HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Medical Records		
Document:	Administrative Policy and Procedure		
Title:	Medical Records Contents		
Applies To:	All MCH Employee		
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1. PURPOSE:

1.1 To standardized the contents of the medical file.
1.2 To maintain records of delinquent medical records of in-patient discharges in compliance with the Hospital Standards.

2. DEFINITIONS:

2.1 **Medical Records Forms** – a paper which is a formal arrangement of information that are usually blank and is intended to be filled out by the healthcare provider authorized to make an entry in the patient medical records.

3. POLICY:

3.1 This policy will serve as a guideline to determine the specific contents of the patient medical file.
3.2 It is the policy of the Maternity and Children Hospital, Hafer Al Batin Medical Record Department top ensure that all medical file are completed in a timely manner and according to the established criteria and contain complete documentation related to the treatment and progress of patient health status.
3.3 The records are partly paper-based and partly electronic
3.4 Ensures that the Medical Record Forms must be available in each unit/Department.
3.5 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

4. PROCEDURE:

4.1 The patient medical file minimally contains the following forms (In – Patient) but is not limited to:
4.1.1 PHYSICIAN
4.1.1.1 Physician Order Form
4.1.1.2 Physician Multidisciplinary Progress Notes Form
4.1.1.3 Physician Assessment Form (Newborn, Paediatric, OBS – GYNE)
4.1.1.4 Consultant Consultation Request Form
4.1.1.5 Pre – Admission Checklist
4.1.1.6 Physician ER Assessment Form
4.1.1.7 Pain Assessment Form
4.1.1.8 Hand Over Form (ICU only)
4.1.1.9 Maturational Assessment of Gestational Age Form (for departments who handles Neonates only)
4.1.1.10 VTE Form (For OBS – GYNE)
4.1.1.11 Physicians Re-assessment Form (Admission)
4.1.1.12 Delivery Form (If applicable)
4.1.1.13 Discharge Summary

4.1.2 ALLIED HEALTHCARE
- 4.1.2.1 Dietary Forms
- 4.1.2.2 Respiratory Therapist Forms (If applicable)
- 4.1.2.3 Physiotherapy Forms (If applicable)
- 4.1.2.4 Social Worker Forms

4.1.3 MULTIDISCIPLINARY
- 4.1.3.1 Multidisciplinary Plan of Care
- 4.1.3.2 Medication Administration Record
- 4.1.3.3 Interdisciplinary Patient Family Education Record Form
- 4.1.3.4 Procedural Time Out (If applicable)
- 4.1.3.5 Blood Transfusion bundle
- 4.1.3.6 Surgical and Medical Procedure Consent
- 4.1.3.7 DAMA

4.1.4 NURSING
- 4.1.4.1 Nurses Notes
- 4.1.4.2 Assessment and Re-assessment Form
- 4.1.4.3 Fall Risk Assessment Form
- 4.1.4.4 Braden Scale Form
- 4.1.4.5 Vital Signs (Graphing Sheet)
- 4.1.4.6 Daily Intake and Output Form
- 4.1.4.7 Flow Sheet (for Intensive care unit)
- 4.1.4.8 Handover Form
- 4.1.4.9 Convulsion Monitoring Sheet (if applicable)
- 4.1.4.10 Diabetic Monitoring Sheet (if applicable)
- 4.1.4.11 Magnesium Sulphate Monitoring Sheet (if applicable)
- 4.1.4.12 Fetal Kick Chart Sheet (for L&D)
- 4.1.4.13 Breast Feeding Notes (OBS – GYNE, L&D)
- 4.1.4.14 Pain Assessment

4.1.5 INVESTIGATIONS REPORT (If applicable)
- 4.1.5.1 MRI Report
- 4.1.5.2 CT – Scan Report
- 4.1.5.3 ULTRASOUND Report
- 4.1.5.4 X – RAY Report

4.1.6 CORRESPONDENCE
- 4.1.6.1 Admission Request Form
- 4.1.6.2 2A form
- 4.1.6.3 Bed Making Form
- 4.1.6.4 All ER Forms (except the assessment form which can still be used (ie. Pain assessment and fall risk)
- 4.1.6.5 Fax Request
- 4.1.6.6 Discharge Plan Checklist (if available in the department)
- 4.1.6.7 CPR Form
- 4.1.6.8 Medical Report
- 4.1.6.9 General Consent Admission
- 4.1.6.10 Narcotic Drug Prescriptions
- 4.1.6.11 IV Access
- 4.1.6.12 Patient Attendant Form
- 4.1.6.13 Out on Pass
- 4.1.6.14 OPD Form

4.1.7 OPERATION
- 4.1.7.1 Operation Notes
- 4.1.7.2 Anaesthesiologist Notes
- 4.1.7.3 Pre – Operative Checklist
- 4.1.7.4 Surgical Safety Checklist

4.1.7.5 Surgical Count
4.1.7.6 Histopathology Request Form
4.1.7.7 Other Forms or Notes needed in the Surgery

4.2 The following forms will be filled as follows:

4.2.1 Admission Request Form – to ensure accurate and complete identification, the MRP should record category of admission date and time, estimated length of stay, provisional diagnosis and problems, planned procedures and etc.

