

- internal and external information sources;
- individual care data and external databases and bodies of expert health-related, administrative, and research knowledge, as well as information from clinical literature; and
- organizational data and management literature.

These processes can be electronic or manual.

Data and information are retained for sufficient periods to comply with law and regulation and support individual care, management, legal documentation, research, and education.

Standards and Intent Statements for Patient-Specific Data and Information

Israel Neustadter's [medical record](#) clearly lacked sufficient information to justify the treatment, document the course and results, and promote continuity of care among health care providers.

Attending physician's [sworn testimony](#) confirms critical break in the continuity of care.

Standards

IM.7 *The hospital defines, captures, analyzes, transforms, transmits, and reports patient-specific data and information related to care processes and outcomes.*

IM.7.1 The hospital initiates and maintains a medical record for every individual assessed or treated.

IM.7.1.1 Only authorized individuals make entries in medical records.

IM.7.1.2 The hospital determines how long medical record information is retained, based on law and regulation and the information used for patient care, legal, research, and educational purposes.

IM.7.2 The medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

Intent of IM.7 Through IM.7.2

Information management processes provide for the use of patient-specific data and information to

- facilitate patient care;
- serve as a financial and legal record;
- aid in clinical research;
- support decision analysis; and
- guide professional and organizational performance improvement.

To facilitate consistency and continuity in patient care, specific data and information are required. Administrative and direct patient care providers produce and use this information for professional and organization improvement. Medical records contain sufficient information to

- identify the patient;
- support the diagnosis;
- justify the treatment;
- document the course and results; and
- facilitate continuity of care.