RAHIM MEDICAL CENTRE AND GENERAL HOSPITAL

Medical Record Timeline Policy

Effective Date: _____

Review Date: _____

1. Purpose

The purpose of this policy is to establish clear timelines for the creation, completion, documentation, and retention of medical records at RAHIM MEDICAL CENTRE AND GENERAL HOSPITAL. Timely and accurate medical records are essential for patient safety, continuity of care, legal compliance, and quality improvement.

2. Scope

This policy applies to:

All healthcare providers including physicians, nurses, allied health professionals, and trainees

Administrative and health information management staff

Any personnel involved in documentation, storage, or retrieval of medical records

3. Definitions

Medical Record: A comprehensive documentation of a patient's medical history, treatment, diagnostic tests, and care provided.

Documentation Timeline: The period within which a particular entry or record must be completed, signed, and filed.

Health Information Management (HIM): Department responsible for the maintenance, storage, and retrieval of medical records.

4. Policy Statement

RAHIM MEDICAL CENTRE AND GENERAL HOSPITAL is committed to:

Ensuring that medical records are completed accurately and within established timelines.

Maintaining records in compliance with national regulations, accreditation standards, and hospital policies.

Supporting continuity of care and minimizing clinical and legal risks.

5. Medical Record Documentation Timelines

5.1 Inpatient Records

Documentation Type

Timeline for Completion

Admission Notes

Within 24 hours of patient admission

Progress Notes

Daily and at each significant change in patient condition

Orders (Medications, Procedures)

Immediately, with signatures at the time of entry

Diagnostic Tests / Imaging Reports

Within 48 hours of result availability

Discharge Summary

Within 24–48 hours after patient discharge

5.2 Outpatient Records

Documentation Type

Timeline for Completion

Consultation Notes

At the time of consultation or within 24 hours

Diagnostic and Lab Reports

Within 48 hours of result availability

Follow-up Instructions

Documented immediately or same day as consultation

5.3 Emergency Department Records

Initial assessment and triage notes: Immediately at the time of care

Procedure and treatment documentation: Within 24 hours

Discharge instructions: Prior to patient leaving the facility

5.4 Operative and Procedure Records

Preoperative assessment: Prior to surgery

Operative notes: Within 24 hours of procedure completion

Postoperative progress: Daily until discharge

6. Responsibilities

6.1 Physicians and Healthcare Providers

Ensure entries are complete, accurate, legible, and signed within the required timeline.

Correct errors according to hospital documentation guidelines.

Review and co-sign records as needed for collaborative care.

6.2 Nursing Staff

Document patient care, vital signs, medication administration, and procedures timely.

Ensure entries are accurate and legible.

Report incomplete or delayed documentation to supervisors.

6.3 Health Information Management (HIM) Department

Monitor compliance with documentation timelines.

Maintain proper filing, storage, and retrieval of records.

Conduct regular audits and generate compliance reports.

7. Quality Assurance and Monitoring

Regular audits will evaluate timeliness, completeness, and accuracy of medical records.

Non-compliance with timelines will trigger corrective action, staff education, or disciplinary measures.

Reports on compliance will be reviewed by the Hospital Management Committee.

8. Retention and Storage

Medical records will be retained according to hospital policy and legal requirements.

Electronic records must be securely backed up, and paper records stored in locked, access-controlled areas.

Obsolete records may be archived or disposed of according to approved procedures.

9. Compliance and Legal Requirements

Staff must comply with all applicable national regulations, accreditation standards, and hospital policies.

Delayed or incomplete documentation may result in clinical, legal, or administrative consequences.

10. Review of Policy

This policy will be reviewed every two years or whenever updates in laws, standards, or hospital procedures occur.

Updates require approval from the Hospital Management Committee.

11. Acknowledgment

I, _____, acknowledge that I have read, understood, and agree to comply with the Medical Record Timeline Policy of RAHIM MEDICAL CENTRE AND GENERAL HOSPITAL.

Signature: _____

Date: _____