



## **On approval of the rules for maintaining source health records and submitting reports**

### *Unofficial translation*

Order № KR DSM-244/2020 of the Minister of Healthcare of the Republic of Kazakhstan as of December 10, 2020. It is registered with the Ministry of Justice of the Republic of Kazakhstan on December 11, 2020 under № 21761

### *Unofficial translation*

In accordance with subparagraph 9) of paragraph 2 of Article 115 of the Code of the Republic of Kazakhstan “On Public Health and the Healthcare System” as of July 7, 2020, I hereby **ORDER**:

1. To approve the rules for maintaining source health records and submitting reports in accordance with the appendix to this order.

2. The Medical Aid Department of the Ministry of Healthcare of the Republic of Kazakhstan shall ensure:

1) the state registration of this order with the Ministry of Justice of the Republic of Kazakhstan;

2) the posting of this order on the website of the Ministry of Healthcare of the Republic of Kazakhstan after its official publication;

3) the submission of information on the implementation of the measures provided for in subparagraphs 1) and 2) of this paragraph to the Legal Department of the Ministry of Healthcare of the Republic of Kazakhstan within ten working days of the state registration of this order with the Ministry of Justice of the Republic of Kazakhstan.

4. Control over the execution of this order shall be entrusted to the supervising deputy minister of healthcare of the Republic of Kazakhstan.

5. This order comes into effect ten calendar days of its first official publication

*Minister of Healthcare of  
the Republic of Kazakhstan*

*A. Tsoi*

Appendix to Order  
№ KR DSM-244/2020  
of the Minister of Healthcare  
of the Republic of Kazakhstan  
as of December 10, 2020

## **Rules**

### **for maintaining source health records and submitting reports**

#### **Chapter 1. General provisions**

1. These rules for maintaining source health records and submitting reports (hereinafter referred to as the Rules) have been developed in accordance with subparagraph 9) of

paragraph 2 of Article 115 of the Code of the Republic of Kazakhstan “On Public Health and the Healthcare System” as of July 7, 2020 (hereinafter referred to as the Code) and establish the procedure for maintaining forms of source health records and submitting reports in the field of healthcare.

2. Basic terms used for maintaining forms of source health records and submitting reports in the field of healthcare are as follows:

- 1) primary statistical data - data obtained or registered in statistical data forms;
- 2) provisional diagnosis – an opinion of an attending physician on diseases (injuries, pathological processes), which is made on the basis of complaints, anamnesis, examination and data from additional and instrumental studies;
- 3) source health records – a set of documents intended to record data on the state of health of the population;
- 4) reporting documents - documents containing information on the results of the organization’s activities over a certain period of time;
- 5) final diagnosis – an opinion of an attending physician on diseases (injuries, pathological processes) for which medical assistance was provided.

## **Chapter 2. Procedure for maintaining source health records and submitting reports**

3. Health records ensure the interaction of medical workers in the treatment and diagnostic process.

4. In accordance with subparagraph 21) of paragraph 1 of Article 77 of the Code, citizens have the right to receive information in an accessible form on the state of health, including information on the results of medical examination, diagnosis and prognosis of the disease, methods of providing medical care, associated risks, possible types of medical intervention, its consequences and the results of medical care.

5. Health records:

- 1) are completed in a timely manner, contain information on the patient’s health status and results of the prescribed treatment;
- 2) help identify factors that led to a violation of the standard of treatment and (or) the emergence of risks for the patient;
- 3) contain medical terminology;
- 4) contain dates and signatures under the entries;
- 5) do not contain strikethroughs and clipped words.

6. The case record of a hospital patient, approved in accordance with the form in subparagraph 31) of Article 7 of the Code, is the main medical document of a medical facility, which is filled in for each patient admitted to the hospital.

7. The case record of a hospital patient contains all the necessary information describing the patient’s condition during his/her entire stay in the hospital, the organization of his/her treatment, data of objective and laboratory studies and prescriptions.

8. Data from the case record of a hospital patient make it possible to control the correctness of the organization of the treatment and diagnostic process and are used to provide information in cases specified in paragraph 4 of Article 273 of the Code.

9. When a patient is admitted to the hospital, the staff of the admission department on the front of the case record put down the patient's passport data.

10. Information on the blood group, Rh factor, drug intolerance is recorded by the attending (receiving) doctor during the initial examination of the patient, except for those cases when these data cannot be obtained. The impossibility to obtain the necessary information is documented by a corresponding entry in the case record of the hospital inpatient.

