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BROOKHAVEN NATIONAL LABORATORY

MEMORANDUM

DATE: 11/3/72

TO: Members of the Medical Record Committee

FROM: W. A. Finn

SUBJECT: JCAH Hospital Survey Questionnaire

Attached are the 9 pages of the Hospital Survey Questionnaire Part I (JCAH) pertaining to the Medical Record Section and showing the replies to each question as forwarded last June to the JCAH as the required preliminary to their visit.

Should you desire more detailed information prior to the next Medical Record Committee meeting at which these answers will be discussed, please call me on Extension 3630.

The Medical Research Center
Brookhaven National Lab
Upton, L. I., New York

REPOSITORY Records Holding Area Bldg. 494
COLLECTION Meetings/Minutes/Agendas
BOX No. 3
FOLDER Medical Records Committee 1969-1973

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JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

MEDICAL RECORD SERVICES

PRINCIPLE

The hospital shall maintain such facilities and services as are adequate to provide medical records that are accurately documented, readily accessible and easily used for retrieving and compiling information.

I. REQUIREMENTS AND PURPOSES

STANDARD

An adequate medical record shall be maintained for every person admitted as an inpatient, outpatient or emergency patient.

1. A medical record is maintained for every:
(Mark the box ☒ of each applicable term.) K.1.1(3)
   a. Inpatient ..... a. ☒
   b. Outpatient (organized OPD clinics) ..... b. ☒
   c. Emergency patient not admitted ..... c. ☒

2. Are medical record entries dated? ..... 2. ✓ K.1.2
   1. Routinely.
   2. Occasionally.
   3. Never.

3. Are entries in the medical record authenticated by means of signature, initials, stamp of signature or computer key? ..... 3. ✓ K.1.3
   1. Routinely.
   2. Occasionally.
   3. Seldom.
   4. Never.

4. Has the medical staff approved a list of symbols and abbreviations for use in medical records ..... 4. ✓ K.1.4
   1. Yes.
   2. No, but such a list is being prepared.
   3. No, symbols and abbreviations are not used.
   4. No.

5. If a list of approved symbols and abbreviations is maintained it is:
(Mark the box ☒ of each applicable term or statement.) K.1.5(4)
   a. A part of the medical record ..... a. ☐
   b. In patient care areas ..... b. ☒
   c. In the medical record department ..... c. ☒
   d. The hospital does not need such a list ..... d. ☐

6. Is the final diagnosis recorded in full, without the use of symbols or abbreviations? 6. ✓ K.1.6
   1. Routinely.
   2. Occasionally.
   3. Seldom.
   4. Never.

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7. When a patient is transferred to another medical facility, appropriate medical, nursing and social information is transferred to the site of continued care: 7. 1/1 K.1.7

1. Routinely.
2. Occasionally.
3. Seldom.
4. Never.

8. Does the hospital use a standard procedure for the transfer of medical record information to other health care facilities? 8. 3 K.1.8

1. Yes.
2. Such a procedure is being developed.
3. No.

9. Indicate the methods used for transfer of medical record information to other health care facilities: (Mark the box ☒ of each applicable term or statement.) K.1.9(5)

a. Abstract of record prepared by medical records personnel ..... a. ☐
b. Clinical resume prepared by the responsible physician ..... b. ☒
c. Copy of all or of part of medical record ..... c. ☒
d. Approved transfer form ..... d. ☒
e. Other (specify)_____ e. ☐

10. Medical records are used in: (Mark the box ☒ of each applicable term.) K.1.10(3)

a. Retrospective study and medical care evaluation ..... a. ☒
b. Education ..... b. ☒
c. Research ..... c. ☒

11. Comments by Respondent.

Use this space to clarify any of the questions in this portion of the questionnaire. When doing so, refer to the question by number.

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II. BASIC CONTENT

STANDARD

The medical record shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment and to document the results accurately.

1. The completed medical record of each inpatient contains the following: (Mark the box ☒ of each applicable term or statement.)

a. Identification data and consent forms. K.2.1.1(5)

1. Patient's name ..... 1. ☒
2. Patient's address ..... 2. ☒
3. Patient's age ..... 3. ☒
4. Next of kin ..... 4. ☒
5. Appropriate authorizations and consents ..... 5. ☒

b. History. K.2.1.2(6)

1. Chief complaint ..... 1. ☒
2. Details of present illness ..... 2. ☒
3. Inventory of systems ..... 3. ☒
4. Medical history ..... 4. ☒
5. Social history ..... 5. ☒
6. Family history ..... 6. ☒