4.2.2 Consents – general consent must be signed by the patient or next of kin after the attending physicians explains the elements of consent and must be witnessed by the assigned nurse.

4.2.3 Patient rights and responsibilities – Maternity and Children Hospital, Hafer Al Batin provides optimum care from all healthcare providers and must explain the rights and responsibilities of the patients (see attached form) for detailed patients' rights and responsibilities.

4.2.4 Patient History and Physical Examination Form (Assessment) – the history should be obtained from the patient or next of kin to be able to relate the facts and will serve as a baseline information that is very significant in decision making for the course of treatment that will be given during the patient hospital stay.

4.2.5 Physicians Progress Notes – clinical observations including course of therapy, patient daily progress, assessment and re – assessment must be entered, with correct date and time, complete name with signature.

4.2.6 Physicians Order – all physicians that are authorized to enter data in the patient medical file must write legibly (written statement of the plan of care, treatments and interventions) must be dated, timed and with complete name (stamp) and signature.

4.2.7 Laboratory and Imaging Request – the physician requesting the investigation or imaging should specify the diagnosis, suspected problems, type of test required in prescribed form. The form should contain correct patient identification, data such as 4 names for Saudi, complete name for non – Saudi and medical record number and etc., must be signed and stamped by the ordering physician, must also secure departmental stamp.

4.2.8 Physician and Nurses Assessment and Re – assessment Form – must be filled out directly by the attending Physician and Assigned Nurse (see assessment and re-assessment policy for correct timing).

4.2.9 Nurses Notes – must give chronological details of nursing care/ intervention given to the patient. Must affix stamp and signature (see policy and procedure).

4.2.10 Handover Form – must be filled out by the assigned nurse/physician and must be use during endorsement (shift to shift) and during patient transfer from higher acuity to lower acuity and vice versa.

4.2.11 Medication Administration Record – provides accurate documentation of medicines that were given orally, topically, by injection, inhalation and infusion including the name of the drug, dosage, frequency, route, date, time and initials of the nurse who administer the medication.

4.2.12 Vital Signs Sheet – the nurse must take the vital signs of the patient and should note the temperature, pulse, blood pressure, circulation of the patient (see policy and procedure for the correct color coding and frequency of checking).

4.2.13 Social Worker Notes – social worker services done to the patient should be documented in patient medical file such as assessment, recommendations, follow-up, discharge planning and etc.

4.2.14 Patient and Family Education – ensure that the patient and next of kin are provided with quality education that increases their knowledge and skill regarding the disease process and how to properly take care of themselves and their patient.

4.2.15 Discharge Summary – should be concise and must contain essential information such as: date of admission and discharge, reason for admission, diagnosis at admission, other diagnosis at discharge, brief history, physical examination, results of investigation, course of treatment, list of medications, recommendations and instructions and recommendation after discharge, appointments and condition and type of discharge and etc.

4.2.16 Consultation Form – each consultation sheet contains a written request that the patient will be seen by other speciality, indicating the reason and the needed data.

4.2.17 Pre – operative Checklist – perioperative care is used to describe the nursing functions in the total surgical experience of the patient. It contains patient preparation and pre-operative data.

4.2.18 Anesthesia Record and Recovery Room Record – there must be a report of the Pre – anesthesia evaluation performed within 24 hours prior to surgery, records of an intra-operative anesthesia record and report of post anesthesia evaluation follow – up that are entered and authenticated within 24 hours after surgery.

4.2.19 Intake and Output Sheet – is a record that shows the accumulation of the hourly total of intake (IV, NGT, ORAL and etc.,) and Output (Urine, Stool, Vomitus and etc.,). The nature and amount of fluid administer at different intervals should be entered. The night duty nurse makes sure that she tallied the total intake and output (24 hours) and must inform the attending physicians if there is any unusualities.