11. The clinical diagnosis is recorded on the front side of the hospital patient's case record within three working days of the patient's admission to the hospital.

12. The final diagnosis is made when the patient is discharged, it is given in expanded form in accordance with the International Classification of Diseases of the Tenth Revision ( hereinafter - ICD-10). The final diagnosis shall be substantiated, correspond to the data available in the case record, include all existing complications, take into account the severity of functional disorders and concomitant diseases of clinical significance.

13. In the case of a surgical intervention in relation to a patient, it is necessary to indicate the name of the operation, date (year, month, day and time (hour)), method of anesthesia.

14. An entry of the issuance of a document certifying the hospital patient's temporary incapacity for work is made in his/her case record by the attending physician indicating the number and series of the sick leave for temporary incapacity for work, or the number of the certificate of temporary incapacity for work, indicating the extension period.

15. Immediately after the examination of the patient, the doctor of the admission department (doctor on duty) fills in the case record of a hospital patient indicating:

- 1) the patient's complaints in order of their importance with detail;
- 2) data from the anamnesis of the disease, indicating information related to the course of the present disease or affecting the tactics of managing the patient;
- 3) information on the presence of allergic reactions, epidemiological history, previous blood transfusions, tuberculosis, sexually transmitted infections, viral hepatitis, HIV infection ;
- 4) expert anamnesis (information on temporary disability for the past twelve months, the number of days of disability in the previous case, the presence of a disability group);
- 5) the data of the initial examination for all organs and systems, the revealed pathological changes are described in detail, indicating the characteristic symptoms by the authors;
- 6) a provisional diagnosis, and a plan of examination and treatment is prescribed (at the end of the examination of the patient).

16. The doctor makes entries in the case record of a hospital inpatient, which reflect the dynamics of the patient's condition, data of an objective examination, laboratory and other

studies, in accordance with the form in subparagraph 31) of Article 7 of the Code, at least three times a week.

17. For patients in a severe or moderate condition, the doctor makes entries in the case record of the hospital patient daily, and if necessary, in cases of deterioration of the dynamics - several times a day, indicating the time of examination of the patient. With intensive observation, the entries in the case record of the hospital patient are hourly, depending on the severity of the patient's condition. For children under three years of age, a doctor makes entries in the hospital patient's case record on a daily basis.

18. On the day the patient is discharged from the hospital, a discharge summary is drawn up.

19. Records on transfusions of biological fluids, the administration of narcotic and potent drugs are certified with the signature of the attending physician.

20. The department chiefs' rounds are documented by an entry in the hospital patient's case record, which reflects the judgment about the patient, the statement of the clinical diagnosis, recommendations, and is signed by the department chief.

21. When patients are examined by a specialized professional, an entry made in the case record of a hospital patient shall contain the date, time of examination, specialty, surname, name, patronymic (if any) of the specialized professional, description of pathological changes, diagnosis and recommendations for further patient management.

22. Records of the case conferences are kept taking into account the opinions of all members of the conference. The case conference is held in agreement with the attending physician.

23. When a patient is admitted to the intensive care (resuscitation) unit (ward), the receiving doctor makes an entry about the patient in the hospital patient's case record indicating the diagnosis or the symptom complex. In the intensive care (resuscitation) unit (ward), entries in the hospital patient's case record are made by the doctors on duty at least three times a day. The entries reflect the dynamics of the patient's condition and the most important indicators of the body's vital functions. The attending physician of the specialized department daily records the dynamics of the patient's condition in the case record of a hospital patient who is in the intensive care (resuscitation) unit (ward).

24. The list of prescriptions (a loose leaf in the case record of a hospital patient), in accordance with subparagraph 31) of Article 7 of the Code, is an integral part of the case record of a hospital patient; medicines and procedures prescribed by the attending physician exclude double or arbitrary interpretation, the date of their prescription and cancellation is indicated. On the day of the prescription, the nurse confirms the doctor's prescription with her signature and indicates the date. In cases where a medication purchased by the patient is used for his/her treatment, a note "the patient's medication" is made next to the prescription.

25. Instead of a list of prescriptions, the intensive care (resuscitation) unit (ward) maintains a medical chart of the main indicators of the patient's condition and prescriptions in

the intensive care and resuscitation unit (ward) (a loose leaf of the case record of a hospital patient) in accordance with subparagraph 31) of Article 7 of the Code, where, in addition to the basic parameters of vital activity, all medical prescriptions are recorded. When a patient is transferred from the intensive care (resuscitation) unit (ward), a short transfer summary is drawn up. The doctor of the clinical department examines the patient no later than one hour after his/her admission from the intensive care (resuscitation) unit (ward) and writes down a brief clinical judgment of the patient.

