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