# On the Line: Professional Practice Solutions (2/03)

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**Q:** I recently heard a group of HIM professionals discussing record completion policies. One professional was discussing her organization's newly adopted policy of defining a delinquent medical record as a record that was missing any one of five items: discharge summary, final diagnoses without abbreviations, history and physical (H&P), consultations, and operative reports.

According to the professional, the delinquency rate reported to upper management reflected this definition. However, a change in policy was made to keep the organization's delinquency rate below the Joint Commission standard of no more than 50 percent delinquent medical records at any given time. This was done in conjunction with tracking and clearing other chart deficiencies that were not counted in their delinquency rate.

The group argued that this policy and reporting was contrary to California state regulations and that it was a limited definition of an incomplete medical record. California state regulations have a much broader definition of a completed medical record. Some of the professionals participating in the discussion questioned this practice and called it fraudulent.

Is it fraud, or just survey-savvy, creative delinquency counting?

**A:** The scenario above is neither fraudulent nor savvy. The delinquency count is only one method of ensuring that the record is complete. Concurrent reviews and auditing must also be done to monitor for timely and complete medical records. The two methods combined are an effective way to make sure that the medical record not only meets the standards and regulations that govern it but remains an effective communication tool for patient care.

There are a number of different accreditation standards and regulations that come into play:

**Joint Commission standard IM.7.6:** This standard requires that medical record data and information be managed in a timely manner. It requires that an organization monitor key pieces of documentation, particularly those that will have an effect after discharge. This standard requires the delinquency rate to be calculated.[1]

**Joint Commission standard IM.7.8:** This standard requires that entries in the medical record have a date and that the author be identified and, when necessary, authenticated. There must be a system in place and a policy defining who can make an entry, the requirement for a date and author with an entry, and authentication of the entry. The standard requires that at a minimum, the H&P, operative report, consultation report, and discharge summary be authenticated.

**Joint Commission standards IM.7.10 and IM.7.10.1:** These standards require that medical records be reviewed on an ongoing basis for completeness and timeliness and that action be taken, particularly when there is an effect on patient care. It is different from IM.7.6 because it does not require every medical record to be reviewed but, instead, only a representative sample. Further, a chart is not considered delinquent if documentation is missing or late.

The process works because action is required when a problem or trend is identified—findings must be communicated, processes reviewed, and retraining conducted when necessary. This type of audit can be conducted concurrently because the focus of the review is to look at the information available at the point of care. This is a very good mechanism to use to monitor for compliance with record completion, timeliness, and authentication requirements.

**State licensure regulations:** Many states and practice settings have statutes similar to California's in which the minimum content of the medical record is outlined. For example, California regulations for hospitals specify the identification information to collect, such as nurse's notes with specific content requirements such as medication administration, lab results, etc.[2] These requirements are particularly important when an organization is developing its medical record and related policies to make sure there is a process to collect and report the required documentation. The state regulations do not require a specific record

completion or delinquency tracking process. However, if the California Department of Health was to survey an organization and find that required content was missing, the organization could be issued a deficiency or citation.

**Federal regulations:** Similar to state regulations, federal regulations for a practice setting also define the minimum content for the medical record but do not require a specific chart completion/delinquency process after discharge.

How do you decide what to review as part of the chart completion/delinquency process? It is a good idea to think about the record completion and delinquency process as a means to ensure that those critical pieces of documentation that affect quality and continuity of care after discharge are in place. These documents are so important that they warrant monitoring 100 percent of the time. Use your concurrent review and sampling audits to monitor for compliance with regulations and policies and take action when a problem or trend is identified.

If you are still not convinced that concurrent monitoring is the best way to ensure compliance, consider the ethics and potential legal implications of asking a practitioner to complete documentation or sign an entry after discharge. For example, a nurse forgot to sign the medication administration record for a patient while he or she was in the hospital (it's required by law) and now it is 30 days after discharge. Is it ethical or legal to have the nurse sign the entry and expect that she or he will remember the patient or will remember administering the medication? A concurrent method of monitoring using samples techniques, problem identification, and quality improvement initiatives identifies problems when something can still be done and potentially affect the quality of care and communication during the patient's stay.

## Notes

1. Fuller, Sandra. "On the Line: Professional Practice Solutions." *Journal of AHIMA* 69, no. 3 (1998): 55-56.

2. California Code of Regulations. "Patient Health Record Content" (section 70749) and "Medical Record Availability" (§70751). Title 22, division 5, chapter 1, article 7. Available online at http://ccr.oal.ca.gov.

## References

Centers for Medicare & Medicaid Services. "2002 Federal Regulations for Hospitals: State Operations Manual, Appendix A. Interpretive Guidelines—Hospitals." Available online at http://cms.hhs.gov/manuals/pub07pdf/AP-A.pdf.

Joint Commission on Accreditation for Health Care Organizations. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*. Oakbrook Terrace, IL: Joint Commission, 2002.

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