consent must be obtained from the parent, nearest-of- kin or legal guardian.

A valid consent must be signed by the patient/relative together with a witness and must also be dated and timed. Aside from these requirements, the person giving the consent should be legally and mentally competent. The consent must be freely/voluntarily given and clearly understood by the authorized person.

CHAPTER 7
Introduction to Electronic Health Record

7.1 Introduction

The rapid changes in the delivery of healthcare and public demand for more extended and improved health services have made electronic health records an obligation of every health facility. The Republic Act No. 11223 or the Universal Health Care (UHC) Act, which has been signed on February 20, 2019, mandates that all Filipino citizens be automatically enrolled in the National Health Insurance Program and prescribes complementary reforms in the health system. This gives citizens access to the full continuum of health services they need, while ensuring financial risk protection. To illustrate, below is an excerpt of Section 36, Health Information System, of the UHC Act:

> *"All health service providers and insurers are required to maintain a health information system on enterprise resource planning, human resource information system, electronic health records, and electronic prescription log, including electronic health commodities logistics management information, which shall be electronically uploaded on a regular basis through interoperable systems consistent with the standards set by the DOH and PhilHealth and in consultation with the DICT and NPC; Provided, That the applicable standards shall set depending on variables such as type and level of healthcare providers."*

Further, the Health Information Systems practitioners play important roles in the application of eHealth in the Philippine standards: from optimizing processes and registration, improving data collection to processing and analysis of health, aligning with the Data Privacy Act of 2012 or RA 10173.

Thus, the DOH has continuously addressed the challenges and demands to further improve health care service deliveries and outcomes through the DOH Integrated Hospital Operations Management Information System (iHOMIS) for government hospitals. The iHOMIS is a computer-based information system developed by the DOH to support hospital management for effective and quality health care providing timely, relevant and reliable information. It uses data from other systems (e.g. DOH Licensing, NHFR (National Health Facility Registry) Systems, PSA data and others). It also assists planning, decision-making and linkages with the different hospital service components and other health facilities.

7.2 Electronic Health Record (EHR) defined

The Electronic Health Record:

- Contains all personal health information belonging to an individual;
- Is entered and accessed electronically by healthcare providers over the person's lifetime; and
- Extends beyond acute inpatient situations including all ambulatory care settings at which the patient receives care.

The World Health Organization's declaration of Health for All by the Year 2000 highlighted the need for better health care services, not only at the hospital (secondary) level, but also for primary healthcare and community health services. This has required a change of focus in healthcare in many areas to ensure, if possible, that the implementation of an electronic health record covers healthcare delivery services across a broad spectrum of healthcare.

Ideally, it should reflect the entire health history of an individual across his or her lifetime including data from multiple providers from a variety of healthcare settings.

Such an extensive system, however, has not been introduced by many institutions/countries to date, although many are planned, but may still not be possible in some developing countries or in fact some developed countries.

Whatever the type of electronic health record decided upon, the health information contained in it must be organized primarily to support continuing, efficient and quality healthcare. It must also continue to meet legal, confidentiality, and retention requirements of the patient, the attending health professional and the healthcare institution/country.

For the purpose of this manual, the title electronic health record (EHR), as defined immediately above, will be used as the preferred definition.

7.3 Goals and Principles upheld by EHR Implementation

With the many advances in information technology over the past years, particularly in healthcare, a number of different forms of electronic health records (EHR) have been discussed, developed, and implemented. Some institutions/countries are currently planning the introduction of a nationwide electronic health record while others have actually implemented some form of EHR. However, the type and extent of electronic health records vary and what one country calls an EHR may not be the same as that developed in another country.

In addition to the above, resistance by some medical practitioners and health professionals generally to a change from manual to electronic documentation may be a problem in both developed and developing countries. Most health administrators and information managers are aware that it may take time to change or at least modify health practitioner behavior and attitudes.

It is recognized as well that more than simply adopting a paperless system, the focus on encouraging departments and healthcare practitioners to move to an electronic system should stem from the following goals:

a. Improvement in the accuracy and quality of data recorded in a health record.
b. Enhancement in the healthcare providers' access to a patient's health care information enabling it to be shared by all for the present and continuing care of that patient.
c. Improvement in the quality of care as a result of having health information immediately available at all times for patient care.

d. Improvement in the efficiency of the health record service; and

e. Reduce health costs brought about by inefficient systems

With these, the following principle shall be considered in adopting EHR:

1. **Patient-centered design**
    a. The use of an EHR should add value for the patient.
    b. The primary function of an EHR is clinical care.
2. **Health care professionals**
    a. The use of an EHR should improve, or at a minimum not reduce, the well-being of health care workers.
    b. The use of an EHR should align the work with the training of the worker.
    c. The EHR is a shared information platform for individual and population health.
3. **Efficiency**
    a. The use of an EHR should minimize waste.
    b. Electronic workflows should align with clinical work.
    c. Various methods of communication, including non-electronic forms, will be necessary for optimal patient care.
4. **Regulation and payment**
    a. Sufficient resources should be available for the new work associated with the advanced use of an EHR.
    b. Policies around EHR use should reflect the strength of the evidence base supporting them.
    c. Regulatory balance between often competing values (i.e., clinical quality vs. security or efficiency vs. performance measurement) should be sought.
5. **Privacy and Confidentiality**

    The principle of privacy, confidentiality, and security shall be upheld by the EHR.

    a. Privacy – A legal concept referring to the protection that has been accorded to an individual to control both access to and use of personal information. Privacy protection varies from one jurisdiction to another and is defined by laws and regulations. Privacy protections provide the overall framework within which both confidentiality and security are implemented.
    b. Confidentiality – Concerns the right of individuals to the protection of their personal data during storage, transfer, and use, in order to prevent unauthorized disclosure of that information to third parties.
    c. Security – refers to the collective body of physical, electronic, and procedural processes designed to prevent breaches in information confidentiality. Security also concerns system availability, including the identification and management of predictable risks to data systems, such as power outages, staff shortages, natural disasters, and user error.

7.4 Guide for Health Facilities towards adopting and EHR

To serve as a guide for health facilities to transition into an EHR, the following steps/procedure should be conducted to ensure that all issues and concerns related to its implementation can be addressed.

7.4.1 Needs Assessment and Review of Current System

1. All health facilities shall ensure that hospitals are adhering to standards set for keeping health records as these EHRs follow the same principles.
2. Emphasis is given to the following:
    - Numbering system dedicating a unique number system for each patient (numbers are not repeated)
    - Ensure that all health records associated with the patient are kept
3. Assessment usually shows the things that the health facility needs to address prior to implementation of the EHR to ensure the smooth transition to EHR.

7.4.2 Planning considerations in the transition to EHR

1. Once issues and challenges are identified health facilities are to do the following:
    a. Establishment of steering committee
    b. Preparation of a clearly defined statement of the type of EHR to be implemented
    c. Identification of perceived benefits to the institution with the introduction of an EHR system
    d. Preparation of a list of clearly stated goals and strategies for implementation
    e. Review of current health record policies and procedures and develop them to cover proposed changes
    f. Determine record structure and content:
        - Ensure a patient identification system is in place
        - Determine an effective means of obtaining the patient's informed consent
2. Other possible issues may include:
    a. Clinical data entry issues and lack of standard terminology
    b. Resistance to computer technology and lack of computer literacy
    c. Strong resistance to change by many healthcare providers
    d. High cost of computers and computer systems and funding limitations
    e. Concern by providers as to whether information will be available on request
    f. Concerns raised by healthcare professionals, patients and the general community about privacy, confidentiality and the quality and accuracy of electronically generated information.
    g. Quality of electronic healthcare information and accuracy of data entries
    h. Lack of staff with adequate knowledge of disease classification systems
    i. Human resources issues – lack of staff with adequate skills
    j. Environmental issues – electrical wiring and supply of electricity, amount and quality of space needed for computers, etc.
    k. Involvement of clinicians and hospital administrators

7.4.3 Identifying the EHR Design and Technical Specification

1. Review of EHR Design should also be conducted to ensure that the following concerns or issues are avoided in the selected HER
    a. Variable levels of functionality and data security
    b. Unpredictable vendor/technical support
    c. Issues with long-term sustainability
    d. Variable reporting functionality
    e. Limited feedback of data in EHR systems for patient care
2. EHR should be able to do the following:
    a. Collect and display essential demographic patient information such as: name, birth date, gender, rank, etc.
    b. Manage patient's problem/diagnosis list: coded diagnosis, onset date, history, chronicity, date resolved
    c. Collect and display patient medication
    d. Collect and display patient allergies
    e. Collect and display test results
    f. Accept encounter clinical data: vital signs, weight, height, calculate BMI, times of rehabilitation
    g. Accept clinical notes in structured format and in free text format which include the Arm Forces of the Philippines (AFP), Philippine National Police (PNP), Bureau of Jail Management and Penology, Bureau of Fire Protection (BFP) and Treatment and Rehabilitation Center (TRCs)
3. In addition, ensure that the EHR is accredited by DOH through Licensing/ Accreditation Implementation of the National eHealth Electronic Health Record System Validation (NEHEHRSV) based on existing guidelines.
4. Implementation
    a. Full implementation requires the following:
        - detailed preparation with all technical requirements in place
        - working telecommunication infrastructure fully operational
        - the system tested thoroughly, and
        - all staff ready and fully trained.
    b. Data for all active patient must be uploaded immediately before the identified cut-off schedule for full migration (e.g. identification and demographic details uploaded in the new system)
    c. Capacity of the electronic system to back up files safely is a critical factor in determining full transition from a manual system to an electronic system.

7.5 Electronic Medical Records

Electronic Medical Records (EMRs) are a digital version of the paper charts in the clinician's office. An **EMR** contains the **medical** and treatment history of the patients in one practice. EMRs have advantages over paper **records**.

The term Electronic Medical Record or EMR, as with Automated Health Records, has been used to describe automated systems based on document imaging or systems which have been developed within a medical practice or community health center. These have been used extensively by general practitioners in many developed countries and include patient identification details, medications and prescription generation, laboratory results and in some cases all healthcare information recorded by the doctor during each visit by the patient. In some countries, such as Korea, the term EMR is used to define an electronic record system within a hospital which as well as the above includes clinical information entered by the healthcare professional at the point of care.

