Hospitals Must Design Systems to Ensure Accurate and Complete Medical Records

In accordance with Record of Care, Treatment, and Services (RC) Standard RC.01.01.01, health care organizations must make sure that all medical records accurately and completely document all orders, test results, evaluations, care plans, treatments, interventions, and care provided—along with the patients' responses to those treatments, interventions, and care. Organizations should regularly review and monitor documentation of care, treatment, and services to ensure the information is accurate and complete. An accurate and complete medical record demonstrates that practitioners have provided appropriate, safe, and high-quality care.

Medical staff involvement in the review of organizationwide medical forms and the process for documentation ensures that practitioner documentation is as accurate as possible. Forms used to complete electronic and paper medical records must be designed in a way to reflect accurate documentation. If a particular aspect of a patient assessment was not completed by a practitioner because it was not necessary for the patient's care, forms and electronic records should be designed to allow practitioners to indicate "Does Not Apply" (or something similar).

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Systems for monitoring the accuracy and completeness of medical records need to be designed to take nonapplicability into account so that practitioners do not feel obligated to indicate an assessment was completed when, in fact, it was not—thus preventing the circumstance of an "incomplete" medical record. Practitioners, including medical staff and nursing staff, should be involved in the development and review of processes for documenting patient care. Involvement of these practitioners helps to make sure that medical records systems meet the documentation needs of all practitioners and accurately reflect the patient care provided.