Improve your clinical record keeping

Accurate, complete, legible medical records are critical to quality patient care. AAAHC sees them as so important that Chapter 6 of the Accreditation Handbook is devoted to Standards relating to clinical records and health information. And surveyors regularly find records missing critical information.

Even if your organization has moved to electronic health records, it can be easy to overlook essential information. If you are using paper records, uniformity and legibility may be an issue. Consider the following tips to ensure that your patients’ records function as intended.

1. **Sweat the small stuff.** Don’t overlook basic information. AAAHC surveyors often note missing:
   - Vital signs
   - Medication history (including OTC and supplements)
   - Physician’s signature for verbal orders
   - Test results with authentication
   - Date and time on entries and orders

2. **Create order, not chaos.** Organize all records uniformly. Maintain consistent content and format for clinical records, including the sequence of information. Establish and use standardized abbreviations and dose designations.

3. **Who’s in charge here?** Designate one person to keep files updated and secure. This includes maintaining a predetermined, organized format and securing the confidentiality and physical safety of the records at all times.

4. **Out of sight is out of mind.** Identify a prominent location for information about allergies and sensitivities. Information, including documentation of the reaction, must be recorded in a uniform location in all records. The information must be verified, updated and
documented at each patient encounter.

5. **Have we met?** Ensure continuity of care for new or transferred patients by obtaining complete records or summaries for those who have been treated elsewhere by another physician or facility. When transferring a patient from your site to another health professional or organization where future care will be rendered, be sure to send a copy of the patient’s records.

6. **Document, document, document...** Any discussion with a patient about the necessity, appropriateness, and risk of proposed treatment or procedure, and treatment alternatives must be reported in the patient's clinical record.

...even when the discussion is over the phone. When significant medical advice is given to patients by telephone, it must be entered in the patient's record and appropriately signed or initialed. This includes medical advice provided by after-hours or triage telephone services.

Following these tips should bring your clinical records up to par. Think you're already there? Check a dozen records using the Clinical Records Worksheet located in the back of the 2012 AAAHC Accreditation Handbooks to be sure. If the information isn't there, in the same location, using the same language, in every record, you may want to implement some change. Devise a simple quality monitoring tool – review five charts at the end of each day for ten days – to make sure the monitored changes are becoming habit. Rotate completion of the monitoring tool through staff who routinely document in patients' records. Then schedule more formal 30-day, 90-day, and 6-month check-ins to see how you're doing. Your surveyors and your patients will thank you!

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**Customer service 101**

Many of the things you do to create excellence within your ambulatory health care organization are not immediately visible to your patients. Some of what is visible to them supports that excellence, yet may be misinterpreted. Review your processes from the patient's point of view.

**Consider this scenario:** Your organization uses the patient's name and date of birth as a unique identifier. Your patient arrives on time and her minor anxiety about the procedure is lessened by being greeted warmly and by name by the receptionist. Mrs. Jones completes some paperwork that includes providing her name and date of birth in multiple places.

Next, Mrs. Jones is called by name and invited back to an exam room where she waits briefly and distracts herself from the returning nervousness by thinking about the upcoming weekend visit with her grandchildren. An RN enters and asks for her name and date of birth before reviewing her health history. Mrs. Jones wonders why the first “medical person” she has seen doesn't know who she is.

Gowned and ready, her MD arrives to mark the surgical site. First
Gowned and ready, her MD arrives to mark the surgical site. First though, he asks her name and date of birth. Mrs. Jones frowns. Doesn't he know who she is and what he's supposed to be doing?

Then an anesthesiologist arrives to find out who she is and when she was born. Mrs. Jones' blood pressure is noted to be a little high.

Everyone in this organization had been well trained. But from the patient's perspective, she was putting herself in the hands of people who apparently couldn't rely on themselves, their chart or each other to know who she was.

An exaggeration yes, but you get the picture. Regardless of setting, patients may see 3 or more health care professionals during a single visit. To be asked to repeat the same identifying information can be confusing, or even irritating. Share your best practices with your patients. Explain early in the appointment that you've put safeguards in place to protect them and their health, and that you hope they'll bear with you. It may even have an impact on your customer satisfaction scores!

**Electronic health records vs. paper records**

<table>
<thead>
<tr>
<th>EMR considerations</th>
<th>The Challenge</th>
<th>Paper considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can everyone use the system? If so, what safeguards patient confidentiality?</td>
<td>Accessibility</td>
<td>Can everyone access the records? If so, what safeguards patient confidentiality?</td>
</tr>
<tr>
<td>What is your practice policy: How often is your system purged of these records? Where are such records housed and for what period of time?</td>
<td>Inactive/Retired records</td>
<td>How are they stored? Are they secured physically? How is the physical storage verified to be intact?</td>
</tr>
<tr>
<td>Does your policy include that passwords are never shared? Is your system partitioned on a &quot;need to know&quot; user basis?</td>
<td>Security</td>
<td>Are paper records left unattended at any &quot;public space&quot; within</td>
</tr>
</tbody>
</table>

TIE
| Automatic alert to the provider ordering a test that results are available. | Authentication of reports: lab/xray/etc | A multi-step manual process. |

If you have questions or comments, please contact Angela FitzSimmons at afitzsimmons@aaahc.org.

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