26. An interim epicrisis, reflecting the dynamics of the judgment of the patient, further tactics of patient management and prognosis, is drawn up by the doctor once every two weeks . In the interim epicrisis, an analytical assessment of the results of laboratory and diagnostic studies is indicated and an expert history is specified (the number of days of temporary disability in the last case).

27. The entries of the temperature dynamics are made by the nurse in the case record of the hospital patient twice a day.

28. While on duty, the doctor on duty dynamically monitors the patient, ascertaining and analyzing all the changes occurring in the patient's condition. He/she substantiates the need for making procedures by a relevant entry in the case record of the hospital patient. In case of a change in the previously planned tactics of patient management, he/she gives reasons for his /her decision.

29. At the end of the duty time, the doctor on duty transmits information on the dynamics of the condition over the past period of time, paying attention to unforeseen circumstances and unpredictable moments in the course of the patient's pathological process to the department chief (attending physician).

30. When the patient is discharged from the hospital, a discharge summary is drawn up, which indicates the final clinical diagnosis, the length of stay (including brief summary data on the patient's condition upon admission and discharge), the treatment measures taken and their effectiveness, recommendations for further tactics of patient management and recommended regimen.

31. When a patient is discharged from a hospital with an open sick leave and certificate of temporary disability, the discharge summary indicates the basis for the discharge with an open sick leave and certificate of temporary disability, the date of attendance. When a patient during his/her stay in a hospital is presented at a meeting of a medical advisory commission ( hereinafter - MAC), the date of the MAC meeting and recommendations are indicated.

32. The discharge summary is drawn up in printed (written) form in three copies: one copy is in the case record of the hospital patient, the second one is transferred to the primary healthcare entity (hereinafter – PHC entity) at the place of residence (observation) of the patient and glued to the outpatient's health record of the patient, the third one is given to the patient.

33. The discharge summary is signed by the attending physician and the department chief with writing their full names. Copies given to the patient and sent to the PHC entity are certified with the seal of the medical facility.

34. In the event of the death of a patient, a postmortem report is filled in the hospital patient's case record.

35. The postmortem report contains a brief history of hospitalization, information on the patient: the dynamics of symptoms, the nature of the treatment and diagnostic procedures performed, the cause and circumstances of the death. A detailed clinical diagnosis is stated with account of modern classifications and requirements for the statement of the diagnosis.

36. If the death occurs before the attending physician's examination of the profile department, the postmortem report is drawn up by the doctor of the admission department or the intensive care (resuscitation) unit (ward) together with the doctor (or chief) of the profile department. In this case, the doctor who treated the patient makes the entries in the hospital patient's case record.

37. The final clinical diagnosis is stated in accordance with ICD-10, indicating the underlying disease (the main cause of death), complications from the underlying disease, concomitant diseases.

38. After the postmortem autopsy of the corpse, the autopsy record with a detailed postmortem diagnosis and epicrisis are entered into the hospital patient's case record within ten calendar days (in case of discrepancy between the diagnoses - the presumptive cause and degree of discrepancy).

39. The case record of a hospital patient is issued from the archive at the request of the Social Health Insurance Fund (hereinafter - SHIF) and its branches, and in cases stipulated by paragraph 4 of Article 273 of the Code. If necessary, copies of the hospital patient's case record and certain types of examination are made. For further consultation, the patient is given X-ray films. The hospital patient's case record is retained in the hospital's archives for twenty-five years.

40. In the case record of a hospital patient of a surgical profile, in cases of surgical pathology, the date and time of any surgical intervention, its volume, type of anesthetic treatment, time and volume of resuscitation measures are indicated. It is necessary to indicate the time period from the onset of the disease (acute surgical condition) until admission to the hospital, the time between admission and the operation, the day of the development of the postoperative complication, the timeliness of taking measures to eliminate it, their completeness and adequacy, individual characteristics of the patient, difficulties encountered during surgery.

41. The case record of a hospital patient of a surgical profile contains information on the patient's informed consent to the operation, with an explanation of the need for surgical intervention, the nature of the planned operation, and possible common complications.

42. The preoperative report substantiates the need for planned and emergency surgery, indicates the diagnosis of the underlying and concomitant diseases, the severity of functional disorders, absolute or relative contraindications to surgery, the adequacy of preoperative preparation, the plan of the operation, the degree of risk of surgery.

