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.

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