The need for mandatory clinical recording standards

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ABSTRACT – Current health information initiatives and targets set by the UK government have brought about a flurry of activity in the National Health Service to try to reach those targets. One target is to implement an electronic patient record system as a replacement for the present paper-based system of record keeping. However, this will not be an easy task; simply introducing information technology into an already chaotic system will only compound existing problems. This article highlights the gaps that must be filled before an electronic record system can be effectively implemented. The two major elements that are missing are mandatory clinical recording standards and a profession that is responsible for monitoring and enforcing those standards. Some examples of relevant standards for clinical recording are provided and the role of a health information management profession is described.

KEY WORDS: clinical recording, documentation requirements, electronic patient record, health information management, health record content, medical record standards

What will the proposed NHS Care Record Service (formerly Integrated Care Records Service) look like if clinicians can record anything, anytime, anywhere in the patient record – or *not*? If mandatory standards are not in place for paper-based inpatient records, information technology (IT) will certainly not solve the problems of poor record-keeping. To quote Dr Lawrence Weed, father of the problem-oriented medical record (POMR), 'There's no point in automating a record until you can control the inputs. Otherwise you're automating chaos'.[1]

Chaos seems to describe the current state of patient records in the NHS.[2,3] If recording of data in a paper-based patient record has no structure, no consistency, no uniformity, and no mandated standardisation, it is unlikely that the clinical information required for optimal patient care will suddenly become available in an electronic environment. In its 1995 report, the Audit Commission stated that 'before technology can be used effectively, hospitals need to improve their manual systems'.[4] Nine years on, little appears to have improved.

In March 2003, based on the initial assessments of NHS hospitals in the UK through the Data Accreditation Programme,[5] many hospitals were lacking even basic policies and procedures for entering patient data (mostly non-clinical) onto their patient administration systems (PAS). Even then, basic policies required by the Programme mainly addressed how clerical staff should enter the data, but did not designate who should enter which data at what point in the patient care pathway. The NHS is thus even further removed from policies which make clinicians accountable for entering clinical data at the point of care. Yet without standards for clinical recording and with no responsibilities assigned for enforcing those standards, hospitals cannot control their data inputs – the electronic record could therefore become automated chaos rather than a repository for good quality information on patient care.

History of standards development

Australia and the USA have mandatory standards for clinical recording, and also recognise the health information management (HIM) profession, which is responsible for ongoing monitoring and enforcement of those mandates. In the USA, most of the standards are based on those from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Even if a hospital chooses not to participate in the voluntary accreditation scheme, there are stringent standards with which they must comply, such as those of the federal Medicare and Medicaid programmes and of state licensing authorities.

Arguments against such ruthless standardisation often heard in the UK apparently stem from the belief that US healthcare regulations are driven mainly by money and lawsuits. However, mandated documentation standards were initially driven by the clinicians themselves in an effort to improve and standardise the quality of patient care. The American College of Surgeons (ACS), founded in 1913, published the first minimum standards for patient records as early as 1919. This was long before diagnostic related groups (DRGs) were introduced for reimbursement in the 1980s, long before the malpractice suits first hit the West Coast in the 1970s, and long before federally funded Medicare was introduced in the 1960s.

The ACS minimum standard for medical records

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required that an accessible and complete case record be developed for every patient, to include: patient identification data; complaint; personal and family history; history of the present illness; physical examination; special examinations (such as consultations, clinical laboratory and X-ray); provisional or working diagnosis; medical or surgical treatment; gross and microscopic pathological findings; progress notes; final diagnosis; condition on discharge; follow-up; and, in the case of death, autopsy findings.[6]

The adoption of the ACS standards marked the start of a standardisation programme for hospitals which led to the accreditation process. The ACS sponsored this voluntary accreditation programme until 1952 when it was formally incorporated into the Joint Commission on Accreditation of Hospitals (JCAH), which by then was also backed by the American College of Physicians, American Medical Association, the Canadian Medical Association, and the American Hospital Association. The accreditation programme has since been expanded to include standards for other types of healthcare organisations including outpatient, psychiatric, home health, and long-term care. It now operates under the name of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[6–8]

Monitoring and enforcement of standards

Ten years after the development of the ACS standards, the HIM profession (formerly known as medical record administration) emerged in the USA. Recognised as a profession allied to medicine (PAM) since 1928, the original objective of the profession was to raise the standards of clinical records in medical institutions.[9] Though the clinical staff have ultimate responsibility for the content of the record, the HIM staff have the main responsibility and authority to monitor and enforce the standards to ensure compliance.[10,11] Sanctions for non-compliance can range from suspension of admitting or operating privileges, withholding of pay cheques, denial of leave until records are complete, to full removal from the medical staff.[3,12] Consistent failure to comply can result in even more severe penalties such as loss of licence to practise, monetary fines, or even criminal penalties resulting in a jail sentence.[13]

