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வடமேல் மாகாண சுகாதார சேவைகள் திணைக்களம்
Provincial Department of Health Services - North Western



නැ.ටෙපි84, සෞඛ්‍ය සංකීර්ණය,
මීගමුණ,
කුරුණෑගල.60000.

தபாற்பெட்டி 84, சுகாதார வளாகம்
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எனது இல :
Mv No

ඔබේ අංකය
உமது இல. :
Your No

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திகதி :
Date

2023. 12. 28

Internal Circular No – NWP/PDHS/07-02/05/2023

Through the Regional Director of Health Services – Kurunegala / Puttalam
All Medical Superintendents, All Divisional Medical Officers, All Medical Officers In -Charge

Proper maintenance of medical statistics at hospitals.

It has been observed that certain procedures in respect of medical statistics are not being adhered in certain hospitals.

Therefore, I hereby instruct you to adhere to the following procedures in your hospitals and necessary instructions given to all officers concerned with regard to proper maintenance of medical statistics.

A copy of updated general circular no 01-05/99 issued by DGHS dated 26/11/1999 as “Procedures pertaining to medical records and hospital statistics” are attached herewith for further information. The above instructions should be brought to the attention of your subordinate’s.

1. Patients are admitted to the hospital after registration of such patients in the Hospital Admission Register. Numbering of the Admission Register must be done with a numbering system that ends at the year. Please see Annex I for details.

1.1. When a bystander is to be admitted (given a diet), two separate BHTs must be written for the patient and the by-stander. The BHT issued to the guardian must be written under the same number as issued to the patient and the word “Guardian” must be written very clearly on top of the particular BHT. The BHT for a guardian is opened only for the purpose of ordering the diet. Hence, only the patient must be registered in the Hospital Admission Register and Ward Admission Register.

1.2. If a newborn infant is treated as an inpatient, a separate BHT must be written after registering in the Hospital Admission Register. In these circumstances drugs must be prescribed on the infant’s BHT and not on the mother’s BHT.

1.3. Reports of laboratory tests etc. should not be pasted on the BHT. These must be pasted on a separate sheet and fixed to the BHT with the continuation sheets.



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1.4. Before a patient is admitted to the ward, he or she must be registered in the Ward Admission and Discharge Register. This register could be in a CR Register, under the headings given in Annex 2. On discharge, the details of the patient such as date of discharge, diagnosis etc. should be entered in the relevant columns of the register.

2. When a patient is being discharged, the final diagnosis must be entered correctly in block capital letters in the appropriate place of the BHT. This must be done at the time of discharge of the patient and should not be postponed to be done sometime later. The final diagnosis must be entered by the discharging medical officer. When patients leave hospital against medical advice, if a confirmed diagnosis cannot be given, a tentative diagnosis should be given depending on the treatment the patient has received/investigations done while in the ward. This would enable the diagnosis to be coded according to the International Classification of Diseases (ICD), and correct morbidity and mortality statistics made available. It is the responsibility of the specialist in charge of the ward to ensure that the final diagnosis is entered.

2.1. BHTs of all patients discharged from the ward must be sent to the officer in charge of Medical Records the following morning, itself. It is the responsibility of the House Officer in charge of the ward to see that this is done.

2.2. BHTs used for an inquest must be returned to the Medical Records Department no sooner the inquest is over.

2.3. BHTs of patients who died should not be sent to the Registrar of Births and Deaths for purpose of death registration. A Death Certificate duly completed on Form B33 should be instead sent to the Registrar.

3. Suitable storage facilities must be made available for filing patient's records. Filing must be done serially according to the admission number i.e., BHT number filing by day of discharge or any other method is not satisfactory.

3.1 After discharge of the patient, if a BHT is required for any purpose, the BHT may be released from the Medical Records after an entry has been made in a register maintained for such purpose. With the approval of head of the institution, the medical officer requesting the BHT will be held responsible for its return.

3.2 BHTs of discharged patients must be maintained in a suitable manner for a period of twelve years. (Right to Information Act, No.12 Of 2016, PART III,7, (3), (b)). Judicial BHTs must be kept for this period plus the period required, till the court case is over.

4. As Hospital Statistics such as 'patient days' have to be prepared certain information such as the midnight report should flow daily from the wards to the Medical Records Department. Institutions that do not have Nursing Officers and a 'Mid Night Census' is not carried out, information to prepare patient days should be taken from the 'Daily state of Sick' maintained for diet purposes.

4.1. In every hospital ward, the Nursing Officers must take a count of patients at 12 midnight each day (Inpatient Census). When 'Admissions' after 12 mid night are added to the midnight balance and total 'discharges' and 'Deaths' for each day are deducted form that figure, the number remaining in the ward is arrived at. This figure should tally with the physical count (Inpatient Census) taken at 12 midnight the following day.