43. An anesthesiologist's examination and anesthesia protocol are mandatory entries in the hospital patient's case record for all types of anesthesia except for local anesthesia.

44. The entry contains data that significantly affect the anesthetic tactics:

1) features of the anamnesis;

2) concomitant diseases;

3) medicines that the patient has taken;

4) bad habits (consumption of tobacco products, including products with heated tobacco, hookah tobacco, hookah mix, tobacco heating systems, electronic consumption systems and liquids for them, alcohol);

5) taking narcotic drugs and psychotropic substances;

6) complications of previous anesthesia;

7) the presence of blood transfusions.

45. Deviations of objective and subjective examination are indicated, as well as blood pressure, pulse, especially in the data of laboratory and instrumental examinations, the nature of the upcoming operation, preoperative preparation.

46. The dynamics of observation of the patient is carried out in the protocol of the operation, every day during the first three calendar days of the operation, then every other day with a positive course of the postoperative period. The entries indicate all the procedures to which the patient was subjected (removal of drains, tubes, dressings), the patient's condition, the dynamics of symptoms, the main parameters of vital activity, the state of the postoperative wound.

47. The discharge summary indicates the diagnosis of the disease, the date and type of surgery performed, features of the postoperative course (timing of drainage removal, removal of stitches, the nature of wound healing), the effectiveness of the treatment. The discharge summary contains recommendations for further treatment and the prognosis of the disease.

48. Peculiarities of maintaining a case record of a hospital patient in obstetric care facilities:

1) the case record of a hospital patient is the main medical document of the obstetric care facility, which is filled in for each admitted pregnant woman, woman in labor or new mother;

2) the case record of a hospital patient indicates the nature of the course of labor, as well as all diagnostic and therapeutic measures. The case record of a hospital patient contains information on the course of labor;

3) the maintaining of the case record of a hospital patient is responsibility of the doctor on duty and (or) the attending physician;

4) the consultations of the department chief and the opinion of case conferences are recorded in the case record of a hospital patient;

5) each operation is entered into the case record of a hospital patient, indicating the indications for the operation, the sequence of its production, the persons who performed the operation, assistants, the operating nurse, anesthesiologists;

6) upon discharge of a pregnant woman, a new mother and her child, the case record of a hospital patient is signed by the attending physician, the department chief and, after analysis by the chief physician (deputy chief physician), is transferred to the archives of the obstetric care facility;

7) the case record of a hospital patient is given to employees of the obstetric care facility (maternity ward of a medical facility) to make statistical reports.

49. The health record of an outpatient is the main source health record of a patient receiving treatment on an outpatient basis, or at home, and is filled out during each visit to a medical facility for receiving medical care.

50. The title page of the health record of an outpatient is drawn up at the front office of a medical facility.

51. In the health record of an outpatient, the attending physician:

1) indicates the date of a visit (in case of emergency - the time of a visit);

2) indicates the patient's complaints;

3) indicates a medical history;

4) indicates objective data;

5) states the diagnosis of the disease according to ICD-10, the presence, severity of complications, the degree of functional disorders;

6) prescribes necessary examinations and consultations;

7) indicates medical and recreational activities;

8) reflects the dynamics of the disease, the effectiveness of the treatment (in case of repeated visits);

9) draws up a list of specified diagnoses and a sick leave for temporary disability.

52. The diagnosis indicates the manifestations of the disease that cause temporary disability, an entry is made of the patient's temporary disability, its terms are determined with account of individual characteristics of the course of the disease, as well as an entry of issuing a sick leave and a certificate of temporary disability indicating the series, number and date of the next visit of a doctor. During subsequent examinations, the dynamics of the disease, the effectiveness of the treatment are indicated and the extension or closing of the sick leave and certificates of temporary disability, referral to MAC, for hospitalization are justified.

53. Peculiarities of maintaining health records of a patient being treated in a hospital-replacing setting and at home are as follows:

1) for a patient receiving treatment in a hospital-replacing setting or at home, a case record of a hospital patient is filled out with the note "day hospital" or "home care";



2) data on the patient's condition, diagnostic tests, as well as information on the treatment performed and its results are indicated in the case record of a hospital patient. Entries in the case record of a hospital patient shall be daily;

3) the treated patient is issued with a discharge summary of the treatment provided and recommendations.

54. Healthcare entities submit reports within the time frame established by the authorized body for the healthcare.