4.2.20 Discharge Against Medical Advise Form – should follow the Maternity and Children Hospital, Hafer Al Batin policy and procedure regarding DAMA and should ensure that the attending physician explains and pros and cons of the decision and must affix the patient or next of kin signature in the form.

5. MATERIALS AND EQUIPMENT:

5.1 FORMS:

5.1.1 Physician Order Form
5.1.2 Physician Multidisciplinary Progress Notes Form
5.1.3 Physician Assessment Form (Newborn, Pediatric, OBS – GYNE)
5.1.4 Consultant Consultation Request Form
5.1.5 Pre-Admission Checklist
5.1.6 Pain Assessment Form
5.1.7 Hand Over Form (ICU only)
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5.1.12 Physician ER Assessment Form
5.1.13 Discharge Summary
5.1.14 Dietary Forms
5.1.15 Respiratory Therapist Forms (If applicable)
5.1.16 Physiotherapy Forms (If applicable)
5.1.17 Social Worker Forms
5.1.18 Multidisciplinary Plan of Care
5.1.19 Medication Administration Record
5.1.20 Interdisciplinary Patient Family Education Record Form
5.1.21 Procedural Time Out (If applicable)
5.1.22 Blood Transfusion bundle
5.1.23 Surgical and Medical Procedure Consent
5.1.24 DAMA
5.1.25 Nurses Notes
5.1.26 Assessment and Re-assessment Form
5.1.27 Fall Risk Assessment Form
5.1.28 Braden Scale Form
5.1.29 Vital Signs (Graphing Sheet)
5.1.30 Daily Intake and Output Form
5.1.31 Flow Sheet (for Intensive care unit)
5.1.32 Handover Form
5.1.33 Convulsion Monitoring Sheet (if applicable)
5.1.34 Diabetic Monitoring Sheet (if applicable)

5.1.35 Magnesium Sulphate Monitoring Sheet (if applicable)
5.1.36 Fetal Kick Chart Sheet (for L&D)
5.1.37 Breast Feeding Notes (OBS-GYNE, L&D)
5.1.38 Pain Assessment
5.1.39 MRI
5.1.40 CT-SCAN
5.1.41 ULTRASOUND
5.1.42 X-RAY
5.1.43 Admission Request Form
5.1.44 2A form
5.1.45 Bed Making Form
5.1.46 All ER Forms (except the assessment form which can still be used (ie. Pain assessment and fall risk)
5.1.47 Fax Request
5.1.48 Discharge Plan Checklist (if available in the department)
5.1.49 CPR Form
5.1.50 Medical Report
5.1.51 General Consent Admission
5.1.52 Narcotic Drug Prescriptions
5.1.53 IV Access
5.1.54 Patient Attendant Form
5.1.55 Out on Pass
5.1.56 OPD Form
5.1.57 Operation Notes
5.1.58 Anesthesiologist Notes
5.1.59 Pre-Operative Checklist
5.1.60 Surgical Safety Checklist
5.1.61 Surgical Count
5.1.62 Histopathology Request Form
5.1.63 Other Forms or Notes needed in the Surgery

6. RESPONSIBILITIES:

6.1 Medical Records Staff
6.2 Physician
6.3 Nurse
6.4 Social Worker
6.5 Nutritionist
6.6 Clinical Pharmacist
6.7 Respiratory Therapist
6.8 Physical Therapist

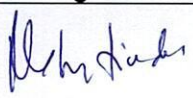
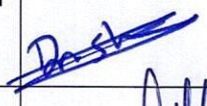
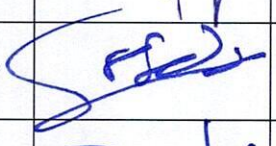
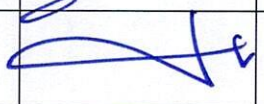
7. APPENDICES:

N/A

8. REFERENCES:

8.1 Ministry of Health Medical Records Policies and Procedures Manual, 2015.
8.2 Maternity and Children Hospital, Al-Jouf, 1438.
8.3 Prince Mutaib Bin Abdulaziz Hospital.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Rhodora Natividad	Document Management Control Coordinator		January 05, 2025
Prepared by:	Dr. Shaimaa Bayoumi Emara	Quality Facilitator in Medical Administration		January 05, 2025
Reviewed by:	Mr. Naif Salman	Medical Records Director		January 07, 2025
Reviewed by:	Mr. Abdulellah Ayed Al Mutairi	QM&PS Director		January 08, 2025
Reviewed by:	Dr. Tamer Naguib	Medical Director		January 12, 2025
Approved by:	Mr. Fahad Hazem Al Shammari	Hospital Director		January 19, 2025