- Patient demographics
- Medications
- Patient diagnoses/problem list
- Assessment/reassessment
- Testing results
- Care plan
- Health maintenance

The medical record needs to present sufficient information to do the following:

- Support the diagnosis.
- Justify the patient's care, treatment, and services.
- Document the course and results of the patient's care, treatment, and services.
- Facilitate the continuity of care.

Monitoring electronic function use in documentation may involve partnering with the electronic health record vendor to develop a way to track information that has been copied-and-pasted or auto-generated (for example, displaying this information in a different font or underlined) or using a manual process to review for copied-and-pasted information.

Measurable Elements of MOI.03.00

1. The patient medical record contains the following:
   - At least two unique identifiers for each item (*See also* IPSG.01.00, ME 1)
   - Author of each entry
   - Date of each entry
   - Time of each entry
2. The specific content, format, and location of entries for patient medical records is standardized and determined by the hospital.
3. The hospital implements a process on the proper use of copy-and-paste, autofill, autocorrect, and templates and provides education and training on the process to all staff who document in the electronic health record.
4. The hospital implements processes to facilitate accurate and complete documentation in patient medical records. (*See also* HCT.01.01, ME 3)
5. There are processes for how entries are corrected, overwritten, reviewed, and authenticated.

Standard MOI.03.01

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

Intent of MOI.03.01

Each hospital determines the content and format of the patient's medical record and has a process to assess the content and completeness as part of the hospital's performance improvement activities and is carried out regularly.

Patient medical record review is based on a sample representing the practitioners providing care and the types of care provided. The review process is conducted by medical staff, nursing staff, and other relevant health care practitioners authorized to make entries in the patient medical record. The review focuses on the timeliness, accuracy, completeness, and legibility of the record and clinical information. Medical record content required by laws or regulations is included in the review process. The hospital's medical record review process includes medical records of all services provided to both current and discharged patients.

A *representative sample* means medical records from all services and not a specific sample size; however, it should make sense for the organization.

Measurable Elements of MOI.03.01

1. Ⓓ A representative sample of medical records that includes active and discharged medical records in all service areas is reviewed at least quarterly or more frequently as determined by laws and regulations.
2. The review is conducted by physicians, nurses, and others authorized to manage or make entries in patient medical records.
3. The review focuses on the timeliness, accuracy, completeness, and legibility of the medical record.
4. Medical record content required by laws or regulations is included in the review process.
5. Ⓓ The results of the review process are incorporated into the hospital's quality oversight mechanism.