Closer Look at Clinical Pertinence Standards

by Jean Clark, RHIA

When the Joint Commission standards related to clinical pertinence review were revised, flexibility and an ongoing process for review of medical records at the point of care was the intent. This continues to be the goal of IM.7.1-IM7.10.1, though there are still directions in the requirement to review 19 items identified on the Medical Record Review Summary Sheet. Even though the standards have been published for some time now, confusion remains related to the 19 items and how often they should be reviewed. This article will provide clarification on these 19 items.

What Are the 19 Items?

IM7.10-IM.7.10.1 require medical records to be reviewed on an ongoing basis for completeness and timeliness of information and action to be taken to improve the quality and timeliness of documentation that affects patient care. The standards go on to say that a representative sample of records is included in the review process. The intent section of the standards lists 19 bulleted items that should be included in an ongoing record review, as appropriate to the organization's needs. They are:

- identification data
- medical history
- summary of the patient's psychosocial needs
- physical examination
- statement on the conclusions drawn from the admission history and physical
- statement on the course of action planned
- diagnostic and therapeutic orders
- evidence of informed consent
- clinical observations and results of therapy
- progress notes
- consultations
- operative reports
- reports of diagnostic and therapeutic procedures
- transplants and implants
- final diagnosis(es)
- conclusions at termination of hospitalization
- discharge summaries
- discharge instructions
- results of autopsy

The Record Review Process

Within the structured parameters, the Joint Commission leaves room for flexibility in application. For a successful survey in IM.7.10–IM.7.10.1, the following ongoing record review process is essential:

- **Focus review at the point of care.** This means reviewing the open records on the nursing units and in other departments—not after discharge.
- **Ensure an adequate sample of records is reviewed** to include all services provided in the organization such as inpatient and outpatient records and all services provided by the organization. The standard does not indicate how many records to review during a 12-month period. Most hospitals have used 5 percent or 30 records, whichever is the greater number of the average annual discharges and average annual outpatient encounters.

- **Reviewers should be nurses, other clinical caregivers, and physicians.** Physicians do not have to do the first reviews. However, they should be involved in identifying criteria and topics for review as well as taking action and ensuring resolution to problems identified in the reviews.
- **Document findings, actions taken, and improvements realized for quarterly reporting should be included on the quarterly medical record** summary form. Supportive documentation should be found in minutes and other reports of ongoing record review functions.
- **Include the 19 items as part of the review process.** At least once a year, the ongoing record review function should include a look at the 19 items.

Review Early, Review Often?

If you decide to review the 19 items once a year, data from the previous two years must be available for the surveyors' review during the document review session. This data, along with data from the year in which the survey occurs, ensures a performance improvement approach to ongoing record review.

If you choose to review the items on a quarterly basis, the data from the four quarters prior to the survey must be made available at the time of the document review session.

The expectation is not that the organization continues to review the 19 items if there are no problems identified, but rather it is for continued review and aggregation of comparative data, supporting the decision to move on to other items for ongoing record review.

An organization might choose to review the 19 items at the beginning and mid point of each year prior to survey and from these reviews determine the focus of ongoing record review and concentrate on resolving known documentation problems throughout the remainder of each year. Because surveys are performed every three years, the organization will have plenty of data for surveyor review and meet the requirements for ongoing review and reporting of the 19 items.

Remember to focus review of the first 14 items at the point of care and have the reviews performed by the individuals who document in the medical record. Save the last five for review by your organization's HIM department after discharge.

Although the 19 items are still required as part of ongoing record review, there is flexibility in the process. Make it work for your organization with the ultimate goal of improving documentation in the medical record to improve the quality of care and safety for the patient.

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