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c. Report of physical examination. K.2.1.3

1. Relevant findings from assessment of all systems ..... 1. ☒

d. Diagnostic and therapeutic orders. K.2.1.4(2)

1. Orders written by authorized house officers and by individuals granted clinical privileges ..... 1. ☒
2. Authenticated transcriptions of verbal orders ..... 2. ☒

e. Observations. K.2.1.5(4)

1. Progress notes ..... 1. ☒
2. Consultation reports ..... 2. ☐
3. Nurses' notes ..... 3. ☐
4. Entries made by allied health personnel ..... 4. ☐

f. Reports of actions and findings, where applicable. K.2.1.6(13)

1. Pathology and clinical laboratory reports ..... 1. ☒
2. Radiologic examination reports ..... 2. ☐
3. Other diagnostic procedures ..... 3. ☐
4. Therapeutic procedures ..... 4. ☒
5. Preoperative diagnosis authenticated by surgeon ..... 5. ☐
6. Operative report, containing
   a. Findings ..... a. ☐
   b. Description of technique used ..... b. ☐
   c. Report of tissue removed or altered ..... c. ☐
   d. Postoperative diagnosis ..... d. ☐
   e. Report on patient's condition at conclusion of procedure ..... e. ☐
7. Obstetrical report, including
   a. Prenatal report ..... a. ☐
   b. Report of delivery ..... b. ☐
   c. Postnatal report ..... c. ☐

g. Conclusion. K.2.1.7(8)

1. Provisional diagnosis at time of admission ..... 1. ☒
2. Final diagnosis ..... 2. ☒
3. Clinical resume, including
   a. Reason for patient's admission ..... a. ☒
   b. Significant findings (examinations and reports) ..... b. ☒
   c. Treatment received in the hospital ..... c. ☒
   d. Patient's condition on discharge ..... d. ☒
   e. Plans for future care ..... e. ☒
4. Necropsy protocol ..... 4. ☒

2. Are verbal orders so identified in the medical record? ..... 2. ☑ K.2.2

1. Yes.
2. No.
3. Verbal orders are not accepted.

3. Does the entry for a verbal order show the date on which the entry was authenticated by the responsible practitioner? ..... 3. ☑ K.2.3

1. Routinely.
2. Occasionally.
3. Seldom or never.
4. Verbal orders are not accepted.

4. Are reports of diagnostic procedures performed by a source outside the hospital acceptable? ..... 4. ☑ K.2.4

1. Yes, if the source is approved by the medical staff.
2. Yes, from any source.
3. No.

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5. Are discharge diagnoses recorded in the terminology of a recognized system of disease nomenclature? ..... 5. [1] K.2.5

1. Routinely.
2. Occasionally.
3. Never.

6. Does the provisional anatomic diagnosis following necropsy become part of the medical record within 72 hours? ..... 6. [2] K.2.6

1. Routinely.
2. Occasionally.
3. Never.

7. Does the complete necropsy protocol become part of the medical record within 3 months? ..... 7. [2] (1) K.2.7

1. Routinely.
2. Occasionally.
3. Never.

8. Is a copy of the clinical resume sent, with the patient's written consent, to any known practitioner or agency who will be responsible for the patient's future medical care? ..... 8. [1] K.2.8

1. Yes, routinely.
2. Yes, upon request of the practitioner or agency.
3. No.

9. Is responsibility for regular analysis of medical records as documents vested in a medical staff committee? ..... 9. [1] K.2.9

1. Yes.
2. No.

IF YOUR ANSWER TO QUESTION 9 WAS NO, PROCEED TO TITLE III, CHARACTERISTICS OF ACCEPTABLE RECORDS.

10. The committee responsible for the adequacy of medical records includes: (Mark the box ☒ of each applicable term.) K.2.10(4)

a. Medical staff members ..... a. ☒
b. Medical record librarian ..... b. ☒
c. Nursing services representatives ..... c. ☒
d. Others (specify) Hospital Administration d. ☒

11. The medical records committee performs the following tasks: (Mark the box ☒ of each applicable statement.) K.2.11(7)

a. Reviews and approves medical record forms ..... a. ☒
b. Develops and reviews policies covering the recording of information in the medical record ..... b. ☒
c. Ensures proper storage, filing, indexing and availability of all records ..... c. ☒
d. Reviews entries for acceptability of terminology ..... d. ☒
e. Reviews recording of diagnoses with reference to identification of site and etiology ..... e. ☒
f. Reviews content of medical records with reference to adequacy of recorded information for effective medical care evaluation ..... f. ☒
g. Scans current inpatient records for compliance with existing medical staff rules ..... g. ☒

