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.

Standard Intent:

A discharge summary is a summary of the patient's stay in hospital written by the attending doctor. The minimum detail provided in a discharge summary is described in the standard. A discharge summary may be written on a pre-printed form or on plain paper and typed or word-processed in the Medical Record Department. The attending doctor writes a discharge summary in duplicate when the patient is discharged. The original is kept in the medical record and the copy given to the patient to take to their local doctor to enable continuing care.

MR.8 The hospital uses nationally recognized standardized diagnosis and procedure codes.

MR.8.1 The hospital uses the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) for diagnosis coding.

MR.8.2 The hospital uses Australian Classification of Health Interventions (ACHI) for procedure coding.

Standard Intent:

Hospitals are expected to meet national laws and regulations including the use of standardized diagnosis and procedure codes. Clinical coding is the translation of diseases, health related problems and procedural concepts from text to alphabetic/numeric codes for storage, retrieval and analysis of health care data. Staff responsible for coding should be formally trained by attending clinical coding courses offered at a local or regional level.

Coded data are used to collect statistics on the types and incidence of diseases and injuries. This information is used at a national level for planning health care facilities, for

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-