Clearing Up the Confusion: Ongoing Record Reviews for 2004

by Jean Clark, RHIA

For years health information managers have coordinated ongoing record reviews. From the early days of "clinical pertinence" review to the most recent "19 items" review, the jury is still out as to whether the process really improved documentation. With the Joint Commission on Accreditation of Healthcare Organizations' 2004 standards and survey process revisions, ongoing record reviews should take on new meaning and provide better outcomes. The new ongoing record review element of performance provides much more flexibility. While this might be frightening for some, it does provide the opportunity to revise a process that has long been a bit of a paper nightmare. This article aims to clear up the confusion that continues to revolve around ongoing record reviews.

The Joint Commission Says…

Ongoing record review requirements are found in Standard IM.6.10, Element of Performance (EP) 11:

Standard: "The hospital has a complete and accurate medical record for every patient assessed or treated."

Rationale: "Patient-specific data and information are contained in the medical record, both inpatient and outpatient, to facilitate patient care, treatment, and services, serve as a financial and legal record, aid in the research, support decision analysis, and guide professional and hospital performance improvement. This information may be maintained as a paper record or as electronic health information."

EP 11: "Medical records are reviewed on an ongoing basis at the point of care and based on organization-defined indicators that address the presence, timeliness, readability (whether handwritten or printed), quality, consistency, clarity, accuracy, completeness, and authentication of data and information contained within the record, as well as appropriate scanning and indexing if document imaging is used."[1]

A timely, accurate, and complete medical record is vital to patient care and safety. It tells the story of the patient's care and treatment and provides the means of communication between caregivers. Because the record is so important, an ongoing record review process to ensure documentation quality and timeliness is time well spent.

What the EP Does Not Require

Gone are requirements for who participates in the reviews, frequency, and reporting time frames. Yes, the 19 items are eliminated, too. This is good news and provides an opportunity to revise the process to meet organizational needs.

What the EP Does Require

EP 11 requires records be reviewed on an ongoing basis and at the point of care. This is not new. The organization can and should define the indicators to be used. The indicators must address the presence, timeliness, readability (whether handwritten or printed), quality, consistency, clarity, accuracy, completeness, and authentication of data and information in the medical record. If document imaging is used, an ongoing review process must be in place for record scanning and indexing processes.

None of this should be difficult. Here is an example of how one topic could be reviewed to meet the intent of EP 11. Review of history and physical reports (H&P) could encompass all of the above. Note that all of the bulleted items do not need to be reviewed all the time. Nurses on the units could review a sample of charts for a three-month period to determine the following:

- Is the H&P available on the record or on the computer screen within 24 hours of an inpatient admission?
- Is the history pertinent and the physical appropriate for the condition being treated?
- If the H&P is handwritten or faxed, is it legible?
- Are prohibited abbreviations used?
- Is the H&P content clear and useful in planning the care of the patient?
- Does the H&P follow the approved format for medical record documentation?
- Are transcribed reports free of typographical errors?
- Has the physician signed the H&P?

If a document imaging system is in place, a retrospective quality check can validate that the paper H&P was scanned into the correct patient's file and that the electronic version is downloaded to the correct patient in the document repository. Data from this review would be aggregated over time and analyzed for compliance. Noncompliance issues should be reported to the appropriate leadership for resolution such as the medical record committee, the performance improvement committee, the medical executive committee, or a record review team. And although the EP does not address frequency, a good rule of thumb is to report these instances quarterly.

A Clean Slate

The EP 11 process revisions provide a good opportunity to accomplish more meaningful reviews. Begin by asking what has and has not worked well in the past:

- Has documentation improved as a result of the record review?
- What, if any, documentation issues are outstanding?
- Are the right people involved in record review and in the resolution of issues?
- Is the process just a paper process with no real improvements?
- Are documentation problems caught when they can affect care or after it's too late? Is the focus at the point of care or is it after discharge?
- Would automation help the process?

Analysis of findings will identify where improvements must be implemented for meaningful ongoing record review.

The key functions of an ongoing record review process require defining:

- Who will do the reviews
- How often the reviews will be conducted
- What the indicators will be for any given time period
- The sample size(s)
- Who will receive the data and turn it into meaningful information
- How often to report findings and to whom
- Who is responsible for addressing and resolving variance in compliance with the indicators

Choosing Indicators

A logical approach is to concentrate, at least for the first year, on important unresolved documentation issues from past reviews. It is also good practice to establish an ongoing record review calendar at the start of each year showing review topics and reporting deadlines. Since the EP requires ongoing reviews at the point of care, let the nursing units and departments decide what indicators to use. This will support buy-in and reporting commitments.

The Joint Commission has revised the record review survey tool to accommodate the revised or reformatted documentation standards. It can be accessed at www.jcaho.org/accredited+organizations/hospitals/survey+process/sample+forms+and+tools/2004_mr_req_2.pdf. The record review tool should be used only as a resource for indicators. It should never be used in its entirety to review records, as it is too cumbersome and has proven to be burdensome to reviewers in the past. It will *not* be used by the surveyors at the time of the on-site survey and has been provided by the Joint Commission as a reference tool only.

With few exceptions, indicators should be set up to address documentation at the point of care where variances can be corrected in a timely manner and patient care can be affected. Indicators for closed records should focus on the content of the discharge summary, autopsy reports, and completion of medical records within the designated time frame but no longer than 30 days after discharge.

Why Good Documentation Is Important

The focus of all Joint Commission activities is quality and safety in patient care. In addition to supporting this ultimate objective, accurate, timely, and complete medical record documentation contributes significantly to successful periodic performance reviews and on-site surveys.

Quality documentation in the open medical record will be important in the tracer methodology part of the survey. It will be used as the road map to the patient's experience in the facility. A poorly documented record will not bode well for the organization. In fact, the documentation EPs are often the ones that cause the most problems for organizations. A good ongoing record review process can go a long way in ensuring a successful survey.

Keeping It Simple and Effective

The bottom line is to keep it simple. Organizations do not have to review the 19 items, and indicator selection is left up to the facility. In other words, downsize the number of indicators reviewed at any one time and make the point of care the focus of reviews. Organizations that take this approach will have well-documented medical records that will affect patient care and be in compliance with Joint Commission Standard 6.10, EP 11.

Note

1. *2004 Hospital Accreditation Standards*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2004.

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