determining the number of health care personnel required, and for educating the population on health risks within the country. It is used at an international level to compare health status of countries in a region or globally.

MR.9 There is a process to ensure availability of the medical records in a timely manner.

MR.9.1 The hospital determines in a policy all disciplines who may have access to the medical records.

MR.9.2 Care providers have access to current and past medical records.

MR.9.3 Medical records are readily retrievable for each patient encounter.

MR.9.4 Medical records are available within thirty minutes of being requested.

MR.9.5 Medical records can be retrieved any time of the day.

Standard Intent:

Doctors, nurses and other health care professionals write up medical records so that previous medical information is available when the patient returns to the hospital. The medical record must therefore be available. This is the job of the medical record staff. If a medical record cannot be located, the patient may suffer because information, which could be vital for their continuing care, is not available. If the medical record cannot be produced when needed for patient care, the medical record system is not working properly and confidence in the overall work of the medical record service is affected.

MR.10 Medical records are consistently organized.

MR.10.1 Individual medical records are securely compiled.

MR.10.2 Medical records are organized into sections. (e.g., a section for test results, operative reports, consultations, discharge summary).

MR.10.3 The different sections of the medical record are organized chronologically (e.g., the physician orders start with the initial set written when the patient was admitted to the hospital and end with the discharge order).

MR.10.4 During each hospitalization episode, both in-patient and outpatient medical records are separated into different sections in the patients' medical record (e.g., for doctors' orders, nursing notes, progress notes).

Standard Intent:

To ensure security of medical record's forms and to prevent loss of patient information, forms should be securely held in the medical record either by a clip or fastener. A two-

pronged clip can be threaded through clip holes in the folder or can be attached to the folder by the adhesive backing.

Each section of the medical record must be separated by a divider; the divider will be slightly wider than the forms in the medical record and have a tab on which to write “test results”, “operative reports”, etc. In addition, if combined with the inpatient notes, all outpatient notes can be stored behind an outpatient divider.

MR.11 The hospital has a system to manage voluminous medical records.

MR.11.1 There is a system that enables medical record linkage.

MR.11.2 When the medical record is divided into volumes, the number of each volume should be clearly visible on the folder and on the sign-out slip (e.g., "Volume 1 of 2", "Volume 2 of 2,").

MR.11.3 When the hospital practices thinning of voluminous medical records:

MR.11.3.1 The hospital develops thinning guidelines that remain consistent for the type of documentation contained.

MR.11.3.2 The hospital retains documentation in the medical record that reflects the current plan of care and services provided.

MR.11.3.3 The hospital removes parts of the medical record older than a certain date and moves them into a secondary record (the overflow record).

Standard Intent:

Hospitals need to have a process based on which voluminous medical records are handled. When a second volume is initiated, what is the essential information that needs to be accessible to care providers at all care intervals and the storage of those records should be clearly defined. This is part of ensuring integrity and completeness of patient records which influence continuity of the care provided as well as informed care plans and interventions.

MR.12 The hospital has a system for the retention of medical records in accordance with laws and regulations.

MR.12.1 The hospital has a policy on the retention of medical records.

MR.12.2 The policy is consistent with laws and regulations.

MR.12.2.1 The medical records are retained for a minimum of five years after the patient was last seen unless otherwise specified by laws and regulations. For minors, records shall be kept until he/she is eighteen years of age, and then for a minimum additional five years.