Medical Record Review

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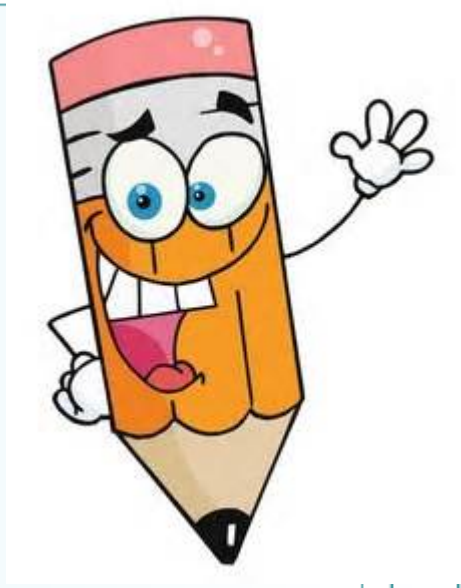
Content



- Purpose of the Medical Record
- Contents of Medical Records
- Medical Record Completion Requirements for Hospital
- The Medical Record as a Review Tool
- Type of Record Review

Purposes Of The Medical Record

- **Continuity of Care:**
  - To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment;
  - To furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the care episode.
- **Communication Among Practitioners:**

  To document communication between the practitioner responsible for the patient and any other healthcare professional who contributes to the patient's care.

Purposes Of The Medical Record

- **Legal Protection:**

  To assist in protecting the legal interest of the patient, the organization, and the practitioner responsible for the patient.

- **Data:**
  - To provide data for use in continuing education, in research, and in quality measurement, assessment, and improvement.
- **Identify of the patient:**
  - Identification data
  - Summary of psychosocial needs appropriate to patient age

Purposes Of The Medical Record

- **Support for the diagnosis:**
  - Medical history
  - Reports of relevant physical examinations
  - Diagnostic orders
- **Justification for treatment::**
  - Evidence of appropriate informed consent
  - Therapeutic orders
  - Clinical observations
- **Documentation of the course and results of:**
  - Therapy
  - Procedures and tests
  - Conclusions at termination of treatment or evaluation

Patient-specific Data/Information Standards

- The organization defines, captures, analyses, transforms, transmits, and reports patient-specific data and information related to care processes and outcomes
- The organization initiates and maintains a medical record for every individual assessed or treated.
- Only authorized individuals make entries in medical records.
- 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 healthcare providers.

Confidentiality, Security, and Integrity

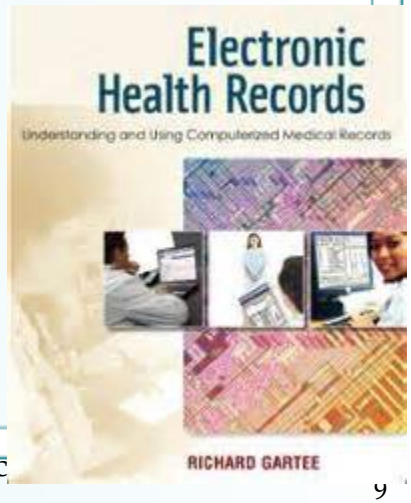
- Confidentiality, security, and integrity of data and information are maintained.
- Collection, storage, and retrieval systems are designed to allow timely and easy use of data and information without compromising its security and confidentiality.
- Records and information are protected against loss, destruction, tampering, and unauthorized access or use.

Somehow your medical record was faxed to a complete stranger. He has no idea of what is wrong with you either.

Contents of The Medical Record 1

Each medical record contains at least the following

- Patient information and authorized representative;
- Legal status, for mental health services;
- Emergency care prior to arrival;
- Record and findings of the patient assessment;
- Conclusions/impressions from history and physical;
- Diagnosis or diagnostic impression;
- Reason(s) for admission or treatment;



Contents of The Medical Record 2

- Goals of treatment and treatment plan;
- Evidence of known advance directives;
- Evidence of informed consent if required;
- Diagnostic and therapeutic orders;
- All diagnostic and therapeutic procedures/tests performed and results;
- All operative and other invasive procedures performed;
- All progress notes;

Contents of The Medical Record 3

- All reassessments;
- Clinical observations;
- Response to care provided;
- Consultation reports;
- Every medication ordered/prescribed for inpatients;
- Each medication dispensed/prescribed for ambulatory patient or inpatient on discharge;
- Every dose of medication administered and any adverse drug reaction;

Contents of The Medical Record 4

- All relevant diagnoses;
- Any referrals/communications to external/internal care providers and community agencies;
- Conclusions at termination of hospitalization;
- Discharge instructions to the patient and family; and
- Clinical resumes and discharge summaries, a final progress note, or transfer summary.

