Mandatory Records List

Document control | REC-FRM-001 | New

Field	Content
Title	Mandatory Records List
Document ID	{{facility.code}}-REC-FRM-001
Version and status	1.0 | Approved by the ASF Expert Committee
Prepared by	{{roles.quality_lead.name}}, Quality lead
Reviewed by	{{roles.clinical_director.name}}, Clinical director date: _____
Approver and signature	{{roles.clinical_director.name}}, clinical director Signature: _____ Date: _____
Effective date	{{document.effective_date}}
Next review	{{document.review_date}} (12 months after effective date)
Supersedes	None (new document)
Standards and criteria supported	Standard 1, criterion 2A.6
Evidence basis	E-007, E-009
Status of this document	Recommended best-practice model. A hospital may adopt, adapt or replace it with an equivalent that meets the same criteria.

1. Purpose

The list of entries every patient record must contain, used by the audit.

2. How to use

Complete one form per patient, per area or per period, as the purpose states. Tick Yes, No or N/A. Any No is actioned at once and reported to the person named in the procedure.

3. Items

#	Item to check	Standard [evidence]	Yes	No	N/A	Action if No
1	Patient identity (two identifiers)	Present [E-007]	[ ]	[ ]	[ ]	Action and who to tell
2	Allergies and alerts	Present [EC]	[ ]	[ ]	[ ]	Action and who to tell
3	Diagnosis and care plan	Present [EC]	[ ]	[ ]	[ ]	Action and who to tell
4	Consent (where required)	Present [EC]	[ ]	[ ]	[ ]	Action and who to tell
5	Medicines given, with time and person	Present [EC]	[ ]	[ ]	[ ]	Action and who to tell
6	Discharge or transfer summary	Present [EC]	[ ]	[ ]	[ ]	Action and who to tell

Completed by (name and role): _____ Date/time: _____ Signature: _____

Retention: {{facility.records_retention_years}} years, filed as set in the retention schedule (REC-POL-001).

4. Evidence

ID	Source	Link / status
E-007	WHO Patient Safety Solutions series (2007).	see source
E-009	ASF Expert Committee consensus.	see source

EC = ASF Expert Committee consensus.