DISC | Corporation

Health Information. Optimized.

HOW-TO GUIDE:
9 Tips for Conducting a Patient Chart Audit

Introduction

As a healthcare provider, your health information management (HIM) processes are more than just charts, filing and paperwork. They represent a vital step in delivering quality care and improving the overall patient experience.

But all too often, organizations fail to evaluate how well these processes are actually being followed. This results in medical records that are filled with errors – leaving both providers and patients at risk.

If you're looking to ensure your medical records are both accurate and compliant, the first step involves identifying the potential problem areas. That's where a patient chart audit comes in.

Regularly auditing your medical records is a great way to not only catch errors, but to identify entire HIM processes that need improvement. And while conducting your own internal patient chart audit does take time, the process is simpler than you may think.

Ready to get started? Here's what you need to know about conducting your own patient chart audit.

What are the Benefits of a Patient Chart Audit?

In today's fast-paced healthcare environment, every organization is short on time and resources. But taking the time to regularly audit your medical records can generate a significant return on your investment. The benefits include:

Accuracy

Improving the accuracy of your medical records is one of the most important benefits of conducting an internal patient chart audit. That's because chart errors can directly impact patient care. If a document is filed incorrectly, a provider may not be notified that follow-up is required. Or, if a document is filed to the wrong patient chart, it may result in a HIPAA privacy violation.

Compliance

Every type of patient record has its own documentation requirement. By identifying process failures, such as late indexing or filing, you can make adjustments to help ensure your medical records remain compliant.

Standardization

For health systems and providers working out of multiple locations, it's not uncommon for patient charts to be handled differently from office to office. Regular patient chart audits can help you identify these discrepancies – allowing you to develop standardized processes across your organization. When processes are standardized, providers can quickly find patient data because it's consistently filed in the same location and labeled the same way every time. Standardization also allows you to pull comprehensive reports on specific documents.

Efficiency

By taking a closer look at your medical records, you can uncover opportunities to save time and improve workflows related to indexing and filing.

What Problem Areas can a Patient Chart Audit Uncover?

Daily chart indexing and filing errors

The most common issue plaguing daily chart indexing is document misfiles. Whether these fax or scanned documents are filed to the wrong patient, document type, or even sent to the wrong provider, accuracy is usually the culprit. Inconsistent filing procedures between staff or clinics can also cause problems.

Why do these problems occur? When filing processes rely on manual data entry, mistakes are bound to happen. Hand-keyed data is often less than 99% accurate. That 1% difference can lead to big problems for your organization – especially when you consider that a 200-provider organization requires about 40 million clicks per year when entering faxes and scanned documents.

Additionally, patient documents may be filed differently depending on the preferences of an individual provider or staff member. These variables in your filing workflow can cause inconsistencies in the medical record.

Open orders

For a large healthcare organization, open referral and lab orders can number in the hundreds of thousands. It's daunting, to say the least. And the closing process can be slow and tedious, especially while fulfilling tracking and reporting obligations.

Open orders leave informational gaps that increase patient risk – and the likelihood of medical error. This can lead to missed or incorrect diagnoses, or cause a patient to have tests repeated unnecessarily.

Duplicate documents

Duplicate documents create more work for everyone on your team. Providers have more documentation to sift through. Your HIM team has a longer queue of unindexed files. And your IT department has more data to manage. Duplicates are a drain on your organizational processes.

Inefficient processes – both internal and external – cause documents to get reproduced and repeatedly indexed. With so many other responsibilities, your team likely struggles to catch them when they occur. Over time, this creates a serious and growing issue.

Paper Workflows

Even with an EHR, many organizations still rely on paper documents. Paper workflows are resource intensive. Each step of the process may not seem like much on its own, but collectively, manual indexing consumes a substantial amount of your team's time and energy.

Scanning, indexing, tasking – it all adds up. And this slow, error-prone process also takes your staff away from providing direct patient care.

9 TIPS FOR PATIENT CHART AUDITS

We know the word "audit" can sound intimidating at first. But the truth is, you don't need to hire an outside third party to audit your medical records. All it takes is a little bit of knowledge and direction.

1

Know your policies

Before starting your audit, make sure you're familiar with your organization's internal policies regarding medical records. Review the policies for each document type you're likely to encounter during the audit. And pay particular attention to how long it should take to index and file documents in your EHR.

2

Choose a focus area

Depending on the size of your organization, it may be helpful to choose one specific focus for your audit. This could include patient charts from a certain office or workflow such as electronic faxes or scanned documents. Narrowing your focus can help you identify recurring issues specific to those providers. It also allows you to target areas that have the biggest impact, or return on investment, for your organization.

3

Determine the scope

Next, you'll need to determine the scope of your patient chart audit. Since the goal is to uncover errors and inconsistencies, the scope of your audit should be large enough to serve as a representative sample of your organization's patient population – but not so large that the audit process becomes overwhelming. Here are a few tips for determining your audit scope:

- **Sample size:** When auditing patient charts, we recommend examining a minimum of 1,000 documents. This should provide you with enough information to discover patterns in the medical record indexing and filing.

- **Random sampling:** To get a representative view of your medical records, choose a random sampling of patient charts for your audit. You can do this by starting with a specific last name or letter. Then, work through your patient database alphabetically until you've audited 1,000 documents.
- **Length of time:** If this is your first audit, review documents that have been filed within the past year. After that, you can conduct quarterly audits where it will only be necessary to review documents filed in the last three months.