Advantages of Electronic Medical Records

- Providing accurate, up-to-date, and complete information about patients at the point of care.
- Enabling quick access to **patient records** for more coordinated, efficient care.
- Securely sharing **electronic** information with patients and other clinicians.

Table 11. Comparison of Paper vs. Electronic

FACTOR	PAPER	ELECTRONIC
Storage/Space Requirement	Filing cabinets Records Room	Computers, servers, switches, etc. Data Center
Manpower	Less efficient work processes Need not be computer experts	More efficient work processes Computer proficiency required
Supplies	Paper, ink, folders, pens, etc. Environmental cost May or may not need electricity	Data servers, computers, etc. Electricity/back-up generator
Management/Sharing	Reproduce copy File/Re-file Slow mobility Difficult to collaborate Maintain original copies	Download file Easy back-up Fast transmission Easy collaboration
Access	Manual retrieval	System search and retrieval
Security/Protection	Location – strategic Records room – authorized staff	Location – strategic Data Center – authorized staff Install CCTV / Air-conditioning System Log-in

	Install CCTV / Air-conditioning	Firewall Maintenance – Annual
Retention/Disposal	Follow NAP guidelines Permanent records – perpetual Temporary records – disposal	Follow NAP guidelines Retention period same as paper records

(See Annex A for the Overview of Electronic Medical Records and its operations by World Health Organization, 2006)

CHAPTER 8
Continuous Quality Improvement for HIMD

The DOH Administrative Order No. 2020-0034, *"Revised Guidelines on the Implementation of Continuous Quality Improvement (CQI) Program in Health Facilities in Support of Quality Access for Universal Health Care"*, mandates the establishment of the CQI program in health facilities. Each hospital department of the health facility is encouraged to implement CQI for the overall quality improvement.

Continuous Quality Improvement (CQI) for HIMD strengthens the implementation of the existing Standard Operating Procedures (SOPs). It provides quality health records for continuity of care to patients and quality data on the health facility planning and decision making to attain cost-effective health record management. It evaluates the quality of service delivered, facilitates necessary corrective actions to provide feedback, identify staff in-service training needs, provide an objective basis for disciplinary actions, encourage employees to achieve optimum level and recognize excellence in employee performance in order to institute staff development.

CQI evolved from Quality Assurance (QA) Program which its main framework provided guidelines for health facilities to plan and systematize procedures in providing quality service. When CQI is adopted by the health facility management as one of each ideals, as part of the health management system, the result is a Total Quality Management (TQM). CQI is founded on a total quality management philosophy, established in a quality management system compliant with ISO 9001:2015 standards, and strategically managed on platforms such as the Performance Governance System and the Strategic Performance Management System.

8.1 Composition of CQI Team in HIMD

The HIMD will organize a quality improvement team with the following members:

- One who is involved and who knows the process
- One who is affected by the problem
- One who has technical expertise
- One who makes decision about the process
- Other members who can contribute to the formulation and implementation of solutions

An employee who has the expertise or one who is affected by the problem can be a member of a QI team regardless of the department she or he belongs to. The composition of the team may be multidisciplinary or cross functional.

The team is mandated to meet regularly to identify problems, understand and analyze the causes, and formulate best solutions for implementation. Evaluation and monitoring must be carried out in order to institute corrective actions making CQI a continuing cycle.

8.2 Expected Outcomes of the Quality Improvement Activities

- Continuous improvement project of clinical and non-clinical care and service.
- Identification of barriers in the achievement of higher quality patient care.
- Motivation for the staff to be more aware of and interested in standards of patient care and service.
- Delivery of safe and efficient care and service.
- Efficient and effective allocation and use of resources.
- Commitment from staff/management which will ensure that the program is ongoing, upgraded, improved standards are long lasting and conformed to the standard required by other agencies.
- Construction input, from all staff levels, into the continuing education program of the complex.
- Communication at all levels about problems related to standards of quality care and service.
- Cooperative problem-solving, where a service involves more than one area in the complex.

8.3 Essential Elements of Quality Improvement

1. ***Planned and Systematic Approach.*** Quality assurance plan should exist and address the following:
    a. Scope of the program
    b. Objective
    c. Methods to be used
    d. The individuals to be involved in the program
2. ***Monitoring.*** There should be a systematic ongoing process of collecting information on clinical and non-clinical performance.
3. ***Assessment.*** The periodic analysis and interpretation of the information collected in order to identify problems in patient care.
4. ***Action.*** At this stage important problems in patient care or opportunities to improve care are identified, action/studies are undertaken.
5. ***Evaluation.*** The effectiveness of actions taken is evaluated to ensure long-term improvement.
6. ***Feedback.*** To be effective, results of the activities should be regularly relayed to the staff of people involved in the program.

8.4 Plan-Do-Study-Act (PDSA) Cycle

One of the frameworks established to facilitate quality improvement is the PDSA Cycle. It is a four-stage problem-solving model used to improve processes and provide a system of organization in its dynamic environment overtime. The cycle is a shorthand for testing change by systematically identifying the problem and its root cause (Plan), carrying out the test (Do), understanding and learning from the results (Study) and determining the needed modifications to be made (Act). Below is a model of the cycle showing the processes involved.

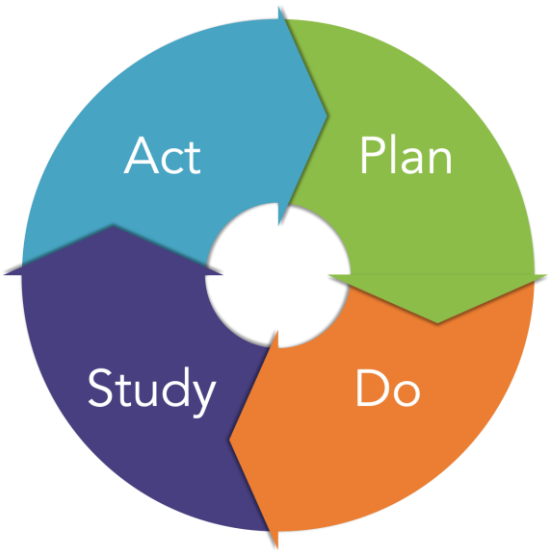


Figure 11. The PDSA Cycle

Table 12. The PDSA Cycle - Step by step (DOH Administrative Order No. 2020-0034)

Steps	Guidelines	Tools and Techniques	Expected Output
PLAN: Define the problem and identify the root cause			
Step 1: Identify areas for improvement	1. Identify the area, problem, or opportunity for improvement. 3. Estimate and commit the needed resources.	- Brainstorming - Prioritization Matrix Criteria - Check sheet (for data collection)	- List of problems identified
Step 2: Assemble a team.	1. Identify and assemble team members. 2. Specify team member roles and responsibilities. 3. Specify meeting frequency and structure. 4. Develop a SMART aim.		- SMART aim statement developed - Complete Team with well-defined roles and responsibilities

Step 3: Identify the current process.	1. Examine the current approach or process flow. 2. Obtain existing baseline data or create a plan to obtain needed baseline data. 3. Obtain input from stakeholders. 4. Determine root causes of the problem.	- Brainstorming - Flowchart - Cause and Effect/ Fishbone Diagram/ Ishikawa Diagram - Control Charts	- Flowchart constructed - Data requirements - List of real causes of the problem - Final Problem statement
Step 4: Identify potential change strategies.	1. Identify all potential change strategies based on root causes. 2. Select change strategy (or strategies) most likely to achieve the SMART aim.		- Alternative solutions or strategies
Step 5: Identify improvement theory.	1. Develop a theory of change for the change strategy. 2. Develop a strategy to test the theory on a small scale (small number of participants.) 3. Determine how the strategy will be measured.	- Documentations / reports i.e. journal articles	- Evidence- based Strategies - Evaluation Plan
DO: Customer Protection and Countermeasure			
Step 6: Test the theory.	1. Carry out the test on a small scale. 2. Collect, chart, and display data to determine the effectiveness of the change strategy. 3. Monitor fidelity of implementation of the change strategy; document problems, unexpected observations, and unintended side effects.	- Check sheet - Flowchart	- Data on the effectiveness of the strategy - Documented problems, unexpected effects and general observations
STUDY: Confirm effectiveness			
Step 7: Study the results.	1. Determine whether the improvement was successful on a small scale. 2. Determine if the results matched the theory/ prediction. 3.Determine unintended consequences if any. 4. Describe and report what you learned.	- Pareto Diagram or Charts - Control Charts	- Trends - Conclusion and recommendations based on the result

ACT: Feedback/ Feed forward			
Step 8: Scale up implementation.	1. Scale up successful change strategies and continue testing until improvement is achieved. 2. Develop and test new theories for unsuccessful changes. 3.Standardize successful improvements.	- 5 Ws and 1H (What, When, Where, Who, Why and How)	- New test theories
Step 9: Establish future plans.	1. Repeat the PDSA cycle, when needed. 2. Take steps to preserve gains and sustain successes. 3. Make a long-term plan for additional improvements. 4. Celebrate your successes.		- Team development plan - Radar Chart

8.5 Risk Management

Risk management is an organized effort to identify, assess, and reduce, where appropriate, risk to patients, visitors, staff and organizational assets. It helps minimize risks and extra costs that may be incurred by any threat to the operations of the HIMD. One important strategy is the identification of serious clinical documentation errors/problems.Clinical Documentation as the foundation of the health record should be accurate, timely and reflect the scope of services provided.

The HIMD has full knowledge of the different documentation and /or recording standards which is used as a guide in the quantitative and qualitative analysis of health records. An inherent function of the HIMD is to assist the members of the medical, nursing and other professionals to come up with quality documentation.

Below introduces the CDI and its direct impact on patient care.

A. **Clinical Documentation Improvement (CDI)**

To facilitate quality documentation of health records, clinical documentation improvement (CDI) is a team approach to improving concurrent (while the patient is receiving care) documentation practices through ongoing education and clarification of clinical documentation that can't be matched with the latest ICD code.

