

## MEDICAL RECORDS: ORGANIZATION AND STANDARDIZATION

Evaluating and improving your medical records procedures promotes quality and enhances the efficiency of use of records during patient care activities. Excellence in medical records documentation is also an important risk management tool.

This COLA Fast Facts checklist was developed to help physicians and office staff establish and implement standards for the content and organization of medical records.

### Organization

Does each patient's medical record minimally include:

- Their own chart or chart cover.
- Full name; Social Security number; day, month and year of birth; and office identification number on the face of the chart.
- Full name and office identification number on each chart page.
- Date-including day, month, and year-on both sides of each page of the chart.
- Patient demographic sheet.

The information on the patient demographic sheet is used as a constant to verify the identification of the patient for all future entries, so it's important that the information is accurate. Ask yourself these questions:

- Is the patient's full address included, with street address or mailing address?
- Are the patient's home and, if applicable, work telephone numbers listed?
- Is the marital status of the patient included?



- Does the record indicate the name and address of the patient's employer, if applicable?

Family practice physicians, general practitioners, or physicians who see patients within the same family unit may keep the individual charts for each member within an identified family unit file or folder.

### Content

You have many different options on how to organize the information contained in medical records. What's important is that, no matter how an office decides to organize the information, the organizational structure is standardized for every patient.

Without such standardization, physicians and other office staff have to search throughout every patient's chart to find important information. In addition, clerical errors and omissions may occur because of unorganized records. The bulleted items below are key elements to be included in every medical record:

- Place all entries in chronological order. Whether the order is ascending or descending is entirely up to each medical practice. What's vital is that the order is consistent for all patients.
- Day, month, year of each entry.
- Initials of the author of each entry or notation of the medical record.
- Problem list is easily identifiable and prominently displayed.
- When the physician is responsible for immunizations, records for immunizations should be included in the medical record.
- When a patient comes in with a medical condition, the entry should include notations regarding the pertinent history, exam, assessment, and plan of action, including necessary follow-up.
- Significant illnesses and medical conditions on the problem list to ensure the list is kept current.
- Prominent list of all allergies and/or history of adverse reactions.
- Past medical history of the patient, including serious illnesses, accidents and operations.
- Documentation of smoking habits and/or history of alcohol or substance abuse.
- Results from laboratory, x-ray, or any other tests ordered by the physician and notations that results have been reviewed.
- Ensure all written entries are completely legible so someone other than the author can read it.

COLA also recommends you include the following items in a medical record as a component of risk management:

- Photocopy of all patient prescriptions.
- Name of the staff member that assisted in any procedure or exam.
- All telephone conversations with or regarding the patient.
- Agreement of patient to accept any sample drugs or products.