12. The committee reviews and evaluates emergency department records ..... 12. [4] K.2.12

1. Routinely.
2. Occasionally.
3. Seldom or never.
4. The hospital has no emergency department.

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13. The committee reviews and evaluates outpatient records from the hospital's organized outpatient department ..... 13. [2] K.2.13

1. Routinely.
2. Occasionally.
3. Seldom or never.
4. The hospital has no organized outpatient department.

14. Indicate the approximate number of completed medical records reviewed each month by the committee: ..... 14. [0 1 6] K.2.14

15. Comments by Respondent.

Use this space to clarify any of the questions in this portion of the questionnaire. When doing so, refer to the question by number.

13-Outpatient service not an organized Department

1-4 6+7— No Surgical nor obstetrical services

III. CHARACTERISTICS OF ACCEPTABLE RECORDS

STANDARD

Medical records shall be confidential, current and accurate.

1. Are there written policies and procedures governing the release of medical record information? ..... 1. [1] K.3.1

1. Yes.
2. No.

2. Medical record information is released upon:
(Mark the box ☒ of each applicable term or statement.) K.3.2(3)

a. Written consent of the patient ..... a. ☒
b. Receipt of a court order ..... b. ☒
c. Other (specify)_____ c. ☐

3. The patient's history and report of the physical examination are routinely made part of the medical record: ..... 3. [2] K.3.3

1. Within 24 hours after admission.
2. Within 48 hours after admission.
3. Other (specify)_____

4. A signed operative report becomes a part of the medical record within 24 hours after the operation: ..... 4. [ ] K.3.4

1. Routinely.
2. Occasionally.
3. Seldom.

5. Indicate the approximate number of current inpatient records reviewed each month by the medical records committee: ..... 5. [0 1 2] K.3.5

6. Are records of discharged patients completed within 15 days following discharge? 6. [1] K.3.6

1. Routinely.
2. Sometimes.
3. Seldom.
4. Never.

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7. Is a list or file of incomplete medical records maintained? ..... 7. [1] K.2.7

1. Yes.
2. No.

8. Indicate the number of medical records which are presently incomplete: ..... 8. [0|0|1|0] K.3.8

9. Describe briefly the chief reasons records are incomplete:

Medical record kept open until all lab work has been entered and reviewed. Because of hospitals research mission lab work may be far more extensive than in community hospital

10. The parts of the medical record that are the primary responsibility of the medical practitioner are authenticated by him when these are entered by members of the house staff ..... 10. [ ] K.3.10

1. Routinely.
2. Sometimes.
3. Seldom.
4. Never.

11. Comments by Respondent.

Use this space to clarify any of the questions in this portion of the questionnaire. When doing so, refer to the question by number.

1/ - No Surgical Service

10 No Separate house staff

IV. ORGANIZATION, STAFFING AND FACILITIES

STANDARD

The medical record department shall be adequately directed, staffed and equipped to facilitate the accurate processing, checking, indexing and filing of all medical records.

1. The Chief Medical Record Librarian is ..... 1. [1] K.4.1

1. A registered record librarian.
2. An accredited record technician.
3. Neither of the above.

2. The services of a registered record librarian are available ..... 2. [1] K.4.2

1. Full time.
2. Part time.
3. As a consultant.
4. Such services are not available.

3. Indicate the number of hours in the usual work week of a full time employee in your department ..... 3. [3] K.4.3

1. 35.
2. 37½.
3. 40.
4. Other (specify)_____

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4. Please give the following information for Medical Record Services personnel presently employed.

Personnel

Position	No. of Full Time Employees K.4.4.1(11)	No. of Part Time Employees K.4.4.2(11)	Total Hrs. per Week Worked by Part Time Employees K.4.4.3(11)
a. Chief Medical Record Librarian	01		
b. Other supervisory personnel			
1. RRL			
2. ART			
3. Other			
c. Medical secretaries	00	01	010
d. Medical stenographers or transcriptionists	01	01	020
e. Coding personnel			
f. Discharge analysis clerks			
g. Abstractors for insurance (clerks)			
h. Messengers			
i. All other personnel			
j. Total, all categories	002 K.4.4.4	002 K.4.4.5	0050 K.4.4.6

5. Indicate the number of hours per day the medical record department is open and staffed.

K.4.5(4)

a. Monday through Friday ..... a. 08
b. Saturday ..... b.
c. Sunday ..... c.
d. Holidays ..... d.

