KINGDOM OF SAUDI ARABIA

Ministry Of Health

General directorate of Health Affairs AL-Baha

Mayyara General Medical Complex

المملكة العربية السعودية
وزارة الصحة
المديرية العامة للشئون الصحية بمنطقة الباحة
مجمع ميارا الطبي العام

☐ADMINISTRATE POLICY & PROCEDURE (APP)	☐ INSTITUTIONAL POLICY & PROCEDURE (IPP) ☐ INTERDEPARTMENTAL ☐ INTERNAL	
TITLE		**POLICY NUMBER/V#**
Standard Medical Record Documentation		MMC- IT -03 (1)
INITIATED DATE	**EFFECTIVE DATE**	**REVISED DATE**
02/08/2025	**01/09/2025**	**01/08/2028**
REPLACES NUMBER		**NO. OF PAGES**
N/A		**04**
APPLIES TO	**RESPONSIBILITY**	
All Admin workers	**Nursing , physicians**	

1. PURPOSE

1.1 To provide a source of patient-specific data and other information required for patient care, serve as a financial and legal record, support diagnosis, justify treatment and promote updated consistency of care among healthcare professionals.

2. DEFINITION

2.1 HIS: Health Information System

2.2 HIM: Health Information Management

3. RESPONSIBILITY

3.1 Nursing

3.2 Physicians

4. POLICY

4.1 Only Physicians, Dentists, Clinical Pharmacists, Nurses, Health Educators, Dieticians, Social Workers, Psychologists, Occupational and Rehabilitation Therapists, Respiratory Therapist, Emergency Medical Technicians and Home Health Care Providers are authorized to make entries

in the Medical Record in the determined format and content of the Medical Record and other guidelines listed in the procedure of this policy.

4.2 All entries in the medical record shall be dated, timed, meaningful, completely detailed, authentic, and signed by the author, also, they should contain legible information such as history, examination, diagnosis, treatment or treatment plan, and follow-up care.

4.3 Entries written in error are not deleted or erased. Instead, a line is passed through the error text and dated, timed, and signed by the author.

4.4 Only standardized and approved abbreviations and symbols are used in medical records. (Refer to Use of Abbreviations Acronyms and Symbols Policy)

5. PROCEDURE

5.1 The following are general documentation guidelines to be followed:

5.1.1 Elements of the medical record are organized in a consistent manner. All entries will be continuous. There will be no skipped lines or spaces

5.1.2 Patient's full name with identification number is on each form of the record.

5.1.3 Entries are legible

5.1.4 Standard use of a **BLUE** and **BLACK INK** in all documentations will be utilized. Pencil shall not be used.

5.1.5 Entries made in error will be stroked through with a single line, and the word 'error' will be written next to the line along with the initials of the person making the correction.

5.1.6 Late entries may be made and are placed after the last documentation. It is noted as a late entry with current time and date and reference made to original time and date. Late entries will be made before the end of twenty-four (24) hours after the occurrence.

5.1.7 All entries are dated. No part of the medical record is to be removed after entry.

5.1.8 Personal and biographical data are included in the record

5.1.9 Initial history and physical examinations for new patients are recorded within 24 hours of a patient first seeking care.

5.1.10 Patient's chief complaint or purpose for visit is clearly documented based on his/her own words.

5.1.11 Plan of action/treatment is consistent with diagnosis/diagnoses

5.1.12 Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate.

5.1.13 Health care education provided to patients, family members or designated caregivers are noted in the record and periodically updated as appropriate.

5.1.14 Screening and preventive care practices are documented.

5.1.15 Requests for consultation are consistent with clinical assessment/physical findings.

5.1.16 Laboratory and diagnostic reports reflect healthcare provider review.

5.1.17 Documentation will support the intensity of the patient evaluation and/or treatment and the complexity of medical decision-making.

5.1.18 All pertinent documentation will be maintained in the patient's medical record, and be made available upon request.

5.2 Electronic Documentation Guidelines:

5.2.1 Documentation function will be available to all physicians, nurses or other healthcare providers entering notes in the HIS for a period of 24 hours.

5.2.2 When correcting or making a change to an entry in HIS (especially in progress notes), amendments will be in chronological order, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted.

5.2.3 Every entry should be dated, timed, and author-stamped by the system.

5.3 Content of the Medical Record:

5.3.1 The patient's name, age, gender, weight, height, contact information, date of birth, and name of any legally authorized representative.

5.3.2 The patient's assessment.

5.3.3 Diagnosis and diagnostic impressions drawn from the medical history and physical examination

5.3.4 The goals of treatment and the treatment plan.

5.3.5 Evidence of informed consent and/or procedure consent, if applicable.

5.3.6 Diagnostic and therapeutic orders, if any.

5.3.7 All diagnostic, therapeutic procedures, laboratory, or test results.

5.3.8 Progress notes made by the medical staff and other authorized individuals.

5.3.9 Consultation reports.

5.3.10 Every medication ordered or prescribed including dosage and adverse reaction.

5.3.11 Any referrals and communications made to external or internal care providers.

5.3.12 Co-morbidities.

5.3.13 A patient's leaving against medical advice (if applicable).

6. EQUIPMENT

6.1 NA

7. REFERENCES

7.1 CBAHI National Standards for Ambulatory Care Centers, Effective Jan,2020.

7.2 The Joint Commission International (JCI), 7th Edition, Effective Jan 2021.

8. Forms and Attachments

8.1 NA

9. APPROVAL:

APPROVALS & REVIEWS:			
Prepared By	**Title**	**Date**	**Signature**
Mr.Mohamed Nasreleslam Sayed	**Information Technology**	**02-08-2025**	
Reviewed By			
Dr. Mostafa Mohammed Osman	**Quality Director**	**02-08-2025**	
Approved By			
Dr. Abdulmajeed Abdullah Saleh	**Medical Director**	**02-08-2025**	
Eng. Meshaal Hussein Alghamdi	**Executive Director**	**02-08-2025**	