# Medical Record Review

Medical records have progressed from paper to electronic to shared electronic, so data accuracy is increasingly important.

Examples of shared records include:

* Multidisciplinary care plans
* My Health Record – accessed by patients themselves, allied health workers, specialists, hospitals
* Referrals to other primary, secondary, and tertiary healthcare services
* Third parties

Medical records have more roles than previously and need to be fit for purpose at numerous levels, so quality is important.

### Uses of health records

1. Patients - Continuity of care, safety, healthcare outcomes
	* Safe clinical decision making
	* Effective communication between health professionals
	* Trusting partnerships with patients
	* Coordination and continuity of care
2. GPs and GP Practices – more efficiently manage patients
	* Follow-up
	* Communicate with other health professionals
	* Evidence of care (medicolegal, Medicare)
	* Quality improvements in practice or wider e.g., NPS Medicine wise Medicine Insight program
	* Practice patient cohort demographics, needs etc. @ local population health level accurate reimbursement
	* Clinical and quality improvement audits
3. Wider Community – Data use
	* Research including adverse outcomes, morbidity and mortality reviews, costs, population health, and broader intervention programs.
	* Policy including health service planning, provision, co-ordination, governance
	* Education, training, and professional development
	* Local population health
	* Intra-practice audit and targeted projects/interventions, practice population health and demographics, complaints, near misses

### Goals of Medical Record Reviews (MRR)

Medical record reviews assess the quality of records and can highlight areas for improvement. Specific review topics may vary depending on the setting e.g., community health, primary care, or hospital but the essentials of MRR are universal.

Hospital specific MMRs could assess the duration of stay, hospital acquired conditions and DRGs. Patient privacy and confidentiality are necessary when doing MRR

### Aspects of high-quality medical records

* Correct patient demographics
* Record ever every clinical encounter e.g., phone advice, presentations, correspondence
* Compiled e.g., correspondence, results are incorporated into the records
* Standardised medical terminology, abbreviations, and coded diagnoses used
* Where possible, the free text should only be used as a complement to the coding system.
* Diagnoses are evidence-based, confirmed
* Records are complete and comprehensive including the reason for presentation, history, examination, diagnostics, management diagnosis, follow-up and also PHx, SHX, FHX, allergies, medication list, alcohol and smoking history, biometrics, ATSI
* Continuity of care is evident e.g., results and issues followed up, recalls used

### Things to consider when planning and doing MRRs

* Near miss register including records issues e.g., wrong chart opened
* Completeness of data fields e.g., demographics, allergies, FHx x
* Percentage use of coded diagnoses
* Accuracy of Rx list e.g., once only medications are removed, regular Rx’s are listed as such
* Compliance with standardised abbreviation use
* Conduct ‘peer reviews’ of health records to see if they can be easily understood by other GPs.
* Trial shortcuts and templates to see if these improve notes accuracy, thoroughness e.g., re ANC visits, DM cycle of care monitoring, standardised management advice
* Allocate a team member to oversee records quality, including team culture, monitoring, staff training, procedures, policy, data safety and integrity.
* Use inbuilt software applications to monitor quality medical records indicators e.g., coded diagnoses, or prompt for reason for prescription or prompt for diagnosis or reason for consultation before closing consultation /patient encounter records.
* Include health record quality review aspects in regular practice meetings
* Conduct regular audits of the quality of health records, comparing outcomes over time or against benchmarks or targets
* Training and clinical capacity of the MRR review/s

- e.g. clinician needs to assess clinical reasoning and if there is adequate evidence for coded diagnoses, or if there is a pattern of adverse outcomes following specific device usage or procedure events, whereas non-clinician can use inbuilt clinical software audit tools for simple data e.g. % of records with allergy status or ethnicity recorded

### Improving systems

* + Implement a feedback process regarding health records to address problems raised by other healthcare professionals, other services, or patients.
	+ Keep track of near misses and mistakes in the incorporation of information from other sources to identify ways to prevent these from happening again.
	+ Subsequent reviews, retrospective or concurrent, can track the impact of post-MRR interventions to improve the quality of records and the subsequent benefits.

### Hospital Based MRRs

Can include different assessment and monitoring parameters such as:

Emergency Department

* + Vital signs recorded
	+ Main complaint recorded
	+ Initial or representation to ED
	+ Relevant physical findings recorded
	+ Recent hospital admission/procedure?
	+ Clinical progress recorded
	+ Diagnostic investigation results included
	+ Procedures and medications adequately recorded
	+ Diagnosis recorded
	+ Disposal documented, including follow up arrangements

### Doing MMRs

**GOALS**

Define the organisational goals e.g.

* + - Reduce the risk of incoming correspondence being incorporated into the incorrect patient record
		- improve the accuracy of records before uploading them to My Health Record
		- increase use of coded diagnoses to improve inhouse clinical audits & searches

Define individual doctor goals, if relevant

* + - Improve the rate of coded diagnoses as an indicator of quality practice
		- Clinical audit thoroughness
		- Identify patients due for recall, follow-up, chronic disease monitoring, vaccination etc
		- Treat to target monitoring

**BENCHMARKS**

* + - Inhouse, e.g., performance monitoring over time e.g., % of vaccination uptake in children
		- Industry standards

**PROCESS**

Outline how the review will occur

* + - Which records?
* What number of records will be assessed e.g., 30 per FTE doctor
* How will the records be selected? E.g., a randomly selected specified number of records of recent clinical encounters, e.g., every 10th consultation, or the last 30 visits seen by each doctor and nurse
* Retrospective of current records assessments?
	+ - How will they be reviewed?
* Manual data search
* Software-driven data search
* Qualitative clinical evaluation by an adequately trained clinician (or medical records auditor)
	+ - Specify what is being reviewed e.g.
* Basic data e.g., completeness of demographic data
* Status recorded e.g., ethnicity, allergies, smoking
* Currency achieved e.g., % children with UTD vaccination
* Thoroughness achieved e.g., % abnormal results followed up
* Compliance e.g., % of visits with diagnosis recorded, % of visits with coded diagnosis used
	+ - Nominate the reviewer, train if required
* Record results – e.g., spreadsheet or software report
* Analyse results
* Overall assessment
* Possible reasons for variations from expected, target or benchmark results
	+ - Actions
* Group discussions, reflection, and subsequent recommendations
* Plan and implement changes to improve records and clinical outcomes using SMART criteria

### Report your MRR in your PD portfolio

Here are some tips on what you might record

* Name of review
* practice/ health facility of review
* purpose/ goal of the review
* benchmark chosen
* process – outline how you did the review
* number of records reviewed
* selection of records reviewed
* what method was used – e.g., software, manual, external provider, NPS Medicinewise, PHN, PenCAT, Polar
* what was reviewed
* summarise the findings
* reflect on the significance of the findings regarding the specific goal
* specify your action plan arising from the MRR findings (suggest using SMART criteria)