The goals of CDI are to facilitate clear, concise, clinically accurate information in the health record through the identification of incomplete, vague, and/or missing diagnoses allowing capture of all applicable diagnoses by the latest ICD code to reflect:

- Accurate reimbursement
- Quality of care/services provided
- Patient severity of illness/risk of mortality
- Appropriate hospital and physician profiles

The Role of CDI

General mission:

- Facilitate the creation of a health record that accurately represents the acuity of the patient's illness and the hospital resources used to treat the patient by ensuring provider documentation can be "matched" with ICD code
- Work collaboratively with the medical staff and coding department to translate provider documentation into diagnostic terms that can be captured by ICD codes while the patient is receiving inpatient hospital treatment (concurrent review)

What is the importance of CDI?

- The convergence of clinical, documentation, and coding processes is vital to a healthy revenue cycle, and more important, to a healthy patient.
- To that end, CDI has a direct impact on patient care by providing information to all members of the care team, as well as those downstream who may be treating the patient at a later date.

High Quality Documentation

1. Legible – clear enough to be read and easily deciphered
2. Reliable – trustworthy, safe, yielding the same result when repeated
3. Precise – accurate, exact, strictly defined
4. Complete – has the maximum content, thorough
5. Consistent – not contradictory
6. Clear – unambiguous, intelligible, not vague
7. Timely – performed at the time of service

B. Self-Assessment Tool of HIMD

The self-assessment tool of the HIMD can be used to evaluate and monitor compliance to the standards of the HIMD. Refer to Annex X.

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ANNEXES

ANNEX A: Overview of EMR

Implementation of a computerized MPI

Computerization of the MPI would be spread over a period of time through:

- entry of information already held on index cards from the manual MPI card system including all patients in hospital at the time of implementation;
- inpatient registration; and
- outpatient registration.

The entry of data on new patients should be completed at the time they are admitted as inpatients or registered as outpatients, that is, in the Admission office for inpatients and the outpatient department registration desk for outpatients.

Search programme

As for the manual system, in a computerized MPI, the search programme should enable the operator to locate a particular patient to determine if that patient has been in hospital previously and has a health record number.

Limited information on a number of patients (one patient per line) may be displayed on a screen for review or further action. These can be displayed by:

- patient name giving hospital number; and
- hospital number giving patient name.

When the particular person is identified, the full index file information for that selected patient may be displayed on the screen. If there are changes to a patient's identification details, they should be made at the time of admission.

- When retrieving information, strict security codes should be used to prevent unauthorized access and alterations. Each user should have his/her own user name as well as a password, which is assigned by the computer manager and changed periodically.
- Only an authorized user should be able to access information relating to a patient and to change, add to or delete records on the master file.

The MPI should force a name search before a name can be entered, unless the name is being entered with a pre-existing medical record number.

Operation of a Computerized MPI

- All name searches should use the name and at least one unique patient characteristic (see PATIENT IDENTIFICATION).
- As in a manual system, correct spelling of names is vital to minimize duplicate registration of a patient.
- Entry of at least one unique patient characteristic is compulsory when adding a patient to the MPI.
- Entry of the medical record number is compulsory when adding a patient to the MPI.
- The computer automatically issues medical record numbers in strict numerical order.

- The MPI should enable the manual entry of pre-existing medical record numbers.
- Reports generated from the MPI should include:
    1. a daily printout of numbers issued, in number order, creating the NUMBER REGISTER; and
    2. regular printouts in alphabetical order of all names by family name or by first name depending on the naming conventions of the country.

A. Computerized Admission, Transfer and Discharge (ATD) System

Like the MPI, the ATD system is one of the most computerized systems involving medical records. The introduction of this type of system enables staff to maintain a file on all patients currently in hospital, awaiting admission and recently discharged. It also enables authorized users around the hospital to have direct access (via a computer terminal) to the file and automatically generate bed census and other daily statistics required by the hospital administration.

The objectives of such a system are to:

- provide an inpatient booking service for patients awaiting admission;
- keep records of the bed state and bed allocation;
- trace patients for inquiries;
- provide daily patient census reports and related statistics;
- provide information for the MPI (directly linked to the MPI system); and
- provide a complete database for all authorized users of patient identification and location information.

Within such a system, a data file is maintained on all patients:

- currently in hospital;
- awaiting admission; and
- recently discharged. In a computerized admission (transfer and discharge system) all admissions are entered at the time of admission and the discharge details are entered for all discharged /died patients at the time of discharge or death.

Important Points of a Computerized ATD System

- All admissions must have an entry in the MPI.
- There must be a linkage between the MPI and the ATD System to enable a name to be added to the MPI as part of the admission procedure.
- Daily reports are generated including:
    a. an admission list;
    b. a discharge list;
    c. a list of all inpatient at a given time; and
    d. a list of inpatients for longer than 90 days

B. Computerization of the Disease and Procedure Index

A computerized disease and procedure index has been developed in many hospitals to enhance the retrieval of medical information for research. As with a manual system, it would contain information relating to diagnoses and procedures, in coded form, to enable the retrieval of individual cases for medical research. It could use the ATD system as the base records to which disease and procedure codes are added following the completion of the medical record at discharge or death of a patient.

- Such a system could also accommodate information relating to tests performed during hospitalization for later review of the utilization of hospital services.
- The program would process the "discharge" area of the ATD master file. In such a system, relevant records in the discharge area are accessed. A specific time limit, however, should be determined regarding transfer from the discharge area to the disease/procedure index. Seven days is the suggested minimum transfer time.

1. Coding

The main condition/principal diagnosis and procedure is coded by the MRO or person given this responsibility. The diagnosis/procedure and code numbers are entered into each individual patient's admission record via a computer terminal.

2. Retrieval

The system would be designed to enable the retrieval and report generation of information on the types of diseases/ procedures treated within the hospital. It should enable retrieval by disease/procedure and also sex/age/doctor/associated diseases and hospital number.

Reports from a computerized Disease/Procedure Index could include:

- a list of all discharges not coded;
- a list of all patients with a particular code or range of codes;
- a list of last month's discharges by ICD code; and
- a list of discharges by notifiable disease code.

The ATD system writes into the MPI and disease and procedure systems. It is a temporary database of patients and kept for about two to five years. It is then archived. The MPI is permanent.

C. Computerized Record Location/Tracking System

Many types of computerized file location/tracking systems are available. With such a system, the location of a medical record can be readily found. In addition, a list of previous places where the medical record was sent can be printed, e.g.; clinics including the date when the record was sent to that location. Some hospitals use a barcode system as seen in department stores and supermarkets while others enter details via a computer terminal in the Medical Record Department.

Source: World Health Organization. Regional Office for the Western Pacific. (2006). *Medical Records Manual: A Guide For Developing Countries*. Manila: WHO Regional Office for the Western Pacific.
View full document through this URL: https://apps.who.int/iris/handle/10665/208125

ANNEX B: Patient's Health Record Audit

PATIENT NAME Last Name First Name Middle Name	HEALTH RECORD NUMBER (HRN): DISCHARGE DATE:

NOTE: Please check □ corresponding boxes for the completeness of patient's health record. This form shall be accomplished upon discharge.

No.	Health Record Form	For Nurse Station (Nurse Supervisor/ Head Nurse)	For HIMD use only	
			Checked and verified	Remarks
BASIC HEALTH RECORD FORMS				
1.	Clinical Cover Sheet			
2.	Admission Slip			
3.	Informed Consent for Admission/Confinement (for outpatient and ER, informed consent for treatment)			
4.	Amendment Form *(if any)*			
5.	Emergency Room Record or Elective Admission Form for OPD patient			
6.	History and Physical Examination			
7.	Clinical/Diagnostic Laboratory Result Forms			
8.	Doctor's Order and Progress Notes			
9.	Nurse's Notes (FDAR)			
10.	Monitoring Sheet			
	- TPR			
	- Pain Monitoring Sheet			
	- Input and Output			
	- Vital Signs			
11.	Intravenous Fluid Sheet			
12.	Medication Sheet			
13.	Discharge Summary/ Tagubilin			
SUPPLEMENTAL HEALTH RECORD FORMS				
	A. Operation Block			

1.	Informed Consent for Surgery			
2.	Informed Consent for Anaesthesia			
3.	Anaesthesia Record			
4.	PACU Monitoring Sheet			
5.	WHO Surgical Safety Checklist			
6.	Pre-operative Checklist			
7.	Operative Record			
	B. Delivery Block			
1.	Labor Room Record (Partograph)			
2.	Operative Technique			
3.	Newborn Record			
4.	Essential Intrapartum Newborn Care (EINC)			
5.	Delivery Slip			

PATIENT NAME	**HEALTH RECORD NUMBER (HRN):**
Last Name **First Name** **Middle Name**	**DISCHARGE DATE:**

NOTE: Please check □ corresponding boxes for the completeness of patient's health record.

OTHER HEALTH RECORD FORMS

No.	Health Record Form	For Nurse Station	For HIMD	Remarks
1.	Inter-departmental Referral Sheet			
2.	Blood Request Form			
3.	Clinical Abstract			
4.	Nutrition Care Plan			
5.	Medical Social Worker's Notes			

6.	Physical Therapy Notes			
7.	Respiratory Therapy Notes			
8.	Interventional Radiology Notes			
9.	Clinical Pharmacist's Notes			
10.	AMS Forms (Antimicrobial)			
11.	Fall			
12.	Consultation Sheet			
13.	Non-Disclosure Agreement for Access of Health Records			
14.	Patient Referral Form			

Checked by: _____ Received by:_____

ANNEX C: Outpatient Clinical Record

PATIENT NAME **Last Name** **First Name** **Middle Name**					**HEALTH RECORD NUMBER (HRN):**
ADDRESS **No.** **Street** **City/Municipality/Province**				**SEX:** **[ ] Male** **[ ] Female**	**STATUS:** **[ ] Single** **[ ] Married** **[ ] _____**
DATE OF BIRTH (mm/dd/yyyy)	**AGE**	**BIRTHPLACE**	**CONTACT NUMBER**	**NATIONALITY**	**RELIGION**
NAME OF SPOUSE			**NEXT OF KIN TO NOTIFY**		
FATHER'S NAME			**ADDRESS**		
MOTHER'S NAME (MAIDEN)			**RELATIONSHIP**		
ALERT NOTATION: **Allergy to: _____ (specify)** **Others: _____**					

CONSENT TO CARE

I hereby authorize Dr. _____ and the staff of your Hospital to perform the treatment and procedures deemed necessary for my care. I also give authorization for the hospital to supply information from my medical records to my insurance carrier and/or to my attorney.

