



Department:	Medical Records		
Document:	Administrative Policy and Procedure		
Title:	Identification of Authorized Staff In Medical Records		
Applies To:	All MCH Employee		
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1. PURPOSE:

- 1.1 To define the mechanism that maintains security of patient information by determining the authorized staff who obtains the patient clinical record and make entries into it.

2. DEFINITIONS:

- 2.1 **Authorized Staff** – Health care providers: physicians, nurses, social workers, clinical dieticians, patient educators, physiotherapists, respiratory therapists, OR technicians, laboratory, radiologist, patient and family rights team, medical record coders and the insurance.
- 2.2 **LOCUM CLINICAL STAFF** A medical professional who substitutes for a practice's regular doctor for a period of time

3. POLICY:

- 3.1 It is the policy of Maternity and Children Hospital to maintain the security of the patient's medical records and only allows the authorized healthcare providers to access these records and make entries.
- 3.2 All clinical entries in the patient's medical records shall be accurately dated and authenticated by the above mentioned authorized personnel. Authentication means authorship of written signature, date, time, identifiable stamp
- 3.3 Request for Electronic Components of Medical Record - Personnel who access to the electronic Medical Record are required to have UNIQUE USER ID and PASSWORD, and access to information is limited according job description and the minimum necessary rule and managed by role, as approved by the designated management personnel.

4. PROCEDURE:

- 4.1 All healthcare professionals are informed during their departmental orientation to have their personal User account on CARE WARE System & personal stamps containing the name and the title/ specialty. These stamps are used, in addition to the signature, whenever they make any entry in the patient's clinical records.
- 4.2 Only authorized staff to make entries in the medical records should have unique identifier for each staff that he/she uses when making entries in the records.
- 4.3 All the entries in the patient's medical records are dated, timed with the stamp and signature of the healthcare providers that makes the entry.
- 4.4 The medical records staff checks the completeness of the entire patient's medical record after collection from a patient care area and the completeness of the entries requires the presence of the health care providers stamp/ name, date and time and signature.
- 4.5 The new entries are verified by the medical records staff who makes the entry (by name and specialty), and when (by date (Gregorian) and time (military) in addition to the health care provider signature.
- 4.6 All entries in the medical records must be legible.

4.7 The medical records are randomly reviewed (opened and closed) and discussed in the Hospital Medical Records Committee to improve the quality of the records.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Medical Records Staff
6.1 Healthcare Professionals

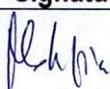
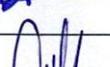
7. APPENDICES:

N/A

8. REFERENCES:

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

9. APPROVALS:

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