



accuracy of patient data and the ability to reach him/her or their next of kin in cases of emergency such as drug recall or deterioration of patient status.

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.

Standard Intent:

The information contained in the medical record allows healthcare providers to determine the patient's medical history and provide informed care. The medical record serves as the central source for planning patient care and documenting communication among patient and healthcare provider and professionals participating in the patient's care. Medical records also ensure documentation of compliance with organizational, professional or governmental regulation.

The hospital determines the specific data and information recorded in the clinical record of each patient assessed or treated on an inpatient, outpatient, or emergency basis. The clinical record needs to present sufficient information to support the diagnosis, to justify the treatment provided, to document the course and results of the treatment, and to facilitate the continuity of care among health care practitioners.

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.5.5 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.5.4 The author of each entry must be identified and authenticated by official stamp, signature, written initials, or computer entry.

Standard Intent:

One aspect of maintaining security of patient information is to determine who is authorized to obtain a patient clinical record and make entries into the patient clinical record.

The hospital identifies a list of healthcare professionals allowed to make entries in the patients' medical records. Identified professionals must receive formal training about clinical documentation improvement. Then, the documentation in the medical records must be reviewed and monitored to detect deficiencies and to endure completion of records before next episode of care.

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 is 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.

Standard Intent:

As part of maintaining integrated and controlled medical records, it is essential that all patient records are stored in a one central place. This aims to prevent missed data pertinent to patient care interventions and their outcomes and to eliminate risks that result of disintegrated documentation of care process which may lead to medical errors.

Having medical records in one central location under one central department enables staff to monitor the availability and timeliness of the records presence in the requesting department such as emergency room and the outpatient department.

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