The Discharge Summary

The discharge summary contains the following information

- Reason for hospitalization;
- Significant findings;
- Procedures performed and treatment rendered;
- Condition on discharge; and
- Specific instructions.

Pre- Operative and Operative Documentation

- Operative or other procedures and the use of anesthesia.
- Preoperative diagnosis
- Operative reports dictated or written immediately after surgery, including
  - Primary surgeons and assistants;
  - Findings;
  - Technical procedures used;
  - Specimens removed;
  - Postoperative diagnosis

Emergency Care

- *When emergency, urgent, or immediate care is provided,*….the medical record documents
- Time and means of arrival;
- Patients left against medical advise(AMA);
- Conclusions, including:
  - Final disposition;
  - Condition at discharge;
  - Instructions for follow-up care.
- Copy of record available to follow-up practitioner or medical organization.

What is medical audit

"A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change."

Medical Record Audit is a planned programme

- which objectively monitors and evaluates the performance of all practitioners,
- which identifies opportunities for improvement, and
- provides mechanism through which action is taken to make and sustain those improvements.

Medical Record Committee

- Review of medical records to ensure that they are accurate, clinically pertinent, complete and readily available for continuing patient care, medico-legal requirements, and medical research;
- Recommend action when problems arise in relation to medical records and the medical record service;

Responsibilities

- To revise and implement the policies and procedures for medical record department.
- To ensure legible and sound documentation within the file of the patient.
- To monitor the progress and patient health information within the medical file.
- To take an action for those who are not compliant with documentation according to the standards.
- To suggest modification or new formats within the medical file.
- To ensure discharge summaries are done on time and by the treating physician.
- To revise and monitor the process of medical reporting for any patient.
- To report according to the reporting system of QI Committee within the hospital and according to the established plan.
- To keep a record of minutes of meeting.

Team Members

- Chairman- Chief of Medical Operations
- Co- Chairman – Manager, Medical Record Dept
- Members from these Specialties:
  - Manager, Polyclinic
  - Doctor, Surgery
  - Doctor, Internal Medicine
  - Doctor, Paediatrician
  - Anesthesia Specialist,
  - Manager, PI.
  - Programmer, Computer Dept.
  - P.I. Nurse
  - Manager, Medical Record Department
  - Secretary from Medical Records Department

Medical Record Completion Requirements for Hospital

- **History and Physical:** Within 24 hours after admission. May be done within 30 days prior to admission. For a readmission within 30 days for the same or related condition, an interval H & P is adequate if the original is available
- **Verbal orders:** Signed within 24 hours
- **Informed Consent:** Evidence of compliance with requirements stated in the organization's policy and consistent with any legal requirements
- **Progress notes:** Chronological report of clinical observations, condition changes, and results of treatment (may be required daily in hospital medical staff bylaws or rules and regulations

Medical Record Completion Requirements for Hospital

- **Operative Report**: "Immediately after surgery" (written if not dictated) [Within 6 hours is usually acceptable with a post-operative note in progress notes];
- **Reports** (lab, radiology, pathology, anesthesia, nuclear medicine, and diagnostic and treatment procedures) [Time limit for results, within 24 hours if possible, no longer in standards];
- **Clinical Resume** (Discharge Summary): 30-day time limit in conjunction with the completion of the record [Most institutions require it within 2 weeks

Medical Record Completion Requirements for Hospital

- **Discharge instructions:** must include physical activity, medications, diet, and follow-up care;
- **A final Progress Note** is acceptable instead of discharge summary if LOS is less than 48 hours for uncomplicated conditions, normal newborns, and uncomplicated deliveries;
- **Deaths:** include reason for admission, findings, course, and events leading to death;
- **Autopsy Report:** provisional anatomic diagnoses within 3 days; complete report within 60 days.

