Record Reviews, Clinician Education Form Best Defense

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by Ray Pinder, MS, RHIA

We have all heard stories about attorneys winning large settlements for their clients due to lack of or insufficient documentation in the medical record. Many HIM professionals have taken steps to teach the basics to physicians, nurses, and other health professionals that have documentation responsibilities. But one of the underlying problems with documentation across the healthcare industry is that clinicians receive little, if any, formal education on documentation. Fortunately, there are several tools available to HIM professionals that can help to educate clinicians and ultimately improve documentation.

An Ongoing Effort

Regardless of the setting, reviewing records post-discharge to ensure completion is essential. The Joint Commission on Accreditation of Healthcare Organizations and the American Osteopathic Association (AOA) have standards for documentation for every discipline in healthcare settings. In addition to the standards, the Joint Commission and AOA require ongoing record reviews (ORRs) to ensure the presence, timeliness, completeness, and accuracy of documentation.

ORR is one of the best methods we can use to ensure high-quality documentation. Make it a continuous process by reviewing a minimum of 30 records or 5 percent of your organization's average monthly discharges, regardless of setting, on a monthly basis. During your record review, you should evaluate every aspect of documentation—presence, timeliness, completeness, and accuracy—on an ongoing basis. (See "Elements for Ongoing Record Reviews".) Note that while the Joint Commission only requires an organization to report on 19 documentation elements, there are more than 145 documentation elements on its Part 1 and Part 2 tools that should be included in your record review program for each of the four components.

The next step is to tally your reviews and report the findings to the necessary committees. When reporting your data, take care to communicate it in an interesting, engaging format using graphs or other visuals. After the committee has reviewed the findings, prepare a list of recommendations for corrective action for any and all documentation deficiencies. This should include every discipline responsible for documentation. Once your corrective action plan has been developed, send letters and e-mail specifying what actions are expected to departments and individuals. For example, such a letter might note, "Due to lack of signatures on nutritional screenings, we recommend a focused record review by your staff as well as an in-service program on documentation requirements."

Get Creative

There are several creative ways to remind clinicians of their documentation responsibilities. E-mail, pop-up screens on nursing unit PCs, posters, presentations, newsletters, and recorded messages on HIM phones are just a few ideas. Start small: focus on one deficiency at a time so clinicians are not overloaded with information or tasks.

ORR is just one tool for HIM professionals to use to improve documentation practices. Education is critical. Look for opportunities to provide continuing education to the medical staff as well as all others who document in the record. Persistence is key.

By the end of this decade, we will see more technology to assist healthcare providers in complying with the ever-growing documentation requirements. A well-documented medical record will always be the most important communication tool from one care provider to another.

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