



MR.5.4 The author of each entry must be identified and authenticated by official stamp, signature, written initials, or computer entry.

Standard Intent:

One aspect of maintaining security of patient information is to determine who is authorized to obtain a patient clinical record and make entries into the patient clinical record.

The hospital identifies a list of healthcare professionals allowed to make entries in the patients' medical records. Identified professionals must receive formal training about clinical documentation improvement. Then, the documentation in the medical records must be reviewed and monitored to detect deficiencies and to endure completion of records before next episode of care.

MR.6 The hospital maintains the medical records in one central place.

MR.6.1 The hospital has a medical records department that accommodates all medical records.

MR.6.2 The hospital has processes to manage the different parts of the medical records.

 MR.6.2.1 The different parts of multiple records are cross referenced to the patient's unique identifier to enable records linkage.

 MR.6.2.2 The different parts can be easily located when not stored together.

 MR.6.2.3 The hospital ensures that all information is available and accessible when needed.

MR.6.3 The processes include, but are not limited to, the following:

 MR.6.3.1 Records that are partly paper-based and partly electronic.

 MR.6.3.2 Records that include items requiring incompatible storage systems such as videos and audio recordings.

Standard Intent:

As part of maintaining integrated and controlled medical records, it is essential that all patient records are stored in a one central place. This aims to prevent missed data pertinent to patient care interventions and their outcomes and to eliminate risks that result of disintegrated documentation of care process which may lead to medical errors.

Having medical records in one central location under one central department enables staff to monitor the availability and timeliness of the records presence in the requesting department such as emergency room and the outpatient department.

MR.7 A discharge summary is completed for all discharged patients.