_____ Signature Over Printed Name of Patient	_____ Signature of Next of Kin (for minor and/or mentally incompetent patients)	_____ Triage Nurse/Witness

DATE	**DOCTOR'S NOTES** **(S O A P)**

ANNEX D: Emergency Treatment Record

I. TRIAGE RECORD

PATIENT INFORMATION				
Name (Last, Given, Middle)				
Age	Sex ☐ Male ☐ Female		Date of Birth	
Address				Private MD
Referred by: • Self • OPD • Priv MD • Hospital	**Mode of Arrival** • Ambulance • Walk-in • Private vehicle • Police escort	**Historian** • Patient • Parent • Family • Friend		Guardian MS
VITAL SIGNS: HR/RR	BP	T	Weight	
CHIEF COMPLAINT				
HISTORY OF PRESENT ILLNESS				

REVIEW OF SYSTEMS				
GENERAL Fever Chills Weakness Nausea	EYE Redness Itching Blurred vision Loss of vision Diplopia	ENT Congestion Epistaxis Sore throat Hoarseness Ear ache Ear discharge	CV Chest pain Palpitations Orthopnea Pedal edema PND	RESP DOB Cough Sputum Hemoptysis Wheezing
GI Abdominal Pain Vomiting Constipation Melena Hematochezia Hematemesis	GU Dysuria Frequency Nocturia Vaginal discharge Vaginal bleeding	NEURO Headache Blackout Numbness Unsteady gait Seizure	MS Neck pain Back pain Hip pain Shoulder pain Joint pain	SKIN Rash Swelling Breast discharge Breast masses
PSYCH Anxious Depression Hallucination Stress Not sleeping	OTHERS	**ALL SYSTEMS REVIEWED** Negative All other systems negative Incomplete due to: Loss of Consciousness/Intubated/Exposure to Toxic Chemicals		
MEDICAL HISTORY				

PAST MEDICAL/SURGICAL	**MEDICATIONS**	**FAMILY**	**SOCIAL**
None PTB Diabetes Hypertension Asthma Cardiac ICU Admission OR		None PTB Diabetes Hypertension Asthma Cardiac Cancer	Smoker ppd X yrs Alcoholic bev drinker Illicit drug use **ALLERGIES**
Triage Officer		**Date**	**Time**

II. EMERGENCY ASSESSMENT AND DISPOSITION

PHYSICAL EXAMINATION			
Initial Assessment			
DIAGNOSTICS			
• CBG • CBC • RBS BUN Crea Na K Cl Ca Mg P • Uric Acid LDH Chol TG LDL HDL • ALT AST alk phos • Protime/PTT • CPK MB CPK MM CPK Total • Trop I T	• Blood CS • Urinalysis • Pregnancy Test • Urine GS/CS • Fecalysis • Stool GS/CS	• 12-L ECG XRAY ☐ chest ☐ abdomen CT SCAN: Plain Contrast Cranial Cervical Abdomen	UTZ: 2D Echo HBT Pelvic Whole abdomen Transvaginal
THERAPEUTICS			
Oxygen: LPM via NPO Diet IVF			
Medications:	Dosage	Time given	Signature
Monitor			
RESULTS			
CBC	CHEMISTRY	EKG	RADIOGRAPHS

REFERRALS					
Referred by	Time	Service	Reason for Referral	Time	Received by

NURSES NOTES									
DATE TIME									
BP									
HR									
RR									
TIME									
WT									
CBG									
Signature									

DISPOSITION			
Date Time	• Treated and discharged • Absconded • Admit	• Home Against Medical Advice • ER Death • Dead on Arrival (DOA)	☐ Transfer of Hospital _____ Self-conduction Ambulance Private

Discharge Diagnosis	Discharge Plans
Medications	Special Instructions

FOLLOW-UP			ATTENDING PHYSICIAN	

ANNEX E: Daily Floor Census

Unit/Ward: _____

ADMITTED (Record total at line no. 2 of summary)				
No.	TIME	HRN	PATIENT NAME	ROOM
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

TRANSFERRED IN (Record total at line no. 3 of summary)				
No.	TIME	FROM	PATIENT NAME	TO
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

ABSCONDED (Record total at line no. 7 of summary)				
No.	TIME	FROM	PATIENT NAME	TO
1				
2				
3				

EXPIRED (Record total at line no. 8 of summary)				
1				
2				
3				
4				

PREPARED BY:	**CHECKED BY:**

Date:_____

DISCHARGED (Record total at line no. 5 of summary)

No.	TIME	HRN	PATIENT NAME	ROOM
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

TRANSFERRED OUT (Record total at line no. 6 of summary)

No.	TIME	FROM	PATIENT NAME	TO
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

CENSUS SUMMARY FOR THE DAY

Line no.	PARTICULARS	No. of Patients
1	Remaining last report	
2	Admitted	
3	Transferred-in from other Census Unit	
4	Total of Lines 1, 2 and 3	
5	Discharged	
6	Transferred-out to other Census Unit	
7	Absconded	
8	Expired	
9	Total of Lines 5, 6, 7 and 8	
10	Remaining at 12:00 midnight (L4-L9)	
11	Admitted and Discharged the same day	
12	Actual Inpatient Service Days (L10+L11)	

ANNEX F: Clinical Cover Sheet

PATIENT NAME Last Name First Name Middle Name				**WARD/RM/BED/SERVICE:**	**HEALTH RECORD NUMBER (HRN):**
PERMANENT ADDRESS No. Street City/Municipality/Province				**TEL NO.:**	**SEX:** [ ] Male [ ] Female **CIVIL STATUS:** [ ] S [ ] D [ ]SEP [ ] W [ ] M [ ] N [ ] C
BIRTHDATE (mm/dd/yyyy)	**AGE**	**BIRTHPLACE**	**NATIONALITY**	**RELIGION**	**OCCUPATION**
EMPLOYER (TYPE OF BUSINESS)			**ADDRESS**		**TELEPHONE NO./ CP NO.**
FATHER'S NAME			**ADDRESS**		**TELEPHONE NO./ CP NO.**
MOTHER'S (Maiden) NAME			**ADDRESS**		**TELEPHONE NO./ CP NO.**
SPOUSE NAME			**ADDRESS**		**TELEPHONE NO./ CP NO.**
ADMISSION DATE: TIME:	**DISCHARGE** DATE: TIME:		**TOTAL NO. OF DAYS**	**ADMITTING PHYSICIAN**	
ADMITTING CLERK				**ATTENDING PHYSICIAN**	
TYPE OF ADMISSION [ ] NEW [ ] OLD [ ] FORMER OPD				**REFFERRED BY** (Physician/Health Facility)	
SOCIAL SERVICE CLASSIFICATION [ ] A [ ] B [ ] C1 [ ] C2 [ ] C3 [ ] D					
ALERT: ALLERGIC TO	**HOSPITALIZATION PLAN** (Company/Industrial Name)			**HEALTH INSURANCE NAME**	**PHIC** [ ] SSS [ ] SSS Dependent [ ] GSIS [ ] GSIS Dependent
DATA FURNISHED BY:		**ADDRESS OF INFORMANT**			**RELATION TO PATIENT**
ADMISSION DIAGNOSIS:					
DISCHARGE DIAGNOSIS PRINCIPAL DIAGNOSIS: OTHER DIAGNOSIS:					**ICD/ RUV CODE:**
PRINCIPAL OPERATION/PROCEDURE					
OTHER OPERATION (S) /PROCEDURE (S)					
ACCIDENT/ INJURIES/ POISONING					
DISPOSITION [ ] Discharge [ ] Transferred	[ ] HAMA [ ] Absconded	**RESULTS** [ ] Recovered [ ] Died [ ] Improved [ ] -48 hours [ ] Autopsy [ ] Unimproved [ ] +48 hours [ ] No			

ANNEX G: Doctor's Orders and Progress Notes

DATE/ TIME	**PHYSICIAN'S PROGRESS NOTES** (Affix printed name and signature.) *S – O – A – P*	**PHYSICIAN'S ORDERS** (Affix printed name and signature.)

ANNEX H: Nurse's Progress Notes

DATE/ TIME/SHIFT	F=FOCUS	D=DATA A=ACTION R=RESPONSE

***ALL ENTRIES SHOULD BE SIGNED AND DATED BY THE NURSES**

ANNEX I: Clinical Laboratory Result Form

NAME:_____ **HRN:**_____

(PLEASE PASTE RESULT CONSECUTIVELY STARTING FROM THE BOTTOM.)

ANNEX J: Medical History and Physical Examination

I. HEALTH CARE INSTITUTION (HCI) INFORMATION

1. Name of HCI	2. Accreditation Number
3. Address of HCI	

Bldg No. and Name/ Lot/ Block	Street/Subdivision/Village	Barangay/City/Municipality	Province	Zip Code

II. PATIENT'S DATA

1. Name of Patient			2. PIN
Last Name	First Name	Middle Name	3. Age
5. Chief Complaint			4. Sex [ ] Male [ ] Female

6. Admitting Diagnosis	7. Discharge Diagnosis	8. a. 1st Case Rate Code
		8. b. 2nd Case Rate Code

9. a. Date Admitted (mm/dd/yyyy)

9. b. Time Admitted:

___ ___ : ___ ___ [ ] AM [ ] PM
hour min

10.a. Date Discharged (mm/dd/yyyy)

9. b. Time Admitted:

___ ___ : ___ ___ [ ] AM [ ] PM
hour min

III. REASON FOR ADMISSION

1. History of Present Illness:

2. a. Pertinent Past Medical History

b. OB/GYN History
G ___ P ____ (_____-_____-_____-_____) LMP: _____ [ ] NA

3. Pertinent Signs and Symptoms on Admission (tick applicable box/es):

[ ] Altered mental sensorium	[ ] Diarrhea	[ ] Hematemesis	[ ] Palpitations
[ ] Abdominal cramp/pain	[ ] Dizziness	[ ] Hematuria	[ ] Seizures
[ ] Anorexia	[ ] Dysphagia	[ ] Hemoptysis	[ ] Skin rashes
[ ] Bleeding gums	[ ] Dyspnea	[ ] Irritability	[ ] Stool, bloody/ black tarry/ mucoid
[ ] Body weakness	[ ] Dysuria	[ ] Jaundice	[ ] Sweating
[ ] Blurring of vision	[ ] Epistaxis	[ ] Lower extremity edema	[ ] Urgency

4. Reffered from another health care institution (HCI):

[ ] No [ ] Yes, specify reason _____

Name of Originating HCI _____

5. Physical Examination on Admission (Pertinent Findings per System)

General Survey [ ] Awake and alert [ ] Altered sensorium _____

Vital Signs: BP: _____ HR: _____ RR:_____ Temp: _____

HEENT:
[ ] Essentially normal [ ] Abnormal pupillary reaction [ ] Cervical lymphadenopathy [ ] Dry mucous membrane
[ ] Icteric sclerae [ ] Pale conjunctivae [ ] Sunken eyeballs [ ] Sunken fontanelle

Others: _____

CHEST/LUNGS:
[ ] Essentially normal
[ ] Lump/s over breast (s) [ ] Asymmetrical chest expansion [ ] Decreased breath sounds [ ] Wheezes
[ ] Rales/crackles/rhonchi [ ] Intercostal rib/ clavicular retra...

