SE04 - Management of Information

4.1 - Information planning and usage

4.1.1 - The healthcare facility meets the data and information needs of those in and outside the facility.

4.1.1.1 - The healthcare facility has a health information management system that contains the data collected about provision of health services and management of the healthcare facility.

4.1.1.2 - The planning and design is based on the healthcare facility's size and complexity and includes all information needs, both from internal (clinical and managerial) and external sources (i.e. national registries).

4.1.1.3 - The system identifies staff permitted access to each category of data and information.

4.1.1.4 - Data for external reference databases are collected and distributed timely and in a correct format when required by laws or regulations.

4.1.2 - Data are used to provide relevant information for improving managerial and clinical practice.

4.1.2.1 - There are regular scheduled meetings, to identify the most frequently diagnosed diseases and morbidities.

4.1.2.2 - Staff have access to the data and information needed to carry out their job responsibilities.

4.1.2.3 - Data is aggregated, analyzed and used to provide relevant information for improving the managerial and clinical service.

4.1.2.4 - The frequency of data analysis meets the requirements for the healthcare facility and its staff.

4.2 - Patient health records

4.2.1 - The healthcare facility maintains a standardized clinical record for each patient assessed and/or treated and determines the record's content, format and location of entries.

4.2.1.1 - Each patient has a health record which has a unique identifier number.

4.2.1.2 - The specific content of entries (assessment and treatment notes) for health records is determined by the healthcare facility.

4.2.1.3 - Patient records are kept in a standardized format.

4.2.1.4 - There is a system that allows rapid retrieval and smooth distribution of health records so they are readily available on each patient visit.

4.2.2 - Patient records contain the required information to support the diagnosis, justify the treatment, and to document the course and results of treatment.

4.2.2.1 - Patient records contain patients' demographic information.

4.2.2.2 - Patient records contain adequate information about physical findings, assessment and diagnosis.

4.2.2.3 - Patient records contain adequate and up to date information about care and treatment.

4.2.2.4 - Patient records contain adequate information to document the course and results of treatment including errors/adverse events.

4.2.3 - The healthcare facility has a record keeping system that ensures the reliability of information.

4.2.3.1 - The staff member who enters clinical information to a patient health record signs and dates the entry.

4.2.3.2 - The patient entry records are clearly readable.

4.2.3.3 - There is a process to ensure that only authorized individuals make entries in patient clinical records.

4.2.3.4 - Patient records are reviewed regularly and results analyzed as part of the quality improvement process.

4.2.4 - There is a 'medical records' storage system that ensures confidentiality and safety.

4.2.4.1 - Storage space for medical records is of sufficient size and secured against unauthorized entry to ensure confidentiality.

4.2.4.2 - A designated individual is responsible for the storage, maintenance and retrieval of health records.

4.2.4.3 - There is provision that ensures authorized access to patient records during all hours of operation.

4.2.4.4 - Guidelines related to health records storage, retention and destruction are available.