Medical Records Standard Intents

MR.1 The Health Information Management (Medical Records) department has adequate qualified staff.

MR.1.1 The health information management (Medical Records) department is directed by individual qualified by education (bachelor in health information management) and experience.

MR.1.2 The department director is credentialed in health information management through formal training as per the national/international guidelines.

MR.1.3 The department has adequate staff to carry out its functions.

MR.1.4 Staff working in the department are credentialed in health information management through formal training as per the national/international guidelines.

MR.1.5 Clinical coding staff working in the department are credentialed/certified in clinical coding through formal training as per the national/international guidelines.

MR.1.6 The department has one or more staff members who are credentialed in Clinical Documentation Improvement (CDI) through formal training as per the national/international guidelines.

Standard Intent:

Patient clinical records are the backbone for communicating care processes, tracking patients' status and progress and ensuring patient safety. Having qualified and adequately staffed department ensures these patient and providers needs are met. Mishandling of patient information and gaps in documentation may lead to risks for the patient and the hospital such as medication errors (omission, overdose, allergies), and breaches in patient information confidentiality. So, formal training in Clinical Documentation Improvement (CDI) should be given to one or more of medical record staff to monitor and improve medical records' documentation deficiencies.

MR.2 A medical record is initiated for every patient.

MR.2.1 The hospital initiates a medical record for each patient on his first contact with the hospital, whether it is for an admission, emergency department or outpatient clinic visit.

MR.2.2 Each medical record is assigned a unique identification number.

MR.2.3 The hospital keeps only one medical record for each patient.

MR.2.4 There is patient identification on each page of the medical record.

Standard Intent:

Every patient assessed or treated in a hospital as an inpatient, outpatient, or emergency care patient has a clinical record. Accurate identification of a patient's record is the backbone of an effective and efficient medical record system. Correct identification is

needed to positively identify the patient and ensure that each patient has one medical record number and one medical record. The record is assigned an identifier unique to the patient, or some other mechanism is used to link the patient with his or her clinical record. A single record and a single identifier enable the hospital to easily locate patient clinical records and to document the care of patients over time as well as eliminate risks result from misidentified information.

MR.3 The hospital maintains a master patient index (either manual or computerized) of all patients who have ever been admitted to or treated by the hospital.

MR.3.1 The master patient index is used to identify a patient's medical record number.

MR.3.2 The master patient index provides basic patient demographic information (identification information collected during the registration process) as well as patient activity (visit) information:

MR.3.2.1 The patient demographic information (identification information) includes: medical record number, patient's full name, date of birth, sex, marital status, address, national identification number, next of kin (and his contacts) and/or a person that the patient wishes to be contacted in an emergency, or authorized representative/designee.

MR.3.2.2 The patient activity (visit) information includes: admission and discharge/transfer dates for inpatient hospitalizations, date of death when a death occurs, encounter date or date of service for outpatient visits, most responsible physician, and mother's name for newborns.

MR.3.3 The patient demographic information (identification information) of the master patient index is recorded on the front sheet of the medical record.

MR.3.4 The master patient index is updated for each new episode of care for any change in information.

MR.3.5 The master patient index is retained permanently to provide historical access to basic patient information and dates of stay in the hospital.

Standard Intent:

The MPI is the key to locating the patient record in a numeric identification system. It identifies all patients who have been treated by the facility and lists the number associated with name. The index can be maintained manually or as part of a computerized system.

The hospital captures and maintains essential demographic and outcome data of all its patients. These data are updated whenever change occurs such as change in address, contact details or next of kin information during new care/visit episodes. This aims at