MR.4 **Medical records contain sufficient information to promote continuity and coordination of care and communication among care providers.**

MR.4.1 The medical record contains sufficient information to identify the patient and his care provider, support the diagnosis, justify the treatment, and document the results of care provided.

MR.5 **The hospital has a complete and accurate medical record for every patient.**

MR.5.1 The hospital identifies in a policy all staff members authorized to make entries in medical records.

MR.5.2 All entries in the medical records must be legible, indelibly verified, dated, and authenticated.

MR.5.3 Clinical staff authorized to make entries in the medical record receive formal training in clinical documentation improvement as per the national/international guidelines.

MR.5.4 The author of each entry must be identified and authenticated by official stamp, signature, written initials, or computer entry.

MR.5.5 Medical record completion is a requirement within thirty days of patient discharge and before any elective vacation or period of absence of the staff member entering the notes in the medical record.

MR.5.6 The hospital has a policy to deal with delinquent medical records.

MR.5.7 The most responsible physician is responsible for the completion of his own records.

MR.6 **The hospital maintains the medical records in one central place.**

MR.6.1 The hospital has a medical records department that accommodates all medical records.

MR.6.2 The hospital has processes to manage the different parts of the medical records.

MR.6.2.1 The different parts of multiple records are cross referenced to the patient's unique identifier to enable records linkage.

MR.6.2.2 The different parts can be easily located when not stored together.

MR.6.2.3 The hospital ensures that all information are available and accessible when needed.

MR.6.3 The processes include, but are not limited to, the following:

MR.6.3.1 Records that are partly paper-based and partly electronic.

MR.6.3.2 Records that include items requiring incompatible storage systems such as videos and audio recordings.

MR.7 **A discharge summary is completed for all discharged patients.**

MR.7.1 There is a discharge summary for all discharged patients.

MR.7.2 The discharge summary is complete and includes:

MR.7.2.1 The reason for the patient's admission.

MR.7.2.2 The patient's diagnosis.

MR.7.2.3 Brief summary of hospitalization (therapies, consultations, interventions and results of any important diagnostic testing).

MR.7.2.4 A list of medications used.

MR.7.2.5 Any surgery or procedures performed and their outcome.

MR.7.2.6 The patient's condition at discharge.

MR.7.2.7 All medications to be taken by the patient after discharge.

MR.7.2.8 Any special care the patient requires after discharge.

Licensed by CBAHI to:FAROUK MOHAMMED ATTIA SOLIMAN (Dr faroukmohammed@yahoo.com). Not for email, distribution or reproducti