6. Medical record service personnel provide transcription service for:
(Mark the box ☒ of each applicable term.)

K.4.6(10)

a. Clinical resumes ..... a. ☒
b. Consultation reports ..... b. ☒
c. Electrocardiogram reports ..... c. ☒
d. Emergency service reports ..... d. ☐
e. Histories and physical examination reports ..... e. ☐
f. Operative reports ..... f. ☒
g. Outpatient clinic reports ..... g. ☒
h. Pathology reports ..... h. ☒
i. Radiology reports ..... i. ☒
j. Other (specify)_____ j. ☐

7. Statistical information maintained includes:
(Mark the box ☒ of each applicable term or statement.)

K.4.7(12)

a. Total admissions ..... a. ☒
b. Total discharges ..... b. ☒
c. Admissions by service or department ..... c. ☐
d. Discharges by service or department ..... d. ☒
e. Discharges by patient age ..... e. ☐
f. Categorization by primary (principal) discharge diagnosis ..... f. ☐
g. Average length of stay ..... g. ☒
h. Average length of stay by diagnosis ..... h. ☐
i. Occupancy rate ..... i. ☐
j. Mortality rate ..... j. ☐
k. Autopsy rate ..... k. ☐
l. Other (specify)_____ l. ☐

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8. Indicate which of the following indexes/registries are maintained by the medical record service. (Mark the box ☒ of each applicable term.)

Index or Registry	Manual System K.4.8.1(8)	Hospital-Based (Rented or shared) EDP System K.4.8.2(8)	Subscription to Outside EDP System K.4.8.3(8)
a. Master patient index	☒	☐	☐
b. Disease and operative index (maintained either individually or in combination)	☒	☐	☐
c. Physician's index	☒	☐	☐
d. Patient number registry	☒	☒	☐
e. Birth registry	☐	☐	☐
f. Death registry	☐	☐	☐
g. Tumor registry	☐	☐	☐
h. Other (specify) Isotope Index	☐	☒	☐

9. Do medical record services personnel participate in educational programs? 9. 3 K.4.9

1. Routinely.
2. Occasionally.
3. Seldom.
4. Never.

10. Indicate the type of programs offered. (Mark the box ☒ of each applicable term.) K.4.10(3)

a. Orientation ..... a. ☐
b. Inservice education ..... b. ☐
c. Continuing education ..... c. ☐

11. Comments by Respondent.

Use this space to clarify any of the questions in this portion of the questionnaire. When doing so, refer to the question by number.

V. RETRIEVAL SYSTEM

STANDARD

The medical record department shall maintain a system of identification and filing to facilitate the prompt location of a patient's medical record.

1. Are the patient's name and identification number recorded on each sheet of the medical record? ..... 1. ✓ K.5.1

1. Yes.
2. No.

2. Is a master index by patient name maintained? ..... 2. ✓ K.5.2

1. Yes.
2. No.

3. Is medical record information on inpatients and outpatients (with the possible exception of outatients referred for diagnostic tests only) concentrated in a single record? ..... 3. ✓ K.5.3

1. Yes.
2. No.

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4. Indicate the system used to identify medical records.
(Mark the box ☒ of each applicable term.) K.5.4(3)

a. Unit numbering ..... a. ☒
b. Modified unit numbering ..... b. ☐
c. Other (specify)_____ c. ☐

5. Is there an established method of recording the withdrawal of medical records? .... 5. [/] K.5.5

1. Yes.
2. No.

6. Records of emergency service patients who are not admitted as inpatients are:
(Mark the box ☒ of each applicable statement.) K.5.6(4)

a. Filed in the emergency service area ..... a. ☒
b. Filed in the medical record department with any other records pertaining to the patient ..... b. ☐
c. Filed in the medical record department as a separate record ..... c. ☐
d. The hospital does not provide emergency services ..... d. ☐

7. The disease and operative classification used is:
(Mark the box ☒ of each applicable term.) K.5.7(4)

a. ICDA-8 ..... a. ☒
b. H-ICDA ..... b. ☐
c. Standard Nomenclature of Disease and Operations ..... c. ☐
d. Other (specify)_____ d. ☐

8. Indicate the approximate number of months for which disease and operative indexing is backlogged. 8. [ ] K.5.8

1. 2 months or less.
2. 3-5 months.
3. 6-11 months.
4. 12 months or more.

9. How are inactive medical records preserved? ..... 9. [/] K.5.9

1. In original form.
2. Microfilmed.
3. Other (specify)_____

10. Comments by Respondent.

Use this space to clarify any of the questions in this portion of the questionnaire. When doing so, refer to the question by number.

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