



SE04

MANAGEMENT OF INFORMATION

The healthcare facility maintains a standardized clinical record of each patient containing sufficient information to identify the patient and support the diagnosis and treatment provided, as well as the course and results of treatment, in order to facilitate continuity of care. Aggregated data is analyzed and transformed into useful information for different cadres of staff, e.g. in the areas of clinical performance, utilization of services, stock management and revenue. Medical staff and healthcare facility leaders make informed decisions for continuous improvement of clinical and managerial processes. The facility reports to the appropriate (regional or national) authorities in order to inform decision makers.

The SafeCare standards cover the full range of clinical services and management functions for healthcare facilities in 13 Service Elements. These Service Elements contain a number of standards that relate to specific services or functions. The rationale of each standard is explained by the standard intent and gives you an idea what the standard really entails.

Each standard contains measurable elements, also called criteria. Measurable elements are related to specific processes, assets or documents (e.g. process for triage, resuscitation equipment or a job description for the lab manager). Compliance to each measurable element is assessed, and scores awarded are either Fully Compliant (FC), Partially Compliant (PC), Non-Compliant (NC) or Not Applicable (NA). The combined scores of the underlying measurable elements reflect the level of compliance to the whole standard.

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.

STANDARD INTENT:

Information is generated and used during patient care and for safely and effectively managing the healthcare facility. The ability to capture and provide information requires effective planning. In planning information management strategies, a healthcare facility should take into account a variety of sources:

- *The healthcare practitioners;*
- *The healthcare facility’s managers and leaders; and*

- *Those outside the healthcare facility who need or require data or information about the facility's operational and care processes.*

The most urgent information needs of those sources influence the healthcare facility's information management strategies and its ability to implement those strategies. The strategies are appropriate for the healthcare facility's size, complexity of services, availability of trained staff and other human and technical resources. The plan should be comprehensive and include all the clinical and non-clinical units of the healthcare facility. Access to the information management system is appropriate for those who collect and use the information.

MEASURABLE ELEMENTS:

- 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.

STANDARD INTENT:

It is important that staff have access to the relevant data so as to incorporate the information in the execution of their job. Periodic sharing of findings and reviewing significant adverse incidents, institutional mortalities and morbidities are vital to understand the cause and prevent recurrence. To reach conclusions and make decisions, data must be aggregated, analyzed and transformed into useful information. Thus, data analysis provides continuous feedback of quality management information to help decision makers and continuously improve clinical and managerial processes.

The healthcare facility determines how often data are aggregated and analyzed. The frequency depends on the activity or area being measured, the frequency of measurement, and the healthcare facility's priorities.

The healthcare facility plans regular meetings in which the specific information is discussed. The frequency of the meetings is dependent on the size of the healthcare facility, the utilization and the number of staff. It is essential that these meetings are organized regularly (preferably monthly) and that the minutes of the outcomes of the meetings are documented.

MEASURABLE ELEMENTS:

- 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.**

STANDARD INTENT:

Every patient assessed and/or treated in the healthcare facility as an out-patient, emergency care patient or in-patient has a clinical record, whether it is an inpatient file or an outpatient carry card held by the patient. The record is assigned an identifier unique to the patient, or some other mechanism is used to link the patient with his or her clinical record. A single record and a single identifier enable the healthcare facility to easily locate patient clinical records and to document the care of patients over time. The content, format, and location of entries for a patient's clinical record is standardized to help promote the integration and continuity of care among the various practitioners of care to the patient.

MEASURABLE ELEMENTS:

- 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.**

STANDARD INTENT:

The patient record needs to present sufficient information to identify the patient, support the diagnosis, to justify the treatment provided, to document the course and results of the treatment, and to facilitate the continuity of care among healthcare practitioners.

MEASURABLE ELEMENTS:

- 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.**

STANDARD INTENT:

It is important that the records of each individual patient are kept appropriately. Requirements for proper and reliable record keeping are:

- *Each entry in a patient file is signed and dated;*
- *The entries are clearly readable;*
- *The entries can only be processed by authorized staff;*
- *The entries are regularly monitored in order to create consistency.*

Staff who are authorized to process patient information in the specific patient records have to be instructed on how to comply with the requirements defined and a system should be in place that the patient records are regularly reviewed in order to investigate if the entries remain of a good quality.

MEASURABLE ELEMENTS:

- 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.

STANDARD INTENT:

Medical record storage is sufficient and secure against unauthorized entry and ensures confidentiality. Health record management must be implemented by a suitable person, who controls the safe storage and retrieval of files. Files must be readily available each time the patient visits a healthcare professional. The healthcare facility develops and implements a policy that guides the retention of patient records and other data and information for sufficient periods to comply with law and regulation (e.g. on confidentiality) and support patient care, the management of the organization, legal documentation, research and education. When the retention period is complete, patient records and other data and information are destroyed appropriately.

The retention of patient records is dependent on the national requirements. If national requirements are not defined the retention times for patient files have to be defined in the healthcare facility manual.

MEASURABLE ELEMENTS:

- 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.