



Chapter XVIII

1. Management of Information (MOI)
2. Medical Records (MR)



Introduction

Management of Information

One of the most valuable resources that the leadership can have is information. Accurate information is necessary for the leadership to make correct decisions. Information that is trended over time can be evaluated to see if any improvements need to be made before there is a crisis.

Medical Records

Medical Records is the backbone of the hospital and considered one of the important elements in the Quality program. The quality of the medical records is essential.

Health care providers must be able to have access to information in the medical record in order to provide safe care. Also, this is vital for the patient continuity of care so that health care providers can find the necessary information every time the patient is admitted.

Management of Information (MOI)

1. Management of Information (MOI)

Scoring:



Management of Information (MOI)

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MOI.1.	The leadership develops and implements an information management plan to meet the information needs of all those who provide clinical services and for those who manage the hospital and the plan includes:					
	MOI.1.1 A definition of data, information, security, confidentiality and integrity.					
	MOI.1.2 A categorization of data available (both manual and computerized).					
	MOI.1.3 An assessment of information needs by both clinical and managerial staff within the hospital.					
	MOI.1.4 A description of how confidentiality, security, and integrity of the data and information will be maintained.					
	MOI.1.5 A description of the various kinds of reports, the frequency of the reports, and who will receive them.					
	MOI.1.6 An educational/training schedule for decision makers and other appropriate staff on the principles of data management for decision-making.					
	MOI.1.7 A description of the technology and other resources required to implement the plan.					
	MOI.1.8 A description of the roles and responsibilities of the leadership and department heads in relation to implementation and evaluation.					
MOI.2.	Appropriate clinical and managerial staff participates in selecting, integrating, and using information management technology.					



Management of Information (MOI)

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
DATA MANAGEMENT						
MOI.3.	The leadership works with all of the department heads to identify the necessary data that will be used for decision-making on a regular basis and this includes:					
	MOI.3.1 The identification of necessary data based on the hospitals scope of service and complexity of care.					
MOI.4.	If data is collected manually (or when data is entered into a computer), the leadership determines the roles and responsibilities for data entry (completion of forms), data collection, data analysis, and report generation and this includes:					
	MOI.4.1 Data elements being defined and forms developed for designated staff to enter the necessary data.					
	MOI.4.2 Establishing time frames for collecting data.					
	MOI.4.3 Displaying and analyzing data using software programs (e.g. excel).					
	MOI.4.4 The leadership deciding the routing of the reports.					
MOI.5.	The leadership analyzes the information with the assistance of the Quality Management Director or leader.					
MOI.6.	The leadership uses the information to make decisions, strategically plan, and identify and prioritize quality improvement projects.					
	MOI.6.1 Planning is based on analysis of patient demographics and services required data.					
MOI.7.	The leadership and all staff receive education on data management appropriate to his/her roles and responsibilities within the hospital.					
SYSTEM MANAGEMENT						
MOI.8.	The hospital maintains a master patient index, updated at least quarterly and/or upon entry of each new patient to the facility.					
MOI.9.	The hospital has a policy on how confidentiality of data and information will be maintained and includes:					



**Management
of
Information
(MOI)**

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MOI.9.1 Who will have access to all different types and categories of information, and describes the penalties for the staff who violate the security and confidentiality of data and information.					
	MOI.9.2 The Policy includes levels of access to patient information on a need to know basis.					
MOI.10.	The hospital contributes to external databases in accordance with Saudi laws or regulations.					
MOI.11.	There is Internet access for staff to obtain information which supports safe patient care.					
MOI.12.	There is a process to obtain the necessary information for the administration and clinical staff and includes:					
	MOI.12.1 The 24-hour inpatient census.					
	MOI.12.2 The dietary requests for patients.					
	MOI.12.3 The laboratory values including 'panic' reports.					
	MOI.12.4 X-ray reports.					
MOI.13.	When there is automation of data, there is a planned, documented recovery system in case of computer malfunction to include system linked and stand alone computers.					

2. Medical Records (MR)

Scoring:



Medical Records (MR)

Standard	FM (3)	PM (2)	MM (1)	NM (0)	NA
MR.1. A record is initiated for every patient assessed and/or provided care or services by the hospital.					
MR.2. The patient record initiated is easily identified by a unique patient identifier either by using pre-printed labels or by using an addressograph machine.					
MR.3. All medical records must contain the following information at a minimum:					
MR.3.1 The patient's name, address, date of birth, and next of kin. The name must include: family name, first name, middle name.					
MR.3.2 The medical history of the patient.					
MR.3.2.1 Details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status.					
MR.3.2.2 Relevant past, social, and family histories appropriate to the age of the patient.					
MR.3.2.3 A clinical review by body systems.					
MR.3.3 As appropriate to the age of the patient, a summary of the patient's psycho/social needs.					
MR.3.4 Reports of relevant physical examinations.					
MR.3.5 Diagnostic and therapeutic orders.					
MR.3.6 Evidence of informed consent.					
MR.3.7 Clinical observations, including the result of therapy.					
MR.3.8 Reports of procedures, tests, and their results.					
MR.3.9 Physician includes his/her assessment, diagnosis, impression, and plan of care					



