Medical File Auditing and Its Effect on Performance Indicators

Thesis

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List of Abbreviations

AHA	**:**	American Heart Association
AHIMA	**:**	American Health Information Management Association
AMA	**:**	American Medical Association
BHTs	**:**	Bed Head Tickets
CBD	**:**	Computer-based documentation
CC	**:**	Chief Complaint
CDQ	**:**	Clinical documentation quality
CPD	**:**	Computerized physician documentation
ECG	**:**	Electrocardiography
ED	**:**	Emergency Department
EMR	**:**	Electronic Health Record
GMC-UK	**:**	General Medical Council- United kingdom
HIM	**:**	Health Information Management
HIQA	**:**	Health Information and Quality Authority.
HOD	**:**	Head of Department
HPI	**:**	History of Present Illness
HQIP	**:**	Healthcare Quality Improvement Partners
HSD	**:**	Health Sub District
HSE	**:**	Health Service Executive
IFHIMA	**:**	The International Federation of Health Information Management Associations
IIJFMT	**:**	Indian Internet Journal of Forensic Medicine and Toxicology

IT	**:**	Information Technology
JCAHO	**:**	Joint Commission on Accreditation of Healthcare Organizations
JCI	**:**	The Joint Commission International
KFSHRC	**:**	King Faisal Specialist Hospital and Research Centre
KPIs	**:**	Key performance indicators
MDS	**:**	Minimum data set
MR	**:**	Medical Records
MRRC	**:**	Medical record review committee
NCQA	**:**	National Committee for Quality Assurance
NHS	**:**	National Health Service
NICE	**:**	National Institute for Clinical Excellence
NLP	**:**	Natural-language processing
NMC-UK	**:**	The Nursing and Midwifery Council-United kingdom
PFSH	**:**	Past, Family, and/or Social History
PHR	**:**	Personal Health Record
ROS	**:**	Review of Systems
UMLS	**:**	Unified Medical Language System
UNTHSC	**:**	University of North Texas ,Health Science Center

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Introduction

Considerable attention has been focused on quality of health care services. Clinical documentation is critical to health care quality and cost ***(Russo et al., 2012).***

Clinical documentation was defined as the process of creating a text record that summarizes the interaction between patients and healthcare providers occurring during clinical encounters ***(Rosenbloom et al., 2011).*** Health care providers generate clinical documents to determine the quality of care provided to patients; to provide clinical data for clinical research and quality-assessment programs ***(Rosenbloom et al., 2010).***

A medical record is a systematic documentation which serves as the business record for a patient encounter for every patient assessed or treated in a health care organization as an inpatient, outpatient, or urgent care patient ***(WHO, 2002).*** It is recommended that more efforts should be made by the institutions/hospital managements, all clinicians and medical record officers to improve the standard of maintenance and preservation of medical records ***(Bali et al., 2011).***

About the importance of Medical Records can be summarized in six points

- to document the course of the patient's illness and treatment.

- to communicate between attending doctors and other health care professionals providing care to the patient.
- for the continuing care of the patient.
- for research of specific diseases and treatment.
- for the collection of health statistics, and
- for the Law (medico-legal issues) ***(Jethani, 2004)***.

As the great importance of correct, complete, and truthful documentation of medical files and records, we should establish medical record committee and assess records regularly by auditing to enhance the quality of health care services.

The Medical Record Committee has to be established as part of the hospital's quality improvement activities to ensure standards of patient care documentation are maintained in conformance to legal and regulatory bodies, including professional and accrediting agency standards. The hospital's multidisciplinary professionals and authorized groups enable this through a process of regular review and evaluation of patient care records. The Committee shall on a regular basis, review and evaluate medical records ***(JCI, 2010; JCI, 2012).*** The committee is responsible for reviewing all new and current forms and evaluates the suitability of these forms to ensure they meet current work practice and design requirements.

Clinical audit is 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. Aspects of the structure, processes, and outcomes of