Medical history and physicals (for in-patient admissions)

Must contain or address the following elements:

- History of current illness
- Current medications
- Significant past medical history
- Social history (may indicate “non-contributory)
- Family history (may indicate “non-contributory”)
- Review of systems and physical exam
- Plan of care

Surgical/invasive Procedure History And Physicals (For In- Or Out- Patients)

Must contain or address the following elements:

- Indications for surgery/procedure (significant history)
- Current medications
- Social history (may indicate as “non-contributory”)
- Family history (may indicate as “non-contributory”)
- Review of systems and physical exam (at a minimum, must include assessment of heart, lungs, neuro status, and surgical site.)
- Plan of care

The Medical Record as a Review Tool

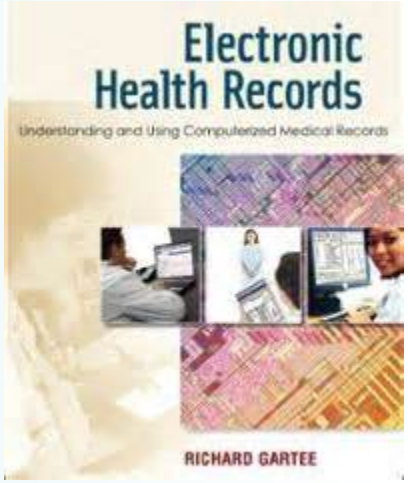
- Continuity of care delivery;
- Completeness, timeliness, and legibility to assure: Adequacy as a legal document;
- Compliance with medical staff bylaws, rules, regulations; accreditation, state, and federal requirements.
- Appropriateness of orders, tests, and treatments;
- Medical necessity and appropriateness of hospital and skilled/sub-acute level of care

The Medical Record as a Review Tool

- Variance and outcome monitoring based on clinical paths or practice, guidelines;
- Timeliness of care delivery;
- Adequacy of the medical record as a clinical, communicative record;
- Medical records are reviewed on an ongoing basis for completeness and timeliness of information, and action is taken to improve the quality and timeliness of documentation that impacts patient care
- A representative sample of records is included in the review process

Type of Record Review

- Open Record Review
- Closed Record Review
- 19 Element Review



Open Record Review

- Prospective review
- Usually done by staff
- Allows for immediate feedback to staff

Closed Record Review

- Usually done by a multi-disciplinary team
- Allows for “practice” in finding information that will be gathered during the real JCIA or national accreditation record review
- Allows for compilation of a list of “good” charts

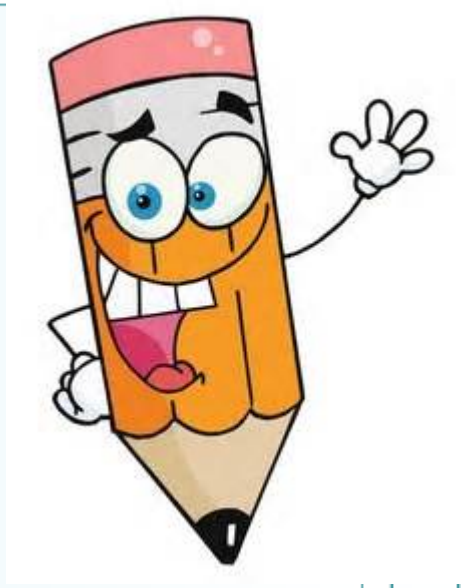
19 Element Review

- Review must address *timeliness and completeness* of each element
- A portion of the 19 elements can be reviewed at each quarterly review provided all 19 elements are reviewed annually.
- If an element is reviewed annually the surveyors will want to see the last three years worth of data

19 Element Review

- Before the survey the organization completes the Summary Review Sheet, indicating at least quarterly findings for the review of each item as part of the ongoing medical record review process as well as performance improvement activities initiated to address findings if appropriate.

19 Element Review



- Identification data
- Medical History:
  - chief complaint
  - present illness
  - past medical history
  - family history
  - social history
  - inventory by body system

19 Element Review

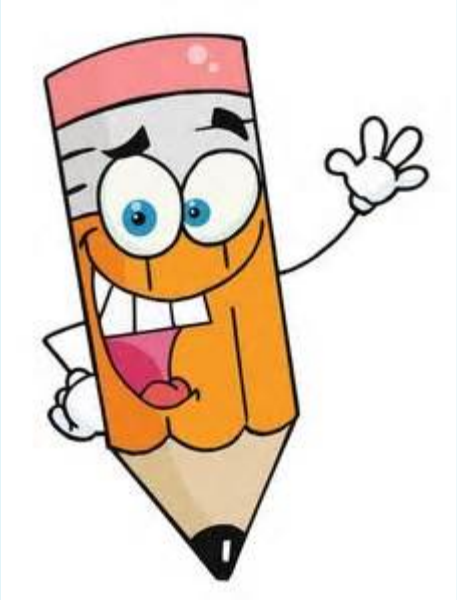
- Age appropriate psycho-social assessment
- Report of relevant physical examinations
- H&P Conclusions or impressions
- Physician Plan of Care
- Diagnostic and therapeutic orders
- Informed Consent
- Clinical observations