During this step, you may also want to enlist your HIM team or medical records manager. They may be able to provide best practices for accessing charts during your audit.

4 Define measurement criteria

Before you begin the audit process, identify the measurement criteria you will use. Here are some factors you will be tracking in this tool:

- Was the document filed to the patient chart within 24 hours of receiving it?
- Was the document filed to the correct patient?
- Was the document correctly separated by document type and date of service (indexed from a batch of multiple documents such as an electronic fax)?
- Is the correct document type listed?
- Is the date and provider information correct?
- Did the provider acknowledge the document (if applicable)? If so, was it acknowledged on time?
- Are there any open orders in the patient chart?
- Which user indexed the document?

Develop a written list of measurement criteria specific to your patient chart audit. Then, use this list as a reference during the audit process.

5 Record any errors

Now that you've determined the parameters of your patient chart audit, it's time to start the review process. Open the patient charts that fall within the scope of your audit and record any data relevant to the measurement criteria identified above.

As you review medical records, it helps to record the results of your audit using a spreadsheet. Using this method will allow you to easily track the number of documents you've audited, while helping you analyze data after the audit is complete.

In addition to recording the raw data, look for any patterns that begin to emerge – particularly if they relate to a specific document type, location, user or workflow.

Click here to download our free patient chart audit template.

6 Analyze the data

Once your audit is complete you will have the information needed to analyze the data. Use your spreadsheet to calculate your audit results. Some helpful metrics may include:

- **Total number of documents audited**
  In addition to representing the sample size of your audit, this number will serve as the basis for calculations of your inaccuracy and late rates.

- **Inaccuracy rate**
  To calculate the total percentage of chart errors, divide the number of errors found by the number of documents audited. It may also be helpful to calculate inaccuracy rates for each error or document type.

- **Most common errors**
  Categorize the types of errors found during your chart audit. Then, rank them from the most prevalent to the least. This can help pinpoint inconsistencies in your existing HIM processes.

- **Most concerning errors**
  When reviewing your data, consider the significance of each error type. For example, filing a document to the wrong patient chart could have major implications – including potential HIPAA violations. Similarly, filing a document under the wrong document type could result in a bypass of the provider review – delaying patient care or communication. Other errors, like a mistake in the "date of service" field, are still important to catch, but will have fewer consequences.

- **Late rate**
  Calculate the percentage of filings that take more than 24 hours to reach the patient chart by dividing the number of late filings by the total number of documents audited. This number will help you discern whether late filings are the result of occasional isolated incidents, or represent a larger operational problem.

- **Most common late filings**
  Categorize all of your late filings by document type to understand if there are any commonalities. For example, your workflow may be filing faxes on time, but scanned documents are consistently filed late. In this case, you may be able to identify an internal process or workflow issue that needs addressed.

Compile this information into a brief report that can be shared within your organization.

7 Evaluate problem areas

Using the results of your patient chart audit, investigate the reasons for the most common errors in your medical records. During this step, it's also important to gather feedback from your physicians and clinical staff.

For example, if certain documents are being filed under the wrong document type, there could be a misunderstanding or lack of standardization between office locations. Are documents routinely being indexed and filed late? If so, ask for feedback related to the barriers for on-time filing.

8 Implement process changes Evaluate problem areas

With the final step of your audit complete, you can now begin to look for process changes that will help reduce your error rate and improve on-time filings.

When it comes to medical record errors, most can be attributed to human error – a natural result of entering patient data by hand. To address this issue, you may want to consider an automated solution, such as SmartFiler from DISC Corporation.

By integrating with your electronic medical record, SmartFiler's time-saving technology can properly index documents automatically. This not only boosts indexing accuracy and compliance up to 99.99%, but also reduces the administrative burden placed on your staff.

If open orders are a problem, SmartFiler can help with that, too. Our service is designed to eliminate your team's manual order closing as soon as a test or lab result is received – saving time and reducing the number of open orders in your system.

9 Establish a regular audit schedule

With your first patient chart audit complete, you'll have produced actionable data to help reduce medical record errors and improve compliance. But don't stop there. To develop a culture of continuous improvement, establish a regular audit schedule. We recommend conducting patient chart audits on a quarterly basis to help catch any errors or inconsistencies before they have a significant impact on patient care.

Why work with DISC Corporation

- Contracted by hundreds of healthcare organizations across the country
- 75 years of experience
- Billions of documents indexed
- Integrated with every EHR system, including Epic, Cerner, Allscripts, NextGen, eClinicalWorks and Greenway

Download our free patient chart audit template

If you're ready to begin your first patient chart audit, start by downloading our patient chart audit template. This free resource is our gift to you. Use it to record the results of your chart audit and uncover ways to improve the accuracy of your medical records.

Download now

Schedule a free patient chart assessment today

Need help conducting your first audit? Let the experts at DISC walk you through the audit process during a free, 30-minute patient chart assessment. During this call, we'll offer:

- An overview of how to conduct an audit using your own electronic medical record.
- A customized assessment of potential problem areas.
- Improvement ideas based on your specific pain points.

Schedule now

Or email our EVP, KC Frank at kfrank@disccorporation.com