needed to positively identify the patient and ensure that each patient has one medical record number and one medical record. The record is assigned an identifier unique to the patient, or some other mechanism is used to link the patient with his or her clinical record. A single record and a single identifier enable the hospital to easily locate patient clinical records and to document the care of patients over time as well as eliminate risks result from misidentified information.

MR.3 The hospital maintains a master patient index (either manual or computerized) of all patients who have ever been admitted to or treated by the hospital.

MR.3.1 The master patient index is used to identify a patient's medical record number.

MR.3.2 The master patient index provides basic patient demographic information (identification information collected during the registration process) as well as patient activity (visit) information:

MR.3.2.1 The patient demographic information (identification information) includes: medical record number, patient's full name, date of birth, sex, marital status, address, national identification number, next of kin (and his contacts) and/or a person that the patient wishes to be contacted in an emergency, or authorized representative/designee.

MR.3.2.2 The patient activity (visit) information includes: admission and discharge/transfer dates for inpatient hospitalizations, date of death when a death occurs, encounter date or date of service for outpatient visits, most responsible physician, and mother's name for newborns.

MR.3.3 The patient demographic information (identification information) of the master patient index is recorded on the front sheet of the medical record.

MR.3.4 The master patient index is updated for each new episode of care for any change in information.

MR.3.5 The master patient index is retained permanently to provide historical access to basic patient information and dates of stay in the hospital.

Standard Intent:

The MPI is the key to locating the patient record in a numeric identification system. It identifies all patients who have been treated by the facility and lists the number associated with name. The index can be maintained manually or as part of a computerized system.

The hospital captures and maintains essential demographic and outcome data of all its patients. These data are updated whenever change occurs such as change in address, contact details or next of kin information during new care/visit episodes. This aims at

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.