Redesigning the Indexed Medical Record

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by Anna Bennet, MA, RN, CPHQ, Estelle Kennedy, MA, ART, and Peggy Looney

In 1994, Calvary Hospital—a 200-bed acute care facility—transformed its performance improvement initiative: from quality assurance to quality assessment and improvement, and ultimately to a facility-wide organizational performance improvement program. At the same time, it decided to reduce operating costs. To achieve this goal, the hospital planned on reducing the number of full-time employees (FTEs). A redesign of processes and work flow was needed to reduce costs and increase efficiency while preserving the quality of Calvary's services.

For its part, the medical records committee met to develop a more efficient, user-friendly process that would also provide pertinent feedback to hospital leaders and staff, using the quality assessment and improvement plan and continuous quality improvement principles. Committee members came from various hospital disciplines and were users of the medical record, either contributing information or assembling and controlling the flow of information inside and outside of the hospital. Over the next year, the committee designed, measured, assessed, improved, and redesigned until achieving its goal.

As the committee initiated reviews of closed records, a single comment from the medical director on the difficulty of finding information within the closed medical record led to revolutionary thinking about the arrangement of Calvary's medical records. It brought forth other questions, including the necessity of reassembling the chart in a different order upon patient discharge and leaving tabs in the closed and active records. Basically, it appeared that countless hours were being spent reviewing the medical records—with questionable yield.

The committee asked medical record staff and other users of the medical record to identify problems encountered: either in preparing the medical record for review or during actual use of the record. The committee took these comments and analyzed the identified problems. The problems were:

- the open medical record was in a different order from the closed medical record
- medical records personnel time was used to reorder the medical record from the open to closed formats
- unit secretaries spent time assembling medical records that were changed once the record arrived in the medical records department
- an increased lag time in the assembly of the closed medical records
- physician dictation and review time was misused due to differing formats
- the outpatient medical record had a completely different format
- medical records were forwarded to the medical records department in an inconsistent order
- loose attachments were not always forwarded in a timely manner
- actual placement of forms and components of charts were not clearly identified, structured, or stored
- the closed medical record did not have labeled dividers, making it hard to find specific sections

Then, potential barriers to the success of this endeavor were identified. Committee members were reluctant to change the medical record format and concerned about changes affecting compliance with regulations, standards, and statutes. Other concerns included potential confusion caused by changes to the existing format and difficulties eliminating and replacing outdated forms since various departments had established their own forms.

Next, a performance improvement team addressed the issues. The team consisted of the medical director, director of medical records, assistant administrator for professional services, director of staff development, director of materials management, chief financial officer, assistant administrator for the utilization of clinical services, director of ancillary services, assistant administrator for clinical support services, and the director of outpatient/discharge planning. The team offered a mix of those familiar with the records and those with the jurisdiction to authorize change. The team first researched legal and regulatory requirements on the sequence of open or closed medical records, contacting and reviewing various organizations and references. No regulations requiring a specific sequence for closed versus open records were found.

At this point, the team moved forward to create and implement its plan. Its first task: collecting every form currently in use and creating an inventory of forms used in the medical record. Forms were then evaluated for format, content, pertinence, and duplication. Duplicate and outdated forms were removed from stock or redesigned, and all forms were presented to the medical records committee for approval and assigned a medical record inventory number. All forms—inpatient and outpatient—were assigned placement within the chart.

The second task: assembling a prototype record for review and evaluation. The team decided an index would facilitate the location of specific forms, reports, and information pertinent to the user, so it organized a redesign process that led to the final product. It designed three different tab/dividers: one with numbered tabs, one with labeled tabs, and one with numbers and labels; and two indexes: numerical and alphabetical. The numerical index lists tabs numbered from 1 to 20, followed by corresponding names (see Exhibit 1). The alphabetical index lists every form used in the medical record and, alongside the name of each form, the number of the tab where it is located in the medical record (see Exhibit 2). Sample charts were assembled in all three formats with both indexes. The team selected the number/label tab as the divider and recommended that both indexes be utilized in the medical record.

exhibit 1—numerical index

ORDER OF ACTIVE AND INACTIVE MEDICAL RECORDS

Tab

1. **Face Sheet**
   - Discharge summary (closed medical record)
   - Face sheet
2. **Admission Records**
   - Application
   - MARS
   - Admission assessments:
     - Initial medical summary
     - Nursing
     - Social work
     - Nutrition
     - Pastoral care
     - Therapeutic recreation
3. **History & Physical**
4. **Graphic Sheets**
   - Vital signs
   - IV administration record
   - Intake and output record
   - Oxygen administration record
   - Enteral feeding record
5. **Patient/Family Education**
   - Interdisciplinary patient/family education record
   - Learner assessment
   - Patient/family advocate office
   - Admitting office patient/family education

exhibit 2—alphabetical index

ORDER OF ACTIVE AND INACTIVE MEDICAL RECORDS

Subject	Tab
Admitting patient/family education	5
Admission assessments	2
Advance directives	15
Advance directive (OPD)	17
Alternate level of care	14
Ambulance report	16
Application	2
Blood transfusion administration record	8
Calvary hospital laboratory reports	8
Clothing sheet	16
Consent for autopsy	16
Consent to obtain medical data	16
Consents	11
Consent to taking and publication of photographs	16
Consultations (OPD)	17
Consults	10
Continuous observation	6
CT scan	9
Certificate of death	16
Diabetic chart	6
Discharge follow-up	14
Discharge notice	14
Discharge planning	14
Discharge summary	1
Discharge transfer form	14
Do not resuscitate	15
EKG	9
Enteral feeding record	4
Face sheet	1
Flow sheet treatment form (OPD)	17
Graphic sheets	4

The third task: evaluating sample dividers and a medical record chart cover/holder. The team evaluated several dividers based on cost and durability and selected a chart cover with an expandable clip. This enabled users to facilitate chart review and add loose attachments without dismantling the record. The redesigned medical record was presented to the hospital's quality assessment and improvement committee for review and approval.

The fourth task: implementing the new medical record through a hospital-wide education program. The unit secretaries were the first to be educated. Education sessions for medical, nursing, and other clinical staff focused on the new format design and

medical records process. Indexes and dividers were delivered to the patient units for inclusion in each of the new binders that held the patient's records. Once the patient was discharged, the record would no longer be reassembled in a different order; it would simply be removed from the binder and forwarded to the medical records department in the current order. Medical records staff would review the chart for format, insert any loose attachments, and process the chart as usual.

Implementation of the redesigned record took place in January 1996, with several positive outcomes:

- The single format for inpatient and outpatient open and closed medical records reduced time spent assembling charts in the medical records department. The time decreased from an average of 53 minutes to an average of 26 minutes
- Through process redesign and attrition, the medical records department reduced its staff by 1.5 FTEs, resulting in annual financial savings of $77,000 in salaries and benefits. Before the redesign, these employees' main responsibility was reordering and reassembling medical records from open to closed format
- Physicians, nursing unit secretaries, other staff members, external reviewers, and other outside consultants said the new format helped them locate information faster and was more organized and easy to navigate

Currently, all medical records remain formatted in this method. Positive feedback from staff, consultants, and surveyors continues. Furthermore, incorporating staff members at all levels and from various departments into the project fostered a cooperative spirit within the facility and led to the identification of additional opportunities for medical record improvement.

***Anna Bennet**, MA, RN, CPHQ, is the Assistant Administrator for the Utilization of Clinical Services, **Estelle Kennedy**, MA, ART, is the Director of Medical Records, and **Peggy Looney** is the Assistant Administrator for Professional Services at Calvary Hospital in Bronx, NY.*

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