One service day should be counted for each patient admission involving admission and discharge during the same day, i.e., between two successive census- taking hours. If this is not done, credit for the services rendered to these patients are lost. Hence, in addition to the 'Inpatient Census' patients admitted to the ward and discharged on the same day, should be counted and recorded separately as illustrated in Annex 3

4.2. In all hospitals, the 'Daily state of sick' must be maintained in Health 102 (similar to Annex 3) for accounting of diets. These registers can be obtained from the Medical Supplies Division, Francis road, Colombo 10/ Divisional Drug Stores.

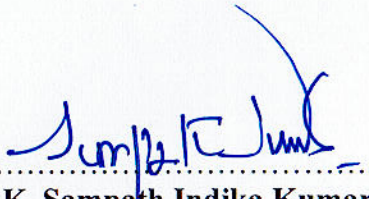
5.The preparation of the Indoor Morbidity and Mortality Return (IMMR) must be assigned to a responsible officer in all hospitals, other than Maternity Homes and Central Dispensaries. If a RMO/AMO has been assigned for this duty in addition to other duties, e.g. OPD work, it is necessary that this officer be given sufficient time daily to attend to this work, depending on the number of daily discharges. An Indoor Morbidity and Mortality Register must be maintained properly by this officer, according to the instructions given by the Medical Statistician.

The completed quarterly Indoor Morbidity and Mortality Returns must be submitted to the DPDHS/Medical statistics Units/ Head of Campaign in time.

It is extremely important that every Head of institution supervises these activities regularly and ensures that they are carried out satisfactorily. The Head of institution should personally scrutinize before certifying the completed IMMR.

6. All cases of communicable diseases must be notified on clinical diagnosis. A list of notifiable diseases, whom to notify and how to notify is given in annex 5 for your guidance. It is important that in filling the Notification Card, the MOH area to which the patient belongs, the address and phone number must be recorded clearly and correctly. Every Provincial and Base Hospital, must maintain a Central Notification Register and Ward Notification Register in each Medical / Pediatric ward. All other institutions i.e. District Hospitals, Peripheral Units, etc. must maintain a Central Notification Register. A responsible officer should be detailed to maintain the Notification Register and Head of Institution must peruse the register regularly and ensure that all cases of Communicable diseases are entered and also notified promptly to the respective MOH's. The format for the Notification Register is in Annex 6 and Ward Notification Register should be maintained under the headings given in Annex 4.

A summary of notifiable diseases reported from the institution should be prepared by disease and ward and sent to the Epidemiological Unit/ Regional Epidemiologist every month. Further details could be obtained from the Epidemiological Unit /Regional Epidemiologist.



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1. Hon.Governor -NWP -f.y.i
2. Secretary, Ministry of Health, Colombo - f.y.i
3. Director General of Health Services, Ministry of Health, Colombo 10 - f.y.i
4. Chief Secretary – NWP - f.y.i
5. Deputy Director General (Medical Services 1), Ministry of Health - f.y.i
6. Secretary, Ministry of Health, North-Western Province. - f.y.i
7. Director – Quality Secretariat, Ministry of Health, Colombo - f.y.i
8. Assistant Audit General - NWP - f.y.i
9. Assistant Internal Audit General – NWP - f.y.i

ANNEX - 01

1. Numbering of Admissions

An admission number has to be allocated for every patient on admission to hospital. Numbering could be done with a new series each year. This means that a new series is started at the addition of last two digits of the year.

E.g. 1/23

1849 /23

ANNEX - 02

2. Ward Admission and Discharge register.

The Ward Admission and Discharge Register must be maintained under the following headings:

- | | |
|-----------------------|-----------------------|
| 1. Monthly serial No. | 8. Religion |
| 2. Admission No. | 9. Date of Admission |
| 3. Name of patient | 10. Time of Admission |
| 4. Address | 11. Date of discharge |
| 5. Age | 12. Diagnosis |
| 6. Sex | 13. Remarks |
| 7. Marital Status | |

ANNEX - 03

3. Sample Inpatient Census Display

Number in hospital at 12 mid night September 8 (Inpatient Census)	230
+ Plus, Number admitted September 9	<u>+35</u>
	265
-Minus: Number discharged (Including deaths) September 9	<u>-37</u>
Number in hospital at 12p.m. September 9 (Inpatient Census)	228
Number admitted and discharged the same day (Including deaths) September 9	<u>+5</u>
Daily Inpatient Census (Inpatient Service Days) September 9	<u>233</u>

ANNEX - 04

4. Ward Notification Register

The ward, notification register must be maintained under the following columns:

1. Serial No.
2. B.H.T.No.
3. Name of Patient, Address, Contact No:
4. Age
5. Sex
6. Disease Notified
7. Date notified
8. To whom notified
9. Signature of the officer
10. Any investigations