Information recorded

In the monitoring process, HIM staff analyse all inpatient records for completeness on a daily basis and flag incomplete or missing content. For example, JCAHO and Medicare Conditions of Participation (COP) standards[14–16] specify what, and in some cases, when information should be recorded. For example:

- A patient's history and physical examination and nursing assessment must be completed within 24 hours of admission (JCAHO PE.1.7.1).
- The patient's history and physical examination, any indicated diagnostic tests, and a preoperative diagnosis must be completed and recorded before surgery is performed (JCAHO PE.1.8).
- Operation reports must be dictated or written immediately after surgery, giving the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and a postoperative diagnosis (JCAHO IM.7.3.2).
- A pre-anaesthesia evaluation must be performed within 48 hours prior to surgery by an individual qualified to administer anaesthesia (COP 482.52(b)(1)).
- A post-anaesthesia follow-up report must written within 48 hours after surgery by the individual who administers the anaesthesia (COP 482.52(b)(3)).
- Upon discharge, a discharge summary must document the reason for hospitalisation, significant findings, procedures performed and treatment given, the patient's condition on discharge, and instructions to the patient and family (JCAHO IM.7).

Importance of the patient record

The patient record is the main communication tool used by the healthcare team and is relied upon to ensure safe continuity of care throughout the health and social care system. As the primary source of written evidence of the care provided to the patient, it is the basis for evaluating the quality and appropriateness of that care in clinical governance. It also serves to protect the legal interests of both the patient and the provider as well as to substantiate costs of the care provided.[12,17,18]

If it is to be useful, clinical information must be recorded in the patient record consistently, comprehensively and in a timely manner. The mandated standards are logically sequenced so that the information necessary to treat a patient effectively is available to clinicians. But what if the clinician does not get around to recording a vital piece of information, or records it in the wrong place in the patient's record, or handwrites the entry illegibly, or writes it legibly but in the wrong patient's notes? What if test results have not yet been reviewed before risky treatment is carried out or dangerous medication is administered? What if the patient is allergic to penicillin? If appropriate patient

Key Points

The quality of the information in electronic patient records depends directly on the quality of data currently being recorded in paper-based records

Standards for clinical recording are needed to assure that consistent data are recorded in a structured and timely manner

The development of standards must be led by clinicians rather than managers

There must be assigned responsibility and accountability for recording of patient data

Continuous monitoring of patient data is needed to assure standards are met

information is not available, is not accurate, is not timely, or simply is not there when decisions are being made, a patient could die. That tragic possibility alone should be enough to mandate at least minimal record-keeping standards.

What is needed in the UK

So why are there no standards in the UK and why does the HIM profession not exist? The culture appears to be very similar to that of an earlier era in the USA, when no-one questioned the clinicians. But times are changing, and a new culture should be fostered where it is accepted that clear recording of a patient's care is part of optimal patient care. Relevant and accurate patient information that is readily available to clinicians when they need it will help to reduce the risk of errors in medication prescribing, in treatment, and in diagnosis. Clinicians should not be working in a vacuum, but as informed members of a healthcare team who share critical information at the point of care through the patient record.

Roderick and Roderick claim that there are two prerequisites for satisfying the information needs of the UK healthcare system.[19] First, the 'information requirements have been specified clearly' and secondly, 'the data required to satisfy the information required are being collected'. The first prerequisite is where the clinical recording standards fit in. The second involves enforcement of compliance with those standards.

Conclusion

Standards must be put in place, responsibility for monitoring and enforcing the standards must be clarified, and clear lines of accountability for meeting the standards must be drawn. Specific, up-to-date, document-controlled policies and procedures must be implemented and maintained. These should clearly specify how, when, and who should document which patient data in the patient record. Written policies and procedures are critical for the current paper-based system, the eventual electronically based system, and the transition period in between. Even when the Care Record Service is successfully launched in the NHS, the reality is that paper records will not simply vanish. They will continue to exist in some form, either as archives or as skeletal back-ups to the computerised systems, so they cannot be ignored.

The medical community must take the lead, as the surgeons did in the USA, in making the changes needed to establish the Care Record Service in the NHS. Mandating clinical recording standards is the first step, and these must come from the clinicians. Champions of the new system are aware of the difficult tasks ahead, and will be needed to encourage continuing clinician involvement in this process. Everyone who contributes information to the patient record must value the information and ensure that accurate and complete data are being recorded consistently. Cultural and behavioural shifts must take place, which will be difficult, because people are reluctant to give up power and, as is more and more evident in healthcare today, information *is* power.

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