HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Medical Records		
Document:	Administrative Policy and Procedure		
Title:	Completion of Medical Records Policy		
Applies To:	All Medical Records Staff and Healthcare Professionals		
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1. PURPOSE:

1.1 To outline the process of medical records completion within Thirty (30) days of patient discharge.

2. DEFINITIONS:

2.1 A complete medical record is one in which all deficiencies has been completed.

3. POLICY:

3.1 It is the policy of Maternity and Children Hospital to ensure that all the medical records are completed by the responsible staff within thirty (30) days of patient discharge and before any elective vacation or period of absence of staff entering the notes in the medical record.
3.2 The records are partly paper-based and partly electronic
3.3 Ensures that the Medical Record Forms must be available in each unit/Department.
3.4 In the event that the system shut down, manual forms will be used in the patient medical record, and the form must be filled out completely and accurately by the physicians, nurses and staff authorized to enter in medical records in the specific forms
3.5 The discharge summary has to be completed by all departments involved in the in-patient care; it concisely restates the reason for the admission, the significant findings, and the procedure performed and treatment rendered, all relevant diagnosis established by the time of discharge and the condition of the patient on discharge and the discharge instructions.
3.6 The correct ICD-10 has to be assigned to the final diagnosis and recorded in the Disease Index; and then the medical record is properly secured and filed.

4. PROCEDURE:

4.1 **The following list outlines the steps for prompt completion of the medical records:**

4.1.1 The department Head Nurse/ Shift In charge reviews all the file deficiencies while it is in the ward and informs the MRP about it within one(1) working day, if he/she does not complete the file, then the head of the department will be informed.
4.1.2 The ward Head Nurse will send the file to the medical records within 2 days from the patient discharge.
4.1.3 Use the 'Medical Records Discharge Checklist' to assemble the charts and documents the deficiencies in the checklist for each medical record.
4.1.4 Notify departments, in writing, of the deficiencies that need to be completed within three (3) working days.
4.1.5 A memo of records is written in all charts that contain unsigned documents to verify that staff are no longer employed at this facility, as such cannot complete their portion of the medical record.
4.1.6 The correct ICD-10 code to be recorded in the Disease Index and in the final diagnosis by the physician.
4.1.7 Sign and date the 'Medical Records Discharge Checklist' to verify completeness.

4.1.8 Properly secure and file the medical record.

5. MATERIAL AND EQUIPMENT:

5.1 Discharge checklist

6. RESPONSIBILITIES:

6.1 Medical Records Department Staff
6.2 Physician
6.3 All Healthcare Providers

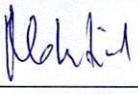
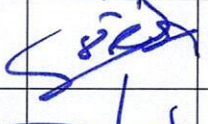
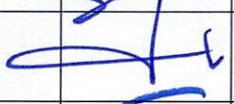
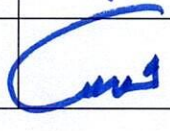
7. APPENDICES:

N/A

8. REFERENCES:

8.1 Ministry of Health Medical Records Policies and Procedures, 2005.
8.2 King Khalid General Hospital, 2016.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Rhodora Natividad	Document Management Control Coordinator		January 05, 2025
Prepared by:	Dr. Shaimaa Bayoumi Emara	Assistant Medical Director for Medical Quality		January 05, 2025
Reviewed by:	Mr. Naif Salman	Medical Records Director		January 06, 2025
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM&PS Director		January 09, 2025
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 12, 2025
Approved by:	Mr. Fahad Hazam Al Shammari	Hospital Director		January 19, 2025