Annex - 05

5. Notifiable Diseases

	Disease	Whom to Notify	How to notify
1.	Group A <ul style="list-style-type: none"> • Cholera • Plague • Yellow fever 	Inform immediately to <ul style="list-style-type: none"> • Director general of Health services • Deputy Director general (Public Health services I) • The Epidemiologist • Regional Epidemiologist • Medical officer of Health 	<ul style="list-style-type: none"> • By telephone, fax or e-mail; followed by form "Notification of a Communicable Disease" (Health -544)
2	Group B <ul style="list-style-type: none"> • Acute poliomyelitis / Acute Flaccid paralysis 	<ul style="list-style-type: none"> • The Epidemiologist • Regional Epidemiologist • Medical officer of Health 	<ul style="list-style-type: none"> • By EPID/37/1/R2004 - AFP/Suspected poliomyelitis form No.1 (PINK Form) • By telephone, fax or e-mail and • By form "Notification of a Communicable Disease" (Health -544)
	<ul style="list-style-type: none"> • Measles • Rubella • Congenital Rubella Syndrome 	<ul style="list-style-type: none"> • The Epidemiologist • Regional Epidemiologist • Medical officer of Health 	<ul style="list-style-type: none"> • By EPID/151/1/2013 - Suspected Measles/Rubella Patient Information

			<p>Form(BLUE Form)</p> <ul style="list-style-type: none"> • By telephone, fax or e-mail and • By form “Notification of a Communicable Disease” (Health -544)
	<ul style="list-style-type: none"> • Chickenpox • Dengue Fever/ Dengue Haemorrhagic Fever • Diphtheria • Dysentery • Encephalitis • Enteric fever • Food poisoning • Human Rabies • Leptospirosis • Leprosy • Leishmaniasis • Malaria • Meningitis • Mumps • Neonatal tetanus • Simple Continued fever of over 7 days or more • Tetanus • Tuberculosis <p>Typhus Fever Viral Hepatitis Whooping Cough</p>	<p>Notify the Medical Officer of health of patient’s area of residence</p> <p>By form</p> <ul style="list-style-type: none"> • “Notification of a Communicable Disease” (Health -544) 	

Any other diseases /conditions occurring in unusual numbers or in unusual pattern also has to be notified.

ANNEX – 06

Notification Register

Serial No.	BHT No.	Ward No.	Name	Age	Sex	Exact Address	Date of Adm./Dis.	Provisional Diagn.	Date Notified	Confirmed Diagnosis	Date Confirmed	Lab. findings	Officer Notified	Initials M.O	Remarks

N.B. A notifiable disease must be notified:

1. When the provisional diagnosis is made.
2. When the diagnosis confirmed the MOH should be notified again.
3. Results of laboratory investigation should also be given to the MOH.

B.H.T Tracing request form

Serial No:

- 01. Name of the patient:
- 02. BHT number:
- 03. Date of admission:
- 04. Date of discharge:
- 05. Date of death:
- 06. Ward number (On discharge):
- 07. Reason for tracing B.H.T:
- 08. Diagnosis:
- 09. The date the B.H.T is required:
- 10. Requesting medical officer's name:

Signature:

Date

Authorizing officers name

Signature:

Date

BHT was Issued / Not issued/ Other.....

B.H.T Returning form

Serial No:

Issuing officer 's name:

Signature:

Date

BHT number:

Date of return of BHT:

Medical officer's Name and signature:

Receiving officer 's name:

signature:

Date

(N.B. The name of the medical officer must be written in block capitals.)

(මෙය වෛද්‍ය නිලධාරියා විසින් පිරවිය යුතුය.)

ආකෘතිපත්‍ර අංකය - NWP/PDHS/QM/20/75

ඇඳ ඉහපත් ඉල්ලුම්පත්‍රය

අනුක්‍රමික අංකය -

- 01. රෝගියාගේ නම -
- 02. ඇඳ ඉහපත් අංකය (BHT No) -.....
- 03. රෝහල් ගත වූ දිනය -
- 04. රෝහලෙන් පිට වූ දිනය -.....
- 05. මරණය සිදු වූ දිනය -.....
- 06. වෘත්තීය අංකය -.....
- 07. ඇඳ ඉහපත් ඉල්ලුම් කිරීමට හේතු -.....
- 08. රෝග නිශ්චය -.....
- 09. ඇඳ ඉහපත් අවශ්‍ය දිනය -.....

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 ඉල්ලුම්කරන වෛද්‍ය නිලධාරියාගේ නම අත්සන
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ආකෘතිපත්‍ර අංකය - NWP/PDHS/QM/20/75

අනුක්‍රමික අංකය -

- 01. ඇඳ ඉහපත් අංකය (BHT No) -.....
- 02. ඇඳ ඉහපත් නැවත භාරදුන් දිනය -
- 03. භාරදුන් වෛද්‍ය නිලධාරියාගේ නම සහ අත්සන -
- 04. නැවත භාරගත් නිලධාරියාගේ නම -

.....
 අත්සන
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(නම් පැහැදිලි අකුරෙන් ලිවීමට සැලකිලිමත්වන්න)