Record Analysis Project

Amy E. Haisten

Georgia Northwestern Technical College

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Dr. Donna Estes

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The health records for both Case 1 and Case 2 in the HIMT 1250 Record Analysis Project are medical and surgical inpatient charts because they were "generated when [the] patient[s] [were] provided with room, board, and continuous general nursing care in an area of an acute care healthcare organization, such as a hospital, where the patient generally stays overnight" (Sayles, 2020, p. 103). These charts both had a label located in the top right corner of the first page indicating inpatient. The facility information found in the top left corner of the first page of both records was for a hospital, Global Care Medical Center. The data entered for both patients indicates overnight stays. In Case 1, the hospital admitted Pam Ray for two days, and in Case 2, the hospital admitted Sally Pire for five days.

According to AHIMA, "a health record is considered complete if it contains enough information to identify the patient; support the diagnosis or condition; justify the care, treatment, and services; document the course and results of care, treatment and services; and promote continuity of care among healthcare providers" (Sayles, 2020, p. 102). Also, each entry must be signed, dated, and timed and, therefore, accurately documented and authenticated. A medical and surgical inpatient record typically contains clinical data including an H&P, "diagnostic and therapeutic procedure orders, clinical observations, diagnostic and procedure reports, surgical procedure documentation, consultation report, discharge summary, patient instructions and transfer record" (Sayles, 2020, p. 104). It would also contain administrative data, patient consent, and authorizations. Sometimes when appropriate, the record might include consultation reports. (Sayles, 2020, p. 104).

Case 1 is a complete health record for Pam Ray. The administrative data contains the patient number, name, address, phone number, birth date, age, gender, race, marital status, and occupation, which is enough data to identify the patient. In addition to this identifying administrative data, this record includes a discharge summary, an H & P, a consultation report, progress notes, doctor's orders, diagnostic reports, an operative report, pathology report, recovery room record, nurses' notes, and nursing discharge. The diagnostic reports include a laboratory report and an EKG report. The record includes consent forms for admission to the hospital, for the surgery, and to release information. The H & P indicates the patient's chief complaint was mouth pain from infected teeth. The doctor conducted surgery to remove the teeth. The documentation contained in this record supports the diagnosis, and it justifies the surgery and the treatment provided. It also thoroughly documents the progress of the treatment by the hospital and the care received by the patient. The staff authenticated all documentation. Each item contained a signature or initials, a date, and a time posted by a healthcare provider within the organization. Since Case 1 is a complete record, it is a legally admissible record.

Case 2 is an incomplete record for Sally Pire. The administrative data contains the patient number, name, address, phone number, birth date, age, gender, race, marital status, and occupation, which is enough data to identify the patient. In addition to this identifying administrative data, this record includes a discharge summary, progress notes, diagnostic reports, nurses' notes, and nursing discharge. The diagnostic reports include a radiology report and a laboratory report. Like Case 1, this record contains consent forms for admission to the hospital and to release information. This record differs from Case 1 by the inclusion of a graphic chart and a medication report. However, the entire H & P is missing, and the doctor's orders are also

missing. This record does not contain an operative report, pathology report, or a recovery room record like Case 1. However, Sally Pire did not have surgery. Therefore, these documents are not missing because the patient did not have surgery.

The documentation contained in Case 2 cannot yet fully support the diagnosis and justify the treatment provided by the hospital because the doctor has not included the H & P or the doctor's orders. Nor can the record fully document the care received by the patient. However, it does document the progress of treatment through the progress notes and the nurses' notes. The staff authenticated most documentation. Someone on the medical team signed or initialed, dated, and timed most entries. The care provider did not authenticate the progress note entered on 7/31 at 1115 regarding the patient's recent wrist fracture and surgical consult because it did not contain a signature, a date, or a time for the service. The care provider also did not authenticate the progress note entered on 7/31 at 1130 for a surgical consult and the therapeutic orders for medications because it did not contain a signature, a date, or a time for the service. The medication records included only partial authentication by posted dates and initials. However, the care providers did not post the time for the entries. A nurse also entered two of these medication entries in her nurse's notes, where she authenticated these two medication entries. Otherwise, the medical team did not wholly authenticate the documentation for administering medication. Since Case 2 is not a complete record, it is not yet a legally admissible record.

Many healthcare providers and staff had a role to play in the records for Pam Ray and Sally Pire. The medical team has "an obligation to document appropriately, reflecting a true picture of the treatment and services rendered to the patient" (Sayles, 2020, p. 118). Also, providing "authenticated, accurate, legible, complete, and timely documentation is paramount to patient safety, quality of care provided to patients, and appropriate reimbursement" (Sayles, 2020, p. 118). Staff admitting patients to the hospital collect identifying data like the patient's names and birthdays. At this stage, the role of the hospital staff is to correctly collect and enter this data, including health insurance information used later for reimbursement. Doctors examine patients and diagnose them. Then they give orders for diagnostics and therapeutic treatment of the patients. Nurses and other allied medical staff carry out these orders and provide care to the patients. Then nurses or other care providers must include notes and reports to document the diagnostic service or therapeutic care give to the patient. For example, if the doctor gives an order for an x-ray, the radiology department carries out these orders by taking an x-ray. Then, radiology must create a report for documentation purposes in the health record.

The diagnosis, observations, and all diagnostic and therapeutic services and treatment must be accurately recorded in the record to accurately depict the diagnosis and the care and treatment received by the patient. The documentation should illustrate the continuity of care regardless of the care provider providing the service at the time and demonstrate that the care provided was appropriate for the diagnosis (Sayles, 2020, p. 102). If the medical team fulfills their roles, then accurate patient information is always accessible for patient care. If they do not adequately perform their functions, then medical errors can occur. Such medical errors could, at best, lead to inefficiency or unnecessary or duplicate charges. At worst, the error could lead to death, injury, or an irreversible and incorrect procedure like amputating the wrong leg. Legal and accreditation issues can also arise, including fines and loss of accreditation. Finally, doctors and facilities may not be reimbursed or fully reimbursed due to missing or incorrectly entered insurance information and inadequate documentation, as it could lead to inaccurate coding.

References

Medical Charts. (n. d.). Practice Fusion. https://www.practicefusion.com/medical-charts/

Sayles, N. B., & Gordon, L. L. (Eds.). (2020). *Health Information Management Technology: An Applied Approach*. (6th ed.). Chicago, IL: The AHIMA Press.