Assignment 4.2: Chapter 2 Navigate the Field Exercise 1

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HIMT 1250: Health Record Content & Structure

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To prepare for the state department of health review and to ensure the facility's health records follow the suggested standards, I recommend following standards and recommendations presented by The Joint Commission and the Accreditation Association for Ambulatory Health Care. Not only can following their guidance on the content and format of the health records lead to accreditation from these organizations, but it can assist HIM in compliance with local health regulations.

The healthcare community sees The Joint Commission as "an industry leader in the area of healthcare accreditation" (Sayles, 2020, p. 99). It is a non-profit organization that accredits a variety of facility types (Foltz, 2018, p. 51), and it utilizes education and compliance outreach to assist the facilities it accredits (Sayles, 2020, p. 99). Compliance with The Joint Commission would provide organization, improve patient safety and the quality of patient care, and reduce risks and mistakes. Accreditation would earn trust from the public, be recognized by insurers, save money and reduce costs, and provide tools, education, and review (*The Joint Commission*, 2018).

The Accreditation Association for Ambulatory Health Care (AAAHC) is a "specialty accrediting organization" (Foltz, 2018, p. 51) focusing on ambulatory facilities. It measures how well a facility performs, and it creates, audits, and edits facility standards. Accreditation with the AAAHC would include compliance regarding the facility's infrastructure, safety, business and clinical operations, and patient records and documentation. The AAAHC also educates its accredited providers. (Sayles, 2020, p. 99). Accreditation with the AAAHC is important because it would improve the quality of patient care, and it provides clear standards, quality assurance, education, and reviews (*Accreditation Association for Ambulatory Health Care*, n.d.).

Based on the guidelines suggested by The Joint Commission and the AAAHC, I propose the following checklist for reviewing all medical records:

- All records must be completed within 15 days, or they will be considered delinquent ["Timeliness of accessibility to required documentation is an evaluative determination" (*The Joint Commission*, 2020).] (Sayles, 2020, p. 77).
- All record entries and reports must be fully authenticated with a date, time, and signature (*The Joint Commission*, 2016, p. 45). The authentication format must be consistent (*Accreditation Association for Ambulatory Health Care*, 2019, p. 14).
- Complete and accurate documentation must be present for all services provided, reflecting an accurate and complete picture of all medical care provided to the patient, including "medical, nursing, rehabilitation, and social services" (*The Joint Commission*, 2016, p. 45). The following must be included in each record:
  - An accurate, complete, and updated Health & Physical (H&P) (*AAAHC*, 2019, p. 14).
    - Use one consistent method for recording allergies. Update and authenticate allergies at every patient visit (*AAAHC*, 2019, p. 14).
  - Accurate and complete doctors' orders for therapeutic and diagnostic care (Sayles, 2020, pp. 104-107).
  - Accurate and complete diagnostic reports for every diagnostic procedure (*AAAHC*, 2019, p. 14).
  - Accurate and complete surgical procedure documentation and reports (Sayles, 2020, pp. 108-109).
  - Accurate and complete progress notes (*The Joint Commission*, 2016, p. 45).

- Accurate, complete, and consistent documentation for medications (*AAAHC*, 2019, p. 14).
  - Ensure all new, discontinued, and resumptive medications are documented (*AAAHC*, 2019, p. 14).
  - Include detailed patient directions, including dosages and schedules (*AAAHC*, 2019, p. 14).
  - Reconcile medication notes regularly to ensure accuracy (*AAAHC*, 2019, p. 14).
- Transfer and follow-up documentation (*AAAHC*, 2019, p. 14).
- Accurate and complete discharge summary (*AAAHC*, 2019, p. 14).
  - Include detailed patient directions, including medication dosages and schedules (*AAAHC*, 2019, p. 14).
  - Ensure the patient receives discharge form and detailed directions (*AAAHC*, 2019, p. 14).

- Review progress notes to ensure all care and elements are adequately documented and authenticated (*The Joint Commission*, 2016, p. 45).
- Facilitate record audits to ensure all documentation and records are complete and authenticated (*AAAHC*, 2019, p. 14).
- Manage verbal orders in compliance with policies, laws, and regulations (*The Joint Commission*, 2016, p. 45).

References

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