Others: _____

CVS:
[ ] Essentially normal [ ] Displaced apex beat [ ] Heaves and/or thrills [ ] Pericardial bulge
[ ] Irregular rhythm [ ] Muffled heart sounds [ ] Murmur

Others: _____

ABDOMEN:
[ ] Essentially normal [ ] Abdominal rigidity [ ] Abdomen tenderness [ ] Hyperactive bowel sounds
[ ] Palpable mass (es) [ ] Tympanitic/ dull abdomen [ ] Uterine contraction

Others: _____

GU (IE):
[ ] Essentially normal [ ] Blood stained in exam finger [ ] Cervical dilatation [ ] Presence of abnormal discharge

Others: _____

SKIN/ EXTREMITIES:
[ ] Essentially normal [ ] Clubbing [ ] Cold clammy skin [ ] Cyanosis/mottled skin
[ ] Edema/swelling [ ] Decreased mobility [ ] Pale nailbeds [ ] Poor skin turgor
[ ] Weak pulses
[ ] Rashes/petechiae

Others: _____

NEURO-EXAM:
[ ] Essentially normal [ ] Abdominal gait [ ] Abnormal position sense [ ] Abnormal/decreased sensation
[ ] Abnormal reflex (es) [ ] Poor/ altered memory [ ] Poor muscle tone/strength [ ] Poor coordination

Others: _____

IV. COURSE IN THE WARD (Attach photocopy of laboratory/imaging results) [ ] Check box if there is/are additional sheet (s).

DATE	DOCTOR'S ORDER/ACTION

SURGICAL PROCEDURE/RVS CODE (Attach photocopy of OR technique):

V. DRUGS/MEDICINES [ ] Check box if there is/are additional sheet (s).

Generic Name	Quantity/Dosage/Route	Total Cost	Generic Name (cont)	Quantity/Dosage/Route (cont)	Total Cost (cont)

VI. OUTCOME OF TREATMENT

[ ] IMPROVED [ ] HAMA [ ] EXPIRED [ ] ABSCONDED [ ] TRANSFERRED Specify reason: _____

VII. CERTIFICATION OF HEALTH CARE PROFESSIONAL

Certification of Attending Health Care Professional:

I certify that the above information given in this form, including all attachments, are true and correct.

_____ Signature over Printed Name of Attending Health Care Professional

_____ Date Signed (mm/dd/yyyy)

ANNEX K: Clinical Abstract

PATIENT NAME Last Name First Name Middle Name	**AGE**	**SEX (M/F)**	**HRN:**
SERVICE/WARD	[ ] ADMISSION DATE: _____ [ ] CONSULTATION DATE: _____		

Brief Clinical History:

Treatment/Operation/Procedure:

Pertinent Laboratory Examinations and Findings:

Interim Diagnosis/Impression:

_____, MD
(Signature Over Printed Name)

Date: _____

ANNEX L: Discharge Summary/ Clinical Abstract

PATIENT NAME Last Name	First Name	Middle Name		
AGE	**SEX (M/F)**	**WARD/SERVICE**	**HRN:**	**ADMISSION DATE**: _____ **DISCHARGE DATE:** _____
ATTENDING PHYSICIAN				
ADMITTING DIAGNOSIS				
FINAL DIAGNOSIS				
CHIEF COMPLAINTS				
BRIEF CLINICAL HISTORY & PERTINENT PHYSICAL EXAMINATION				
LABORATORY FINDINGS: (Incl. ECG, X-Ray & other diagnostic procedures)				
COURSE IN THE WARD: (Incl. Medications)				
DISPOSITION: (Indicate home meds, special instructions & ff-up)				

_____ _____**, MD**

DATE ACCOMPLISHED RESIDENT IN-CHARGE

ANNEX M: Admission Slip

Date: _____ Time: _____ [ ] AM [ ] PM
(mm/dd/yyyy) (hh:mm)

PATIENT NAME Last Name First Name Middle Name	**AGE**	**SEX (M/F)**
COMPLETE ADDRESS	**CIVIL STATUS**	
ADMITTING DIAGNOSIS		

_____, MD
Admitting Physician

ANNEX N: Patient Information Sheet

PATIENT NAME Last Name First Name Middle Name				**WARD/RM/BED/SERVICE:**	**HEALTH RECORD NUMBER (HRN):**	
PERMANENT ADDRESS No. Street City/Municipality/Province				**TEL NO.:**	**SEX:** [ ] Male [ ] Female	**CIVIL STATUS:** [ ] S [ ] D [ ]SEP [ ] W [ ] M [ ] N [ ] C
BIRTHDATE (mm/dd/yyyy)	**AGE**	**BIRTHPLACE**	**NATIONALITY**	**RELIGION**	**OCCUPATION**	
EMPLOYER (TYPE OF BUSINESS)			**ADDRESS**		**TELEPHONE NO./ CP NO.**	
FATHER'S NAME			**ADDRESS**		**TELEPHONE NO./ CP NO.**	
MOTHER'S (Maiden) NAME			**ADDRESS**		**TELEPHONE NO./ CP NO.**	
SPOUSE NAME			**ADDRESS**		**TELEPHONE NO./ CP NO.**	

ANNEX O: Request for Access To Health Records

Date: _____

To the Chief, Health Information Management Department (HIMD):

May we request from your good office to lend us the following charts of the patients for

_____.
(Purpose/Reason)

NO.	HEALTH RECORD NO.	NAME OF PATIENT	DATE OF ADMISSION	DATE OF DISCHARGE	RECEIVED BY	RETURNED TO
1.						
2.						
3.						
4.						
5.						

It is understood that I am responsible for the above-mentioned health records and I will return the said health records in the same order and condition as they were received.

Very truly yours,

_____
Signature over Printed Name

Noted by:

_____
Chairman of the Department
Or Duly Authorized Representative

Approved by:

_____
Medical Center Chief II
Or Duly Authorized Representative

ANNEX P: Referral Form

Name of initiating facility _____ Contact Number:_____

Address_____

Date of Referral _____ Time called* _____

Name of Receiving facility _____ Receiving personnel _____

Address _____ Response _____

Referral Category ☐ Emergency ☐ Outpatient

Working Impression _____

Reason for Referral ☐ Consultation _____

☐ Diagnostics _____

☐ Treatment/ Procedure _____

☐ Others _____

Name of Patient _____ Identity Number _____

Age _____ Sex ☐ Male ☐ Female

Address _____

Chief Complaint _____

Clinical History _____

_____

Findings _____

Vital Signs: BP _____ HR _____ RR _____ O2 sats _____ Temp _____ Weight _____

(attach laboratory results) _____

Treatment Given _____

(attach treatment cards) _____

_____ _____

Print Name & Signature of Health Professional Date and Time

*for emergency cases

ANNEX Q: Inter-Departmental Referral Sheet

Date: _____
Time: _____ [ ] EMERGENCY [ ] URGENCY [ ] ROUTINE

PATIENT NAME Last Name First Name Middle Name			**HRN:**
AGE	**SEX (M/F)**	**SERVICE/WARD**	**BED**
DIAGNOSIS			
REFFERRAL TO:			
REASON(S) FOR REFERRAL [ ] OPINION [ ] CO- MANAGE [ ] OTHERS (Please specify) _____ [ ] CLEARANCE [ ] TRANSFER SERVICE			
CLINICAL FINDINGS (Brief history, PE, patient laboratory) / State assessment and/or intervention done			

REFERRED BY:_____
Printed Name & Signature

POSITION:_____

Referral Received by: _____
Date & Time: _____

(TO BE FILLED BY RECEIVING DEPARTMENT/ SERVICE)
FINDINGS:
RECOMMENDATION:

_____ _____ __ __ : __ __ [ ] AM [ ] PM
Physician's Printed Name & Signature Date (mm/dd/yyyy) Time

ANNEX R: Certificate of Confinement

Certificate No. _____
HRN:_____

Date:_____

This is to certify that _____, _____ years old of _____ has been confined in this hospital from _____ to the present.

This certification is being issued at the request of _____ for _____.
(Name of Person Requesting) *(Purpose)*

_____
HIMD Head/Supervisor

(NOT VALID WITHOUT SEAL)

ANNEX S: Medical Certificate

Certificate No. _____
HRN:_____

Date:_____

MEDICAL CERTIFICATE

This is to certify that _____, _____ years old of _____ was examined and treated/confined in this hospital from _____ to _____ with the following findings and/or diagnosis:

This certification is being issued at the request of _____ for _____.
(Name of Person Requesting) *(Purpose)*

_____
Attending Physician

License No. _____

(NOT VALID WITHOUT SEAL)

ANNEX T: Medico-Legal Certificate

Certificate No. _____
HRN:_____

Date:_____

MEDICO-LEGAL CERTIFICATE

To Whom It May Concern:

This is to certify that _____, _____ years old male/female, single/married/widow, Filipino, and a resident of _____ at about _____ AM/PM for the following lesion/injury _____

_____

sustained by _____.