19 Element Review

- Progress notes
- Consult reports
- Operative/Invasive Procedure Reports
- Reports from diagnostic or therapeutic procedures
- Records of donation and receipt of transplants and/or implants
- Final diagnosis
- Conclusions at termination of hospitalization

19 Element Review

- Discharge Instructions
- Discharge summaries
- Results of autopsies



JCIA *Closed Patient Medical Record Review Form*-*Purpose of the Form*-

- The purpose of the Closed Patient Medical Record Review Form is for the organization to gather and document continuous evidence of compliance with standards that require documentation in the medical record.
- The form is intended to be used on an ongoing basis as well as in preparation for the survey.
- The organization should use the form as an audit of its medical records to identify potential discrepancies in documentation and areas for improvement.

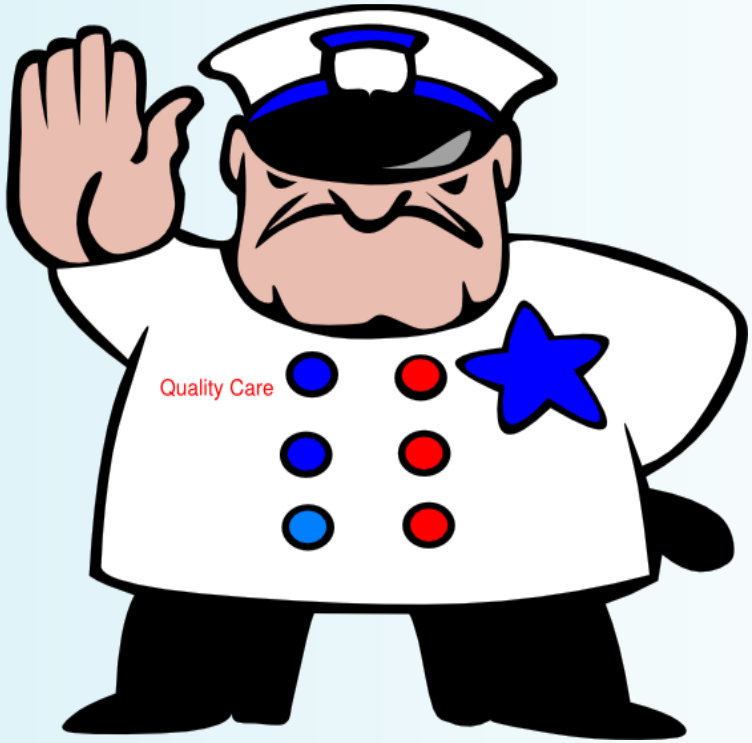
JCIA *Closed Patient Medical Record Review Form-Organization of the Form-*

- The form is organized by topic headings (**for example, "Assessments" and "Consents" and includes the specific** standard number and the standard requirement (**for example, blood consent and medical assessment).**

JCIA *Closed Patient Medical Record Review Form-Review Process-*

- The surveyor(s) may use a blank Closed Patient Medical Record Review Form or another means to record information during the session.
- The surveyor(s) enters the number of the medical record being reviewed and the type of medical record requested (recorded by diagnosis); **for example, Record #1 Congestive Heart Failure").**
- The medical record is reviewed briefly
  - to establish what type of patient or care was received (**for example, surgery, medical, emergency,**rehabilitation);
  - to verify compliance with the documentation track record (6 months for initial surveys and 12 months for triennial surveys).

IF IT IS NOT DOCUMENTED, IT HASN'T BEEN DONE!!



Conclusion

GOOD MEDICAL CARE GENERALLY MEANS A GOOD MEDICAL RECORD, WHILE AN INADEQUATE MEDICAL RECORD GENERALLY REFLECTS POOR MEDICAL CARE

Questions? Comments?


Thank You!
Prof. Seval Akgun, MD, PhD