HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER MATERNITY AND CHILDREN HOSPITAL

Department:	Medical Records		
Document:	Administrative Policy and Procedure		
Title:	Medical Record Documentation Policy and Procedures		
Applies To:	All MCH Employee		
Preparation Date:	January 05, 2025	**Index No:**	MR-APP-003
Approval Date:	January 19, 2025	**Version :**	2
Effective Date:	February 19, 2025	**Replacement No.:**	MR-APP-003 (1)
Review Date:	February 19, 2028	**No. of Pages:**	5

1. PURPOSE:

1.1 To foster high quality and continuity of patient care.
1.2 To meet the requirements of the legal and regulatory agencies.
1.3 To supply a database for all other uses of documents.

2. DEFINITIONS:

2.1 **Medical Records Form** – A paper which is a formal arrangement of information usually with blanks for the entry of additional information without risk of misinterpretation.
2.2 **Format** – The arrangement of a form or an organization of form in a permanent folder, which directs the type of entries, the way entries are made, and the future use of those entries.
2.3 **Legible Entries** – Authentic documentation in clear written English.
2.4 **Authorized Members** – Physician, Nurses, Rehabilitation Therapists, Respiratory Therapist, Social workers, Clinical Dietitian, Dietitian, Pharmacists, Own Resources and Admission Clerks.

3. POLICY:

3.1 It is the policy of Maternity and Children Hospital, Hafer Al Batin to identify all staff members authorized to make entries in medical records.
3.2 All entries in the medical records must be legible, readable and follows the standard documentation policy.
3.3 Clinical staff authorized to make entries in the Medical Record receive formal education and training based on MCH policy and Procedure.
3.4 Nurses should document using black ink (Nurses Notes) and blue or black for physicians (Physicians order sheet and Progress notes).
3.5 For Mistaken entry, Draw a straight line on the word or sentence, then write **Mistaken Entry** and initials on top of it.
3.6 Procedures for late entries. When making a late entry; document as soon as possible. The maximum time allowed is limited to 24 hours only; the longer the time lapse, the less reliable the entry becomes.
  3.6.1 Add the entry to the first available space.
  3.6.2 Label the entry "Late Entry".
  3.6.3 Record the date and time it should have been made.
  3.6.4 Record the date and time of entry.
  3.6.5 If you anticipate having to make late entry, don't ask other nurses to leave some blank space for you.
3.7 The attending physician is responsible for the completion of his own records.
3.8 It is the policy of Maternity and Children Hospital, Hafer Al Batin to initiate a medical record for each patient on his first contact with the hospital, whether it is for an admission(from Emergency Department or Outpatient Clinic) , emergency department visit or outpatient clinic appointment.
3.9 Use proper spelling and grammar:
  3.9.1 Write clear and concise sentences.

3.9.2 Avoid useless and unnecessary words.
3.9.3 Clearly identify the subject of the sentence.
3.9.4 Consult the dictionary if in doubt.

3.10 Use military time and Gregorian date during each entry.

3.11 Use authorized/ standard abbreviations only.

3.12 The medical records are partly paper-based and partly electronic (CARE WARE System)

3.13 Ensures that the Medical Record Forms must be available in each unit/Department.

3.14 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.

3.15 For The Paper Forms:

3.15.1 Forms that needs witnesses among healthcare worker e.g. (doctors, nurses, technicians). Forms included but not limited to blood transfusion, cross matching, consents, any invasive procedure time out.)

3.15.2 Diagnostic procedure : ECGs, CTG results

4. PROCEDURE:

4.1 The hospital initiates a medical record for each patient.

4.1.1 On his first contact with the hospital, whether it is for an admission in emergency department or outpatient clinic visit.

4.1.2 Each medical record has a unique medical record #.

4.1.3 There must be 2 patient identifier (4 names for Saudi, complete name for non-Saudi and medical record number) in all the pages of the patient file.

4.2 Staff members authorized to make entries in medical records:

4.2.1 The following disciplines are authorized to make entries into the patient's Medical Record

4.2.1.1 Physician
4.2.1.2 Nurses
4.2.1.3 Rehabilitation Therapist
4.2.1.4 Respiratory Therapist
4.2.1.5 Dietician
4.2.1.6 Clinical Dietician
4.2.1.7 Pharmacist
4.2.1.8 Admission clerk
4.2.1.9 Own resources
4.2.1.10 Social Worker

4.3 Documentation Guidelines

4.3.1 All documentation must be written in English.

4.3.2 Correction Guidelines:

4.3.2.1 Correction of errors shall not be carried out haphazardly and tardily.
4.3.3.2 The corrected version of the error shall be entered next to it.

4.3.3 Physician should check that patient medical record number, data and essential information like allergies are located in the admission form of the folder.

4.3.4 Physician should admit patient to the ward with a complete admission form signed with stamped and dated.

4.3.5 The final laboratory or other essentials reports must be included in the discharge report.

4.3.6 Orders for ancillary and diagnostic services must include diagnosis and, as necessary, other appropriate information about the patient's diagnosis, history of allergy, or the signs(s) or symptoms (s) providing justification for the service/treatment. An order for medication must comply with the Medical Staff's approved policies and procedures.

4.3.7 A discharge report shall be typed for all patients hospitalized or underwent surgery.

4.3.8 All original documents, or appropriate copies received from patients/ other sources should be retained in the patient's medical file.

4.3.9 As appropriate consent for treatment or procedure and authorization for information should be obtained with witness.

4.3.10 Final diagnosis shall be recorded in full, without the use of symbols or abbreviations. It must be dated and signed by the responsible physician or his/her designee at the time of discharge of patient.