In my opinion, the injury/injuries sustained by the patient will incapacitate or require medical attention for a period of _____ days barring complications, otherwise the period of healing will vary accordingly.

_____
Attending Physician

License No. _____

NOT VALID WITHOUT SEAL)

ANNEX U: Proposed Qualification Requirements and Job descriptions for the Different HIMD staff.

Position Title	**Records Officer IV/ Supervising Records Management Analyst/ Supervising Administrative Officer (SG-22)**
Minimum Qualification Standard	1. Qualification Standard based on CSC minimum requirement.
Additional Requirements	1. Must be a graduate of master's degree; 2. Must have knowledge of Human Anatomy & Physiology, and medical terminologies; 3. Must have attended a Certificate Course in HIMD and training course of at least 120 hours in HIM conducted by a Department of Health recognized institution/organization or academe; 4. Must have in-depth knowledge on Data Privacy Act; 5. Must have at least five (5) years of experience in the HIM Department of a Level 2 or Level 3 hospital, one year of which must have been in a supervisory capacity.
Job Description	1. Shall plan, organize and control all activities in the service; 2. Shall attend court proceedings and represent the hospital in court cases involving subpoena of medical/clinical records; 3. Shall exercise direct administrative supervision and control over all subordinates in the service; 4. Shall establish policies and procedures in relation to the content, control, storage and retrieval of records; 5. Shall organize the workflow throughout the service; 6. Shall represent the service to top management; 7. Shall ensure the maintenance of the patient's right to privacy and confidentiality; in value health records / information. 8. Shall serve on appropriate committees and attend meetings which are of relevance to the HIM; 9. Shall supervise the implementation and evaluation of quality control measures of specified areas within the service; 10. Shall meet and discuss with the administration of other departments within the hospital, issues which are related to the HIM; 11. Shall answer by correspondence or by telephone inquiries regarding information recorded in the patients' health records; 12. Shall keep abreast of current medical record practices and developments; 13. Shall assist the medical staff in authorized research projects; and 14. Shall perform other related functions as may be assigned by the immediate supervisor.
Competency	**Core Competencies**
	• Exemplifying Integrity
	• Professionalism
	• Service Excellence
	Organizational Competencies
	• Effective Communication Skills
	• Effective Interpersonal Relations
	• Organizational Awareness and Commitment
	Technical Competencies

	• Achieving High Standards
	• Government and Departmental Policies and Procedures
	• Management Acumen
	• Planning, Organizing and Delivering
	• Records Management
	• Respecting and Caring for Patients
	• Medico-legal aspects of health records
	• Coaching and Monitoring
Proficiency	Advanced

Position Title	**Records Officer III/ Senior Records Management Analyst/ Administrative Officer V (SG-18)**
Minimum Qualification Standard	1. Qualification Standard based on CSC minimum requirement.
	1. Must have knowledge of Human Anatomy & Physiology, and medical terminologies; 2. Must have attended a Certificate Course in HIMD and training in International Classification of Disease-10 conducted by a Department of Health recognized institution/organization or academe; 3. Must have in-depth knowledge on Data Privacy Act; 4. Must have at least four (4) years of experience in the HIM Department of level of a Level 2 hospital, one (1) year of which must; have been in a supervisory capacity.
Job Description	1. Shall plan, organize and control all activities in the department; 2. Shall attend court proceedings and represent the hospital in court cases involving subpoena of medical/clinical records; 3. Shall exercise direct administrative supervision and control over all subordinates in the department; 4. Shall establish policies and procedures in relation to the content, control, storage and retrieval of health records; 5. Shall organize the workflow throughout the department; 6. Shall represent the service to top management; 7. Shall ensure the maintenance of the patient's right to privacy and confidentiality of the health records or related documents; 8. Shall serve on appropriate committees and attend meetings which are of relevance to the HIM; 9. Shall supervise the implementation and evaluation and quality control measures of specified areas within the service; 10. Shall meet and discuss with the administration of other departments within the hospital, issues which are related to the HIM; 11. Shall answer by correspondence or by telephone inquiries regarding information recorded in the patients' health records; 12. Shall keep abreast of current health record practices and developments; 13. Shall assist the medical staff in authorized research projects; and 14. Shall perform other related functions as may be assigned by the immediate supervisor.
Competency	**Core Competencies**
	• Exemplifying Integrity
	• Professionalism

	• Service Excellence
	Organizational Competencies
	• Effective Communication Skills
	• Effective Interpersonal Relations
	• Organizational Awareness and Commitment
	Technical Competencies
	• Achieving High Standards
	• Government and Departmental Policies and Procedures
	• People Management
	• Planning, Organizing and Delivering
	• Records Management
	• Respecting and Caring for Patients
Proficiency	Advanced

Position Title	**Statistician III of Level 3 Hospitals (SG-18)** (Advanced Statistics, Planning and Management, Clinical Documentation Improvement, Health Records Analysis, Filing and Archiving of Health Records, Encoding, and Clinical Coding)
Minimum Qualification Standard	1. Qualification Standard based on CSC minimum requirement.
Additional Requirements	1. Must have a college degree preferably a graduate of BS Statistics/BS Math. 2. Must have units in graduate studies; 3. Must have a first grade civil service eligibility; 4. With certificate in ICD-10 coding; 5. Must have attended Certificate Course in HIMD to include related training course in International Classification of Diseases and healthcare statistics conducted by a Department of Health recognized institution/organization or academe; 6. Must have in-depth knowledge on Data Privacy Act; 7. Must be computer literate and familiar with available statistical packages; 8. Must have at least three (3) years of experience in the HIM Department of a Level 2 or Level 3 health facility.
Job Description	1. Shall, as an assistant to the head of the HIMD in the health facility, manage the department in the absence of the HIMD head/supervisor; 2. Shall consolidate the Daily Floor Census report into the 24-hour census report of the health facility; 3. Shall summarize and prepare monthly, quarterly and annual statistical reports of health facility activities; 4. Shall recommend appropriate action to be taken based on the analysis and interpretation of data gathered 5. Shall assist the resident physicians and other employees in the conduct of their scientific research; 6. Shall prepare a health facility statistical reports in of budgeting and planning processes; and 7. Shall perform other related functions as may be required by the immediate supervisor.

Competency	**Core Competencies**
	• Exemplifying Integrity
	• Professionalism
	• Service Excellence
	Organizational Competencies
	• Effective Communication Skills
	• Effective Interpersonal Relations
	• Organizational Awareness and Commitment
	Technical Competencies
	• Data Management
	• Data Recording and Reporting
	• Research and Analysis
	• Statistical Research for Health
	• Technical Consulting
Proficiency	Advanced

Position Title	**Statistician II of Level 3 Hospitals (SG-15)** (Health Records Analysis, Basic Statistics (interpretation and reporting), Clinical Coding, Filing and Archiving of Health Records)
Minimum Qualification Standard	1. Qualification Standard based on CSC minimum requirement.
Additional Requirements	1. Must have a college degree/graduate studies preferably with units in statistics and a graduate of BS Statistics/BS Math 2. With certificate of completion in ICD-10 coding; 3. Must have attended Certificate Course in HIMD to include related training course in International Classification of Diseases and healthcare statistics conducted by a Department of Health recognized institution/organization or academe; 4. Must have in-depth knowledge on Data Privacy Act; 5. Must be computer literate and familiar with available statistical packages; 6. Must have at least two (2) years of experience in the HIM Department of a Level 2 or Level 3 health facility.
Job Description	1. Shall, as an assistant to the head of the HIMD in the health facility, manage the department in the absence of the HIMD head/supervisor; 2. Shall consolidate the Daily Floor Census report into the 24-hour census report of the health facility; 3. Shall summarize and prepare monthly, quarterly and annual statistical reports of health facility activities; 4. Shall recommend appropriate action to be taken based on the analysis and interpretation of data gathered 5. Shall assist the resident physicians and other employees in the conduct of their scientific research; 6. Shall prepare a health facility statistical reports in budgeting and planning processes; and 7. Shall perform other related functions as may be required by the immediate supervisor.

Competency	**Core Competencies**
	• Exemplifying Integrity
	• Professionalism
	• Service Excellence
	Organizational Competencies
	• Effective Communication Skills
	• Effective Interpersonal Relations
	• Organizational Awareness and Commitment
	Technical Competencies
	• Data Management
	• Data Recording and Reporting
	• Planning, Organizing and Delivering
	• Research and Analysis
	• Statistical Research for Health
Proficiency	Intermediate

Position Title	**Records Officer II (SG-14)** (Health Records Analysis, Basic Statistics, Clinical Coding, Filing and Archiving of Health Records)
Minimum Qualification Standard	1. Qualification Standard based on CSC minimum requirement.
	1. Must have a college degree; preferably with knowledge in Human Anatomy & Physiology, and medical terminologies; 2. Must have a first grade civil service eligibility; 3. Must have attended Certificate Course in HIM and basic course in International Classification of Diseases conducted by a Department of Health recognized institution/organization or academe; 4. Must have in-depth knowledge on Data Privacy Act; 5. Must be computer literate; 6. Must have at least one (1) year of experience as disease and operations coder, and 7. Must be well acquainted with the different coding tools.
Job Description	1. Shall work directly under the supervision of the chief of the HIMD; 2. Shall analyze specific portions of the health record and assign code numbers to disease and operations based on the mandated classification system; 3. Shall update and maintain the disease and operation index file; 4. Shall file the disease and operation indexes numerically by disease and operation codes; and 5. Shall perform other related functions as may be assigned by the immediate supervisor.
Competency	**Core Competencies**
	• Exemplifying Integrity
	• Professionalism

	• Service Excellence
	Organizational Competencies
	• Effective Communication Skills
	• Effective Interpersonal Relations
	• Organizational Awareness and Commitment
	Technical Competencies
	• Computer Skills
	• Diversity Management
	• Managing Work
	• Providing Support and Services
	• Records Management
	• Respecting and Caring for Patients
Proficiency	Intermediate