Medical Records (MR)

Standard	FM (3)	PM (2)	MM (1)	NM (0)	NA
revisions when indicated and therapeutic intervention.					
MR.3.10 Conclusions at termination of hospitalization or evaluation/treatment.					
MR.4. Only authorized staff members are allowed to make entries in records and:					
MR.4.1 There is a unique identifier (name and/ or number) for each staff member that he/she uses when making entries in the records.					
MR.4.2 The staff dates and times each entry into the medical record.					
MR.4.3 The staff signs every entry.					
MR.5. The hospital uses standardized diagnosis codes (such as International Classification of Diseases 9 th & 10 th , Current Procedure Terminology or Diagnostic Related Groups), procedure codes, and definitions so that data can be aggregated and transformed into information by:					
MR.5.1 Using standardized diagnosis codes.					
MR.5.2 Using standardized procedure codes.					
MR.5.3 Using standardized symbols and definitions.					
MR.6. The hospital has a policy on the storage and retention of records, data and information and:					
MR.6.1 The policy is consistent with the Ministry of Health rules and regulations.					
MR.6.2 The policy defines the length of time required to retain the records including x-rays (minimum 5 years).					
MR.6.3 The policy addresses how confidentiality, integrity, and security of the records will be maintained.					
MR.7. There is a policy that outlines how records are protected from loss, theft and/or deliberate alterations, or tampering with any medical records that includes but is not limited to:					
MR.7.1 Describing how records will be protected from loss, theft and/or					



Medical Records (MR)

Standard	FM (3)	PM (2)	MM (1)	NM (0)	NA
	deliberate alterations or destruction.				
	MR.7.2 Describing the disciplinary action to be taken if staff make any deliberate alterations (tampering), take a record without authorization, and/or destroy any part of the record.				
MR.8.	There is a medical records tracking system which can identify the location of any record not in the medical records department.				
MR.9.	Each hospitalization episode, both in-patient and out-patient records, are separated into different sections in the patients' chart for doctors orders, nursing notes, progress notes for physicians, etc.				
MR.10.	The hospital has a policy for the Medical Records Department, which includes the content and the forms that go in the record.				
	MR.10.1 A complete Medical Record is the one that contains the following:				
	MR.10.1.1 Identity information of patients and next of kin.				
	MR.10.1.2 History and physical examination.				
	MR.10.1.3 Typewritten operative report.				
	MR.10.1.4 Typewritten Histopathology report.				
	MR.10.1.5 Typewritten Radiology report.				
	MR.10.1.6 Typewritten Discharge summary.				
	MR.10.1.7 Progress notes of Physicians.				
	MR.10.1.8 Progress notes of Nurses.				
	MR.10.1.9 All physician orders signed.				
MR.11.	The following issues are included in the hospital policy for the completions of medical records:				
	MR.11.1 Chart completion is a requirement within 30 days of patient discharge and before any elective vacation or period of absence of staff entering				



Medical Records (MR)

Standard	FM (3)	PM (2)	MM (1)	NM (0)	NA
	the note in the medical record and must contain:				
	MR.11.1.1 All relevant diagnoses established by the time of discharge, as well as all operative procedures performed.				
	MR.11.1.2 A discharge summary concisely restating the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, and the condition of the patient on discharge.				
	MR.11.2 The attending physician is responsible for the completion of his own record.				
	MR.11.3 Physicians, who do not complete their records in a timely manner, receive disciplinary actions as outlined in the Hospital's Delinquent file policy.				
MR.12.	The head of Medical Records works closely with the Medical Records Review Committee to check the quality of the following documentation:				
	MR.12.1 History and physical.				
	MR.12.2 Admission assessments.				
	MR.12.3 Operative notes.				
	MR.12.4 Histopathology report.				
	MR.12.5 Lab results.				
	MR.12.6 Typed x-ray reports.				
	MR.12.7 Discharge summaries.				
	MR.12.8 Documentation of patient education activity.				
	MR.12.9 Progress notes.				
	MR.12.10 Plan of care.				
MR.13.	There is a written policy on verbal and telephone orders and includes:				
	MR.13.1 Not considering a record complete				

Standard	FM (3)	PM (2)	MM (1)	NM (0)	NA
	for release of the medical record.				
MR.21.	Essential information about the patient is legible and located in the face sheet along with the information such as allergies and code status.				
MR.22.	All entries in the Medical Records are clear and legible.				
	MR.22.1 There are specific guidelines for correcting an error in the medical record that does not include the use of correction fluid to erase any entry.				
MR.23.	All laboratory results are seen and signed by a physician before being filed in the patients' record while the patient is on the Ward.				
MR.24.	The hospital prepares a list of prohibited abbreviations not to be used (JCHAO Patient Safety Goals) and it is recommended and approved by related committee such as the Pharmaceutical & Therapeutic Committee and Medical Records Review Committee.				
MR.25.	The hospital prepares a list of approved abbreviations as suggested by Ministry of Health to be used in the institution (MOH) and it is recommended by the Medical Records Review Committee.				
MR.26.	The Medical Records Director participates in the Quality Management program.				



Medical Records (MR)