4.3.11 Nurses should:

- 4.3.11.1 In carrying Physician's order:
  - 4.3.11.1.1 Check each order and write your name, date and time on the right hand side parallel to the physician's name and signature who wrote the order.
  - 4.3.11.1.2 If in doubt, ask the doctor who wrote the orders for clarification.
- 4.3.11.2 Avoid taking telephone/ verbal orders whenever possible. But if you must take one, repeat the order and patient's name.
  - 4.3.11.1.1 Verbal orders should be reconfirmed before carrying out such as during code **Blue**.
  - 4.3.11.2.2 Step for Telephone Order : WRITE DOWN, READ BACK
- 4.3.11.3 Document complete information about medication.
  - 4.3.11.3.1 Write your initials beside the medication administered according to the standard time or the time it has been administered.
  - 4.3.11.3.2 Write your complete name, job number and initials at the bottom of Page 1 of medication sheet.
  - 4.3.11.3.3 Document sites of all parenteral injections.
  - 4.3.11.4.4 When you omit a medication, document why.
  - 4.3.11.5.5 If the doctor orders a medication/ dose you feel is inappropriate, contact the doctor clarify and discuss.
- 4.3.11.4 Chart Promptly: Chart as soon as an observation, nursing care, treatment or procedure is done.
- 4.3.11.5 Never chart nursing care or observation ahead of time.
- 4.3.11.6 Clearly identify care given by another member of the health care team.
- 4.3.11.7 Don't leave any blank spaces on chart forms.
  - 4.3.11.7.1 Write entries in the appropriate spaces.
  - 4.3.11.7.2 In case a space is left out for physician order's sheet draw a line using a BLACK ink pen across the space and write the word "space".
- 4.3.11.8 Correctly identify late entries.
  - 4.3.11.8.1 If chart is not available when it's needed, when a patient is taken for diagnostic procedure.
  - 4.3.11.8.2 If you forgot to add important information after notes have been completed.
  - 4.3.11.8.3 If you forgot to write on a particular chart.
- 4.3.11.9 Correct mistake entries properly
  - 4.3.11.9.1 Never try to cover up an error by using correction fluid or scratching it.
- 4.3.11.10 Don't sound tentative: Be exact and specific. Avoid words such as appears, apparent, these words conclude that you did not know what you were doing.
- 4.3.11.11 Write your full name legibly or use your stamp with the salary number.
  - 4.3.11.11.1 When writing your notes on the last line of the page
  - 4.3.11.11.2 When closing your notes at the end of your shift.
  - 4.3.11.11.3 When carrying out doctors order.
  - 4.3.11.11.4 Preoperative checklist sheet.
  - 4.3.11.11.5 Follow DAR documentation in sequence in a narrative form.

4.4 Training on documentation in MR:

4.4.1 All staffs authorized to make entries in MR must receive formal training on how to document in MR.

4.4.2 These training are to be done during the departmental orientation program.
4.4.3 These training are to be done by the most relevant staff.
4.4.4 A document of receiving these training must be involved in the staff personnel file.

4.6 Deal with delinquent medical records:

4.6.1 Medical Record Department

4.6.1.2 The Medical Records Staff must notify the departments, in writing, of the deficiencies that need to be completed within three (3) working days.

4.6.1.3 Place in the Medical staff Office copies of all suspension letters mailed.

4.6.2 Head of Medical Records Submits to the Medical Director names of all physician on suspension for a total of thirty (30) cumulative days in the fiscal year, and the committee then submit his/her name to the Maternity and Children Hospital, Hafer Al Batin Medical committee.

4.7 Medical Record forms should be uniform, A4 size with some exception such as cases where the contents of the form contain only half sheet of A4 size paper.

4.8 **Completion of Incomplete Medical Records:**

4.8.1 Medical Records will be completed by the attendee physicians within thirty days of patients' discharge, being transferred or death.

4.8.2 Charts not completed within this time-frame will result in being reported "incomplete" to the Director of Medical Services.

4.9 Filing: No medical record will be filed until it is complete and properly signed. In the event that the record remain incomplete by reason of death, resignation or other inability or unavailability of the responsible practitioner to complete the medical record.

4.10 Patient's Confidentiality:

4.10.1 All information related to the patient's condition will be maintained in a confidential manner by all the staff, directly involved in the treatment of the patient. This includes all written information such as case records (Physician as well as Nurse's note), laboratory results, x-rays and operation records.

4.10.2 Patient's information cannot be shared under any circumstances unless specified under the law of the Kingdom of Saudi Arabia. In cases of Road Traffic Accident (RTA), crime and death when requested, relevant information can be released with consent from the hospital Director. A duplicate copy of patient's medical record shall be provided to concerned government agencies and the original file is kept in MRD for safety.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurses
6.3 Rehabilitation Therapist
6.4 Respiratory Therapist
6.5 Dietician
6.6 Clinical Dietician
6.7 Pharmacist
6.8 Admission clerk
6.9 Own resources
6.10 Social Worker

7. APPENDICES:

N/A

8. REFERENCES:

8.1 Medical Division Rules and Regulations: KSMC 2006.
8.2 New Webster Dictionary: ISBN 971-30-0258-XO-933895-28-3.
8.3 Blakiston's Pocket Medical Dictionary , Fourth Edition: ISBN 0-07-005715-X.
8.4 MRD-DPP, 2007-King Saud Medical Complex.
8.5 Ministry of Health, General Nursing Administration Functions and duties, Policies and Procedures, Nursing Standards Organizing Committee for Hospital Services- 2006.
8.6 CBAHI national's standards 3rd Edition, 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, 2022
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 06, 2025
Reviewed by:	Mr. Abdulellah Ayed Al Mutairi	QM&PS Director		January 08, 2025
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 12, 2025
Approved by:	Mr. Fahad Hazam Al Shammari	Hospital Director		January 19, 2025