Position Title	**Records Officer I (SG-10)** (Basic Statistics, Clinical Coding, Filing and Archiving of Health Records)
Minimum Qualification Standard	1. Qualification Standard based on CSC minimum requirement.
	1. Must have Learning and Development Intervention in health record documentation standards; 2. Must have thorough knowledge in Human Anatomy & Physiology, and medical terminologies; 3. Must have at least work in the HIMD or other related office; 4. Must have in-depth knowledge on Data Privacy Act; and 5. Must be computer literate.
Job Description	1. Shall arrange and assemble the health record of discharged patients based on the approved format; 2. Shall analyze quantitatively and qualitatively health records to ensure the creation of complete and accurate health records; 3. Shall coordinate with concerned members of the medical and nursing service in relation to incomplete health records; 4. Shall maintain statistics of incomplete and complete health records and prepare reports of delinquent doctors; and 5. Shall perform other related functions as may be assigned by the immediate supervisor.
Competency	**Core Competencies**
	• Exemplifying Integrity
	• Professionalism
	• Service Excellence
	Organizational Competencies
	• Effective Communication Skills
	• Effective Interpersonal Relations

	• Organizational Awareness and Commitment
	Technical Competencies
	• Computer Skills
	• Diversity Management
	• Energy to Work
	• Government and Departmental Policies and Procedures
	• Occupational Safety and Health Knowledge
	• Resilience
	• Respecting and Caring for Patients
Proficiency	Intermediate

Position Title	**Administrative Assistant II (SG-8)** (Encoding, Filing and Archiving of Health Records)
Minimum Qualification Standard	1. Qualification Standard based on CSC minimum requirement.
Minimum Qualification Standard	1. Must have attended a medical record related training; 2. Must have knowledge in Human Anatomy & Physiology, and medical terminologies; 3. Must have undergone training in medical transcription and/or is a certified medical transcriptionist; 4. Must have in-depth knowledge on Data Privacy Act;
Job Description	1. Shall transcribe operating room reports and other dictated/recorded information; 2. Shall type/encode letters and reports, birth and death certificates; and 3. Shall perform other related functions as may be assigned by the immediate supervisor. 4. Shall transcribe operating room reports and other dictated/recorded information; 5. Shall transcribe all dictated medical reports; 6. Shall transcribe birth, death, medical and medico-legal certificate from the pre-form to the corresponding official forms; 7. Shall coordinate with the concerned staff and/or patient in relation to problems involving the accomplished birth, death, and other certificate pre-form or worksheet; 8. Shall transcribe official communications and reports; and 9. Shall perform other related functions as may be assigned by the immediate supervisor.
Competency	**Core Competencies**
	• Exemplifying Integrity
	• Professionalism
	• Service Excellence
	Organizational Competencies
	• Effective Communication Skills
	• Effective Interpersonal Relations

	• Organizational Awareness and Commitment
	Technical Competencies
	• Computer Skills
	• Diversity Management
	• Managing to Work
	• Providing Support and Services
	• Records Management
	• Respecting and Caring for Patients
Proficiency	Basic

Position Title	**Administrative Assistant I (SG-7)** (Filing and Archiving of Health Records)
Minimum Qualification Standard	1. Qualification Standard based on CSC minimum requirement.
Minimum Qualification Standard	1. Must have attended a training course in health record documentation standards; 2. Must have thorough knowledge Human Anatomy & Physiology and medical terminologies; 3. Must have at least work in the HIMD or other related office; 4. Must have in-depth knowledge on Data Privacy Act; and 5. Must be computer literate.
Job Description	1. Shall arrange and assemble the health record of discharged patients based on the approved format; 2. Shall analyze quantitatively and qualitatively health records to ensure the creation of complete and accurate health records; 3. Shall coordinate with concerned members of the medical and nursing service in relation to incomplete health records; 4. Shall maintain statistics of incomplete and complete health records and prepare reports of delinquent doctors; and 5. Shall perform other related functions as may be assigned by the immediate supervisor.
Competency	**Core Competencies**
	• Exemplifying Integrity
	• Professionalism
	• Service Excellence
	Organizational Competencies
	• Effective Communication Skills
	• Effective Interpersonal Relations
	• Organizational Awareness and Commitment
	Technical Competencies
	• Computer Skills
	• Diversity Management

	• Managing to Work
	• Providing Support and Services
	• Records Management
	• Respecting and Caring for Patients
Proficiency	Basic

ANNEX V: Proposed Standard Staffing Pattern for HIMD in Level 3 Government Hospital with 200 to 1500 Beds*

Health Information Management Department	SG	Bed Capacity													
		200	**300**	**400**	**500**	**600**	**700**	**800**	**900**	**1000**	**1100**	**1200**	**1300**	**1400**	**1500**
Records Officer IV	22	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Records Officer III	18	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Statistician III	18	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Statistician II	15	1	1	2	2	4	4	4	4	5	5	5	5	5	5
Records Officer II	14	4	5	6	8	9	10	11	12	13	14	15	16	17	18
Records Officer I	10	16	20	24	28	32	36	40	44	48	52	56	60	64	68
Administrative Assistant II	8	3	4	4	4	5	5	5	5	6	6	6	6	6	6
Administrative Assistant I	7	4	4	5	5	6	6	6	6	7	7	7	7	7	7
Sub-total		**33**	**39**	**46**	**52**	**61**	**66**	**71**	**76**	**84**	**89**	**94**	**99**	**104**	**109**

**Proposed as of June 2021. Subject to updates based on the Department of Budget and Management's latest Issuances*

ANNEX W: Summary of Formulas for Hospital Statistics

Indicators/Rates	Formula	Reference/ Source
Inpatient service days/Inpatient bed days	Total inpatient service days/inpatient bed days= [(Inpatients remaining at midnight + total admissions) - Total discharges/deaths + (number of admissions and discharges on the same day)]	HHIM Manual 2010
Average Daily Census	Total Inpatient Service days for a period / Total days in the same period	HHIM Manual 2010
Bed Occupancy Rate (BOR)	Total inpatient service days for a period x 100 / Total number of authorized beds x total days in the same period	HHIM Manual 2010
Bed Turnover Interval	(Implementing beds x days in the period) - Inpatients Service days for a period / Total discharges and deaths in the same period	HHIM Manual 2010
Bed Turnover Rate	No. of discharges (including deaths) for a period / Average bed count during the period	HHIM Manual 2010
Average Length of Stay (ALOS)	Total length of stay of discharged patients (including Deaths) in the period / Total discharges and deaths in the period	Annual Hospital Statistical Report
Average Number of Outpatient visits per OPD day	Total no. of Outpatient visits/attended (both new and revisits) during a period / Total no. of days for the same period	HHIM Manual 2010
Average number of ER patients per day	Total no. of Emergency and Non-Emergency Patients attended in the ER for a given period / Total no. of days for the same period	HHIM Manual 2010

Gross Infection Rate	Total no. of infection in the health facility (or ward) for a period x 100 Total discharges and deaths in the health facility (or ward) for same period	HHIM Manual 2010
Net Infection Rate	Total no. of infections debited against the health facility (or ward) for a period x 100 Total discharges and deaths from health facility (or ward) for same period	HHIM Manual 2010
A. Device Related Infections		
Ventilator Acquired Pneumonia (VAP)	Number of patients with VAP x 1000 Total Number of Ventilator Days	Annual Hospital Statistical Report
Blood Stream Infection (BSI)	Number of Patients with BSI x 1000 Total patient days	Annual Hospital Statistical Report
Central Line Associated Bloodstream Infections (CLABSI)	Number of patients with CLABSI x 1000 divided by Central line days	Based on WHO/ CDC formula
Catheter Acquired Urinary Tract Infection (CAUTI)	Number of Patients (with catheter with UTI x 1000) Total Number of Catheter Day	Annual Hospital Statistical Report
B. Non-Device Related Infection		
Surgical Site Infections (SSI)	Number of Surgical Site Infections x 100 Total number of Procedures	Annual Hospital Statistical Report
Post-operative infection rate	Total no. of infections occurring after a clean surgical operation x 100 Total number of clean surgical operations/procedure for the same period	HHIM Manual 2010
Consultation Rate	Total consultations (all departments) for a period x 100 Total discharges and deaths	HHIM Manual 2010

Caesarean Section Rate	Total no. of cesarean sections in a given period x 100 Total no. of deliveries for the same period	HHIM Manual 2010
Maternal Death Rate	Total no. of direct maternal death in a given period x 100 Total no. of maternal (obstetrical) discharges including deaths for the same period	HHIM Manual 2010
Gross Death Rate/Mortality Rate	Total deaths (including newborn for a given period) x 100 Total discharges and deaths for the same period	Annual Hospital Statistical Report
Net Death Rate	Total deaths (including newborn for a given period) - death <48 hours for the period x 100 Total Discharges (including deaths and newborn) - death <48 hours for the same period	Annual Hospital Statistical Report
Post-Operative Death Rate	Total post-operative deaths for the period x 100 Total patients operated for the same period	HHIM Manual 2010
Anesthesia Death Rate	Total no. of deaths caused by anesthetic agent for a period x 100 Total no. of anesthetics administered for the same period	HHIM Manual 2010
Fetal Death Rate/ Stillbirth Rate	Total no. of intermediate and late fetal deaths for the period x 100 Total no. of birth (including intermediate and late fetal deaths) for the same period	HHIM Manual 2010
Neonatal Death Rate/ Infant Newborn Mortality Rate	Total no. of newborn deaths for the period x 100 Total no. of newborn infant discharges (including deaths) for the same period	HHIM Manual 2010
Infant Death Rate	Total no. of infant deaths (neonatal and post neonatal during a period) x 100 Number of live births during the period	HHIM Manual 2010

Gross Autopsy Rate	Total no. of autopsies performed for a period x 100 Total no. of inpatient deaths for the same period	HHIM Manual 2010
Net Autopsy Rate	Total no. of autopsies performed for a period x 100 Total deaths - unautopsied cases for the same period	HHIM Manual 2010

ANNEX X: Self-Assessment Tool

SELF ASSESSMENT TOOL
HEALTH INFORMATION MANAGEMENT DEPARTMENT

Name of Hospital: _____

Address: _____

It is the duty of the Health Information Management Department (HIMD) to effectively and efficiently manage its records. The purpose of the self-assessment tool is to evaluate and monitor the compliance of the HIMD staff to the policies and set standards.

