MR.16 The hospital uses standardized forms in medical records.

MR.16.1 The hospital uses standardized forms in medical records, generated based on hospital needs and the needs of healthcare professionals.

MR.16.2 The hospital assigns a structure to control the development of medical records forms (e.g., a forms committee or the medical records review committee).

Standard Intent:

The content, format, and location of entries for a patient's clinical record are standardized to help support the integration and continuity of care among the various practitioners of care to the patient.

Some important points to be considered about forms in the medical record

- Forms should all be the same size, usually A4.
- The patient's name and medical record number, and the name of the form should be in the same place on EVERY form.
- Only official forms approved by the administration or forms committee or the medical records review committee (if there is one) should be included in the medical record.

Additionally, forms are reviewed and approved by the committee to prevent duplication of entries, involve the concerned parties, and to ensure compliance with regulatory and accreditation standards.

MR.17 The hospital has a system in place for monitoring completion of medical records.

MR.17.1 The medical records are reviewed on an ongoing basis (e.g., monthly or quarterly).

MR.17.2 The review includes a representative sample.

MR.17.3 The review is conducted by care providers authorized to make entries in medical records.

MR.17.4 The review process focuses on the appropriate and comprehensive documentation, timeliness, and legibility.

MR.17.5 Data collected are analyzed and corrective actions are taken.

Standard Intent:

Each hospital determines the content and format of the patient clinical record and has a process to assess record content and the completeness of records. That process is a part of the hospital's performance improvement activities and is carried out regularly.