This self-evaluation guide is intended for the use of HIMD Officials and staff to be able to:

a. Make preliminary assessment on the status of their records management practices
b. Identify major problems to be included in the risk management scheme
c. Recognize priorities for the HIM Department on areas to improve
d. Assist in the development of the health facility's own comprehensive health records management procedures and programs

Instructions:

1. Complete all questions. Answers must accurately reflect the current environment. This will help you identify what is being done well in your area and also those that need improvement.
2. After completing all questions, total your points and get the equivalent percentage.
3. Note for other findings seen, if any and write the Name and Designation of the assessor on the corresponding area on the tool.
4. Refer to the Given interpretation of your scores given at the end of the tool to determine your next steps if needed.

	Validation	Evidence	Data Collected	SCORE
INPUT				
Hospital Health Information Management Department Planning, Execution and Monitoring System				
1. Has an existing Manual of Procedure	Document Review	Presence (1 pt)	Yes No	
2. Has an approved work and financial plan	Document Review	Presence (1 pt)	Yes No	

3. Has an approved DPCR	Document Review	Presence (1 pt)	Yes No	
4. Has an approved PPMP, APP	Document Review	Presence (1 pt)	Yes No	
5. Compliant with the latest Standard Staffing Pattern	Comparison of staffing with standards	Compliant (1 pt)	Yes No	
6. Approved TNAs	Document Review	Presence (1 pt)	Yes No	
7. Approved Individual Development Plan (if appropriate)	Document Review	Presence (1 pt)	Yes No	
8. Training Report, if required; Re-entry Plan implementation	Document Review	Presence (1 pt)	Yes No	
9. All staff received Learning Development Intervention	Document Review	100% (1 pt) Less than 100% (0)	Yes No	
10. Provided with office and storage space compliant with DOH standards	Comparison with standard space requirement	100% compliant (1 pt) Less than 100% (0)	Yes No	
11. Designated space for completion of health record	Ocular Visit	Presence (1 pt)	Yes No	
12. Proper lighting, ventilation and temperature of storage area	Ocular Visit	Presence (1 pt)	Yes No	
13. Provided with office equipment; Adequate and appropriate working tables, filing cabinets, and mandatory office equipment and materials	Ocular Visit	100% compliant (1 pt) Less than 100% (0)	Yes No	
Administration and Supervision				
1. Attendance to MANCOM Meetings	Document Review; NOM, Attendance Sheet	Presence (1 pt)	Yes No	
2. Regular Conduct of HIMD Meetings	Document Review; Minutes of Meetings	Presence (1 pt)	Yes No	
3. Functional Patient Health Records Committee (PHRC)	Document Review; Minutes of Meetings	Presence (1 pt)	Yes No	
PROCESS				
Health Record Creation				
1. Established Health Record Identification System	Document Review; Interview	Presence (1 pt)	Yes No	
2. Maintains/ Updates a Standardized Health Record for every patient assessed or treated	Document Review	All health records are updated (1 pt)	Yes No	
3. Duly accomplished consent form should accompany each patient health record.	Document Review (Sampling)	Presence (1 pt)	Yes No	

4. Authorized personnel to make entries in the health record are clearly defined as per Hospital Policy	Document Review; Presence of Approved Policy and Procedures Manual	Presence (1 pt)	Yes No	
5. Abbreviations and symbols used in health records are in accordance with WHO or approved by the PHRC	Check documented process with policy	Compliant (1 pt)	Yes No	
6. Data of Patients receiving emergency care includes: - time of arrival and departure - conclusion at termination of treatment - patient's condition at discharge - follow-up care instructions	Document Review (Sampling)	Presence (1 pt)	Yes No	
7. Assign codes to Diseases and Procedures	Check documented process with policy and procedure	Compliant (1 pt)	Yes No	
8. Observed proper use of copy and paste function when electronic health records are used	Check documented process with policy and procedure	Compliant (1 pt)	Yes No	
9. OPD and In-patient Records include all the necessary information based on the Standard.	Document Review (Sampling)	Presence (1 pt)	Yes No	
10. Health record follows Standard Health record arrangement	Document Review (Sampling)	Follows proper arrangement (1 pt)	Yes No	
11. “ALERT” notation for conditions (i.e., allergic responses and adverse drug reactions) prominently displayed on the clinical cover sheet	Document Review (Sampling)	Presence (1 pt)	Yes No	
12. Contains patient's past medical history and Sufficiently detailed report of a relevant Physical Examination (PE) completed within 24 hours upon admission	Document Review (Sampling)	Presence (1 pt)	Yes No	
13. Therapeutic and Special diagnostic test orders reflected	Document Review (Sampling)	Presence (1 pt)	Yes No	
14. Progress Notes, observations and consultation reports recorded	Document Review (Sampling)	Presence (1 pt)	Yes No	
15. Admission and discharge record completed with all the diagnoses and procedures at the time of discharge or as soon as all relevant information is available	Document Review (Sampling)	Timely (1 pt)	Yes No	

16. Admission and discharge record use terminology based on the International Standard Nomenclature of Medicine	Check documented process with policy and procedure; Document Review	Compliant (1 pt)	Yes No	
17. Discharge summary contain the following: a. Discharge diagnosis b. Procedures performed c. Follow-up arrangements d. Therapeutic orders (home medications) e. Patient home instructions	Document Review (Sampling)	Presence (1 pt)	Yes No	
18. Certified true copy of discharge summary when patient is discharged or transferred to another facility	Document Review (Sampling)	Presence (1 pt)	Yes No	
19. Autopsy report filed when applicable, with provisional diagnosis noted within 72 hours	Document Review (Sampling)	Presence (1 pt)	Yes No	
20. Incomplete health records must be completed; diagnostic results must be submitted and attached to health records	Document Review (Sampling)	Compliant (1 pt)	Yes No	
Health Record Documentation				
1. Completeness of health record with no missing or detached form	Documentation review; Quantitative/ Qualitative analysis checklist	Complete (1 pt)	Yes No	
2. Documents are legible and written in ink or typewritten	Document Review (Sampling)	Compliant (1 pt)	Yes No	
3. Written documents, including policies, procedures and programs, are updated as necessary	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
4. HIMD staff assists attending physician in reviewing records for completeness	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
Health Record Storage and Safekeeping				
1. Inactive records are transferred to inactive filing storage to give way to the incoming records, decongest the area, and to facilitate retrieval	Document Review (Sampling)	Presence (1 pt)	Yes No	
2. HIMD has a good and efficient retrieval system in accordance with policies and standards	Document Review (Sampling)	Presence (1 pt)	Yes No	
3. The hospital safeguards all information contained in the health record against loss, destruction or unauthorized use.	Document Review (Sampling)	Presence (1 pt)	Yes No	

Health Record Accessibility				
1. All information in the health record treated is confidential and disclosed only to authorized individuals.	Document Review (Sampling)	Presence (1 pt)	Yes No	
2. Release of information with or without clinical value done only with written consent/waiver from the patient.	Document Review (Sampling)	Presence (1 pt)	Yes No	
3. Hospital policy on the release of non-clinical information (name, address, attending physician, relative staying with patient during admission, admission and discharge dates)	Presence of Approved and updated Policy and Procedures Manual	Compliant (1 pt)	Yes No	
4. Updated policy on the release of health records outside healthcare facilities and use for research and insurance providers.	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
5. MSS has access to health records for patient classification and referral; Linkage to MSS reflected in policy	Presence of Approved and updated Policy and Procedures Manual; Document Review (Check linkages)	Presence (1 pt)	Yes No	
Health Records Systems and Procedures				
1. Policy on health record identification system	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
2. Established proper assembly of health records	Presence of Approved and Updated Procedures Manual	Presence (1 pt)	Yes No	
3. Policy on the arrangement/structure/format of the content of health records	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
4. Documentation guidelines implemented	Presence of Approved and Updated Procedures Manual	Presence (1 pt)	Yes No	
5. Policy and procedures on the analysis of health record; Quantitative and Qualitative analysis of health record done properly	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
6. Disease indexing correctly carried out	Document Review	Presence (1 pt)	Yes No	

7. Policy/ procedure on filing of health records	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
8. Established proper filing and storage of health records	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
9. Maintains and updates Procedure on Retrieval of the health records	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
10. Policy and Procedure on Retention and Disposal of Health Records	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
ICD-10 Coding				
1. Staff trained on ICD-10 and clinical coding	Document Review	All staffs are trained (1 pt)	Yes No	
2. Sample health records conformed with ICD-10 and clinical coding	Document Review; Random Sampling	Compliant (1 pt)	Yes No	
Medico-Legal Aspects of Health Record				
1.Consents and certificates properly filled up with complete and accurate clinical data before its intended use	Presence of Approved and Updated Procedures Manual	Presence (1 pt)	Yes No	
2. Policy and procedure on the handling telephone inquiries pertaining to demo data and clinical information	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
3. Policy and procedure on dealing with HIMD clients requesting for patient's clinical information.	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	
Continuous Quality Improvement (CQI)				
1. Trains staff on the development and implementation of CQI	Document review (Annual report)	Presence (1 pt)	Yes No	
2. Implemented CQI for HIMD	Document review	Presence (2 pts)	Yes No	
Risk Management				
1. Trained staff on the development and implementation of Risk Management	Document review (Annual report)	Presence (1 pt)	Yes No	

2. Implemented risk assessment and management for HIMD	Document review; Risk Management Plan	Presence (2 pts)	Yes No	
OUTPUT				
1. Analysis of Statistical Report; file copy duly received at the Office of Agency/Health Facility Head	Document review	Presence (1 pt)	Yes No	
2. The statistical reports must be translated by Statisticians into relevant and meaningful information for use in the management process;	Document review	Presence (1 pt)	Yes No	
3. Submission of timely and accurate statistical report required by the DOH, PhilHealth and other agencies	Document review	Timely (2 pts)	Yes No	
4. Customer Satisfaction	Document review	Presence (1 pt)	Yes No	
5. HIMD officers provide assistance to researchers in compliance with updates Standards and policies	Presence of Approved and updated Policy and Procedures Manual	Presence (1 pt)	Yes No	

Total Score:

_____

Other findings:

_____

_____

Name